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Subtitle H—Medicaid

CHAPTER 1—MANAGED CARE

**SEC. 4701. STATE OPTION OF USING MANAGED CARE;
CHANGE IN TERMINOLOGY.**

(a) USE OF MANAGED CARE GENERALLY.—Title XIX is amended by redesignating section 1932 as section 1933 and by inserting after section 1931 the following new section:

“PROVISIONS RELATING TO MANAGED CARE

“SEC. 1932. (a) STATE OPTION TO USE MANAGED CARE.—

“(1) USE OF MEDICAID MANAGED CARE ORGANIZATIONS AND PRIMARY CARE CASE MANAGERS.—

“(A) IN GENERAL.—Subject to the succeeding provisions of this section, and notwithstanding paragraph (1), (10)(B), or (23)(A) of section 1902(a), a State—

“(i) may require an individual who is eligible for medical assistance under the State plan under this title to enroll with a managed care entity as a condition of receiving such assistance (and, with respect to assistance furnished by or under arrangements with such entity, to receive such assistance through the entity), if—

“(I) the entity and the contract with the State meet the applicable requirements of this section and section 1903(m) or section 1905(t), and

“(II) the requirements described in the succeeding paragraphs of this subsection are met; and

“(ii) may restrict the number of provider agreements with managed care entities under the State plan if such restriction does not substantially impair access to services.

“(B) DEFINITION OF MANAGED CARE ENTITY.—In this section, the term ‘managed care entity’ means—

“(i) a medicaid managed care organization, as defined in section 1903(m)(1)(A), that provides or

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1 arranges for services for enrollees under a contract
2 pursuant to section 1903(m); and

3 “(ii) a primary care case manager, as defined
4 in section 1905(t)(2).

5 “(2) SPECIAL RULES.—

6 “(A) EXEMPTION OF CERTAIN CHILDREN WITH
7 SPECIAL NEEDS.—A State may not require under para-
8 graph (1) the enrollment in a managed care entity of
9 an individual under 19 years of age who—

10 “(i) is eligible for supplemental security in-
11 come under title XVI;

12 “(ii) is described in section 501(a)(1)(D);

13 “(iii) is described in section 1902(e)(3);

14 “(iv) is receiving foster care or adoption as-
15 sistance under part E of title IV; or

16 “(v) is in foster care or otherwise in an out-
17 of-home placement.

18 “(B) EXEMPTION OF MEDICARE BENE-
19 FICIARIES.—A State may not require under paragraph
20 (1) the enrollment in a managed care entity of an indi-
21 vidual who is a qualified medicare beneficiary (as de-
22 fined in section 1905(p)(1)) or an individual otherwise
23 eligible for benefits under title XVIII.

24 “(C) INDIAN ENROLLMENT.—A State may not re-
25 quire under paragraph (1) the enrollment in a managed
26 care entity of an individual who is an Indian (as de-
27 fined in section 4(c) of the Indian Health Care Im-
28 provement Act of 1976 (25 U.S.C. 1603(c)) unless the
29 entity is one of the following (and only if such entity
30 is participating under the plan):

31 “(i) The Indian Health Service.

32 “(ii) An Indian health program operated by an
33 Indian tribe or tribal organization pursuant to a
34 contract, grant, cooperative agreement, or compact
35 with the Indian Health Service pursuant to the In-
36 dian Self-Determination Act (25 U.S.C. 450 et
37 seq.).

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1 “(iii) An urban Indian health program oper-
2 ated by an urban Indian organization pursuant to
3 a grant or contract with the Indian Health Service
4 pursuant to title V of the Indian Health Care Im-
5 provement Act (25 U.S.C. 1601 et seq.).

6 “(3) CHOICE OF COVERAGE.—

7 “(A) IN GENERAL.—A State must permit an indi-
8 vidual to choose a managed care entity from not less
9 than two such entities that meet the applicable require-
10 ments of this section, and of section 1903(m) or section
11 1905(t).

12 “(B) STATE OPTION.—At the option of the State,
13 a State shall be considered to meet the requirements of
14 subparagraph (A) in the case of an individual residing
15 in a rural area, if the State requires the individual to
16 enroll with a managed care entity if such entity—

17 “(i) permits the individual to receive such as-
18 sistance through not less than two physicians or
19 case managers (to the extent that at least two phy-
20 sicians or case managers are available to provide
21 such assistance in the area), and

22 (ii) permits the individual to obtain such as-
23 sistance from any other provider in appropriate cir-
24 cumstances (as established by the State under reg-
25 ulations of the Secretary).

26 “(C) TREATMENT OF CERTAIN COUNTY-OPERATED
27 HEALTH INSURING ORGANIZATIONS.—A State shall be
28 considered to meet the requirement of subparagraph
29 (A) if—

30 “(i) the managed care entity in which the indi-
31 vidual is enrolled is a health-insuring organization
32 which—

33 “(I) first became operational prior to Jan-
34 uary 1, 1986, or

35 “(II) is described in section 9517(c)(3) of
36 the Omnibus Budget Reconciliation Act of

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1 1985 (as added by section 4734(2) of the Om-
2 nibus Budget Reconciliation Act of 1990), and

3 “(ii) the individual is given a choice between
4 at least two providers within such entity.

5 “(4) PROCESS FOR ENROLLMENT AND TERMINATION
6 AND CHANGE OF ENROLLMENT.—As conditions under
7 paragraph (1)(A)—

8 “(A) IN GENERAL.—The State, enrollment broker
9 (if any), and managed care entity shall permit an indi-
10 vidual eligible for medical assistance under the State
11 plan under this title who is enrolled with the entity
12 under this title to terminate (or change) such enroll-
13 ment—

14 “(i) for cause at any time (consistent with sec-
15 tion 1903(m)(2)(A)(vi)), and

16 “(ii) without cause—

17 “(I) during the 90-day period beginning
18 on the date the individual receives notice of
19 such enrollment, and

20 “(II) at least every 12 months thereafter.

21 “(B) NOTICE OF TERMINATION RIGHTS.—The
22 State shall provide for notice to each such individual of
23 the opportunity to terminate (or change) enrollment
24 under such conditions. Such notice shall be provided at
25 least 60 days before each annual enrollment oppor-
26 tunity described in subparagraph (A)(ii)(II).

27 “(C) ENROLLMENT PRIORITIES.—In carrying out
28 paragraph (1)(A), the State shall establish a method
29 for establishing enrollment priorities in the case of a
30 managed care entity that does not have sufficient ca-
31 pacity to enroll all such individuals seeking enrollment
32 under which individuals already enrolled with the entity
33 are given priority in continuing enrollment with the en-
34 tity.

35 “(D) DEFAULT ENROLLMENT PROCESS.—In car-
36 rying out paragraph (1)(A), the State shall establish a
37 default enrollment process—

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1 “(i) under which any such individual who does
2 not enroll with a managed care entity during the
3 enrollment period specified by the State shall be
4 enrolled by the State with such an entity which has
5 not been found to be out of substantial compliance
6 with the applicable requirements of this section and
7 of section 1903(m) or section 1905(t); and

8 “(ii) that takes into consideration—

9 “(I) maintaining existing provider-individ-
10 ual relationships or relationships with providers
11 that have traditionally served beneficiaries
12 under this title; and

13 “(II) if maintaining such provider relation-
14 ships is not possible, the equitable distribution
15 of such individuals among qualified managed
16 care entities available to enroll such individuals,
17 consistent with the enrollment capacities of the
18 entities.

19 “(5) PROVISION OF INFORMATION.—

20 “(A) INFORMATION IN EASILY UNDERSTOOD
21 FORM.—Each State, enrollment broker, or managed
22 care entity shall provide all enrollment notices and in-
23 formational and instructional materials relating to such
24 an entity under this title in a manner and form which
25 may be easily understood by enrollees and potential en-
26 rollees of the entity who are eligible for medical assist-
27 ance under the State plan under this title.

28 “(B) INFORMATION TO ENROLLEES AND POTEN-
29 TIAL ENROLLEES.—Each managed care entity that is
30 a medicaid managed care organization shall, upon re-
31 quest, make available to enrollees and potential enroll-
32 ees in the organization’s service area information con-
33 cerning the following:

34 “(i) PROVIDERS.—The identity, locations,
35 qualifications, and availability of health care pro-
36 viders that participate with the organization.

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1 “(ii) ENROLLEE RIGHTS AND RESPONSIBILITIES.—The rights and responsibilities of enrollees.

2
3 “(iii) GRIEVANCE AND APPEAL PROCEDURES.—The procedures available to an enrollee
4 and a health care provider to challenge or appeal
5 the failure of the organization to cover a service.
6

7 “(iv) INFORMATION ON COVERED ITEMS AND SERVICES.—All items and services that are avail-
8 able to enrollees under the contract between the
9 State and the organization that are covered either
10 directly or through a method of referral and prior
11 authorization. Each managed care entity that is a
12 primary care case manager shall, upon request,
13 make available to enrollees and potential enrollees
14 in the organization’s service area the information
15 described in clause (iii).
16

17 “(C) COMPARATIVE INFORMATION.—A State that
18 requires individuals to enroll with managed care enti-
19 ties under paragraph (1)(A) shall annually (and upon
20 request) provide, directly or through the managed care
21 entity, to such individuals a list identifying the man-
22 aged care entities that are (or will be) available and in-
23 formation (presented in a comparative, chart-like form)
24 relating to the following for each such entity offered:

25 “(i) BENEFITS AND COST-SHARING.—The ben-
26 efits covered and cost-sharing imposed by the en-
27 tity.

28 “(ii) SERVICE AREA.—The service area of the
29 entity.

30 “(iii) QUALITY AND PERFORMANCE.—To the
31 extent available, quality and performance indicators
32 for the benefits under the entity.

33 “(D) INFORMATION ON BENEFITS NOT COVERED
34 UNDER MANAGED CARE ARRANGEMENT.—A State, di-
35 rectly or through managed care entities, shall, on or be-
36 fore an individual enrolls with such an entity under this
37 title, inform the enrollee in a written and prominent

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1 manner of any benefits to which the enrollee may be
2 entitled to under this title but which are not made
3 available to the enrollee through the entity. Such infor-
4 mation shall include information on where and how
5 such enrollees may access benefits not made available
6 to the enrollee through the entity.”

7 (b) CHANGE IN TERMINOLOGY.—

8 (1) IN GENERAL.—Section 1903(m)(1)(A) (42 U.S.C.
9 1396b(m)) is amended—

10 (A) by striking “The term” and all that follows
11 through “and—” and inserting “The term ‘medicaid
12 managed care organization’ means a health mainte-
13 nance organization, an eligible organization with a con-
14 tract under section 1876 or a Medicare+Choice organi-
15 zation with a contract under part C of title XVIII, a
16 provider sponsored organization, or any other public or
17 private organization, which meets the requirement of
18 section 1902(w) and—”; and

19 (B) by adding after and below clause (ii) the fol-
20 lowing:

21 “An organization that is a qualified health maintenance organi-
22 zation (as defined in section 1310(d) of the Public Health Serv-
23 ice Act) is deemed to meet the requirements of clauses (i) and
24 (ii).”

25 (2) CONFORMING CHANGES IN TERMINOLOGY.—(A)
26 Each of the following provisions is amended by striking
27 “health maintenance organization” and inserting “medicaid
28 managed care organization”:

29 (i) Section 1902(a)(23) (42 U.S.C. 1396a(a)(23)).

30 (ii) Section 1902(a)(57) (42 U.S.C.
31 1396a(a)(57)).

32 (iii) Section 1902(p)(2) (42 U.S.C. 1396a(p)(2)).

33 (iv) Section 1902(w)(2)(E) (42 U.S.C.
34 1396a(w)(2)(E)).

35 (v) Section 1903(k) (42 U.S.C. 1396b(k)).

36 (vi) In section 1903(m)(1)(B).

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1 (vii) In subparagraphs (A)(i) and (H)(i) of section
2 1903(m)(2) (42 U.S.C. 1396b(m)(2)).

3 (viii) Section 1903(m)(4)(A) (42 U.S.C.
4 1396b(m)(4)(A)), the first place it appears.

5 (ix) Section 1925(b)(4)(D)(iv) (42 U.S.C. 1396r-
6 6(b)(4)(D)(iv)).

7 (x) Section 1927(j)(1) (42 U.S.C. 1396r-8(j)(1))
8 is amended by striking “***Health Maintenance Orga-
9 nizations, including those organizations” and inserting
10 “health maintenance organizations, including medicaid
11 managed care organizations”.

12 (B) Section 1903(m)(2)(H) (42 U.S.C.
13 1396b(m)(2)(H)) is amended, in the matter following
14 clause (iii), by striking “health maintenance”.

15 (C) Clause (viii) of section 1903(w)(7)(A) (42 U.S.C.
16 1396b(w)(7)(A)) is amended to read as follows:

17 “(viii) Services of a medicaid managed care or-
18 ganization with a contract under section
19 1903(m).”.

20 (D) Section 1925(b)(4)(D)(iv) (42 U.S.C. 1396r-
21 6(b)(4)(D)(iv)) is amended—

22 (i) in the heading, by striking “HMO” and insert-
23 ing “MEDICAID MANAGED CARE ORGANIZATION”; and

24 (ii) by inserting “and the applicable requirements
25 of section 1932” before the period at the end.

26 (c) COMPLIANCE OF CONTRACT WITH NEW REQUIRE-
27 MENTS.—Section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A))
28 is amended—

29 (1) by striking “and” at the end of clause (x),

30 (2) by striking the period at the end of clause (xi) and
31 inserting “; and”; and

32 (3) by adding at the end the following:

33 “(xi) such contract, and the entity complies with the
34 applicable requirements of section 1932.”.

35 (d) CONFORMING AMENDMENTS TO FREEDOM-OF-CHOICE
36 AND TERMINATION OF ENROLLMENT REQUIREMENTS.—

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1 (1) Section 1902(a)(23) (42 U.S.C. 1396a(a)(23)), as
2 amended by section 4724(d), is amended by striking “and
3 in section 1915” and inserting “, in section 1915, and in
4 section 1932(a)”.

5 (2) Section 1903(m)(2) (42 U.S.C. 1396b(m)(2)) is
6 amended—

7 (A) in paragraph (A)(vi)—

8 (i) by striking “except as provided under sub-
9 paragraph (F),”

10 (ii) by striking “without cause” and all that
11 follows through “for such termination” and insert-
12 ing “in accordance with section 1932(a)(4);”

13 (iii) by inserting “in accordance with such sec-
14 tion” after “provides for notification”; and

15 (B) by striking subparagraph (F).

16 **SEC. 4702. PRIMARY CARE CASE MANAGEMENT SERV-**
17 **ICES AS STATE OPTION WITHOUT NEED FOR**
18 **WAIVER.**

19 (a) IN GENERAL.—Section 1905 (42 U.S.C. 1396d) is
20 amended—

21 (1) in subsection (a)—

22 (A) by striking “and” at the end of paragraph
23 (24);

24 (B) by redesignating paragraph (25) as paragraph
25 (26) and by striking the period at the end of such
26 paragraph and inserting a comma; and

27 (C) by inserting after paragraph (24) the following
28 new paragraph:

29 “(25) primary care case management services (as de-
30 fined in subsection (t)); and”; and

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

32 “(t)(1) The term ‘primary care case management services’
33 means case-management related services (including locating,
34 coordinating, and monitoring of health care services) provided
35 by a primary care case manager under a primary care case
36 management contract.

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1 “(2) The term ‘primary care case manager’ means any of
2 the following that provides services of the type described in
3 paragraph (1) under a contract referred to in such paragraph:

4 “(A) A physician, a physician group practice, or an
5 entity employing or having other arrangements with physi-
6 cians to provide such services.

7 “(B) At State option—

8 “(i) a nurse practitioner (as described in section
9 1905(a)(21));

10 “(ii) a certified nurse-midwife (as defined in sec-
11 tion 1861(gg)); or

12 “(iii) a physician assistant (as defined in section
13 1861(aa)(5)).

14 “(3) The term ‘primary care case management contract’
15 means a contract between a primary care case manager and a
16 State under which the manager undertakes to locate, coordi-
17 nate, and monitor covered primary care (and such other cov-
18 ered services as may be specified under the contract) to all in-
19 dividuals enrolled with the manager, and which—

20 “(A) provides for reasonable and adequate hours of
21 operation, including 24-hour availability of information, re-
22 ferral, and treatment with respect to medical emergencies;

23 “(B) restricts enrollment to individuals residing suffi-
24 ciently near a service delivery site of the manager to be
25 able to reach that site within a reasonable time using avail-
26 able and affordable modes of transportation;

27 “(C) provides for arrangements with, or referrals to,
28 sufficient numbers of physicians and other appropriate
29 health care professionals to ensure that services under the
30 contract can be furnished to enrollees promptly and without
31 compromise to quality of care;

32 “(D) prohibits discrimination on the basis of health
33 status or requirements for health care services in enroll-
34 ment, disenrollment, or reenrollment of individuals eligible
35 for medical assistance under this title;

36 “(E) provides for a right for an enrollee to terminate
37 enrollment in accordance with section 1932(a)(4); and

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1 “(F) complies with the other applicable provisions of
2 section 1932.

3 “(4) For purposes of this subsection, the term ‘primary
4 care’ includes all health care services customarily provided in
5 accordance with State licensure and certification laws and regu-
6 lations, and all laboratory services customarily provided by or
7 through, a general practitioner, family medicine physician, in-
8 ternal medicine physician, obstetrician/gynecologist, or pediatri-
9 cian.”.

10 (b) CONFORMING AMENDMENTS.—

11 (1) APPLICATION OF REENROLLMENT PROVISIONS TO
12 PCCMS.—Section 1903(m)(2)(H) (42 U.S.C.
13 1396b(m)(2)(H)) is amended—

14 (A) in clause (i), by inserting before the comma
15 the following: “or with a primary care case manager
16 with a contract described in section 1905(t)(3)”; and

17 (B) by inserting before the period at the end the
18 following: “or with the manager described in such
19 clause if the manager continues to have a contract de-
20 scribed in section 1905(t)(3) with the State”.

21 (2) CONFORMING CROSS-REFERENCE.—Section
22 1902(j) (42 U.S.C. 1396a(j)) is amended by striking
23 “paragraphs (1) through (25)” and inserting “a numbered
24 paragraph of”.

25 **SEC. 4703. ELIMINATION OF 75:25 RESTRICTION ON RISK**
26 **CONTRACTS.**

27 (a) IN GENERAL.—Section 1903(m)(2)(A) (42 U.S.C.
28 1396b(m)(2)(A)) is amended by striking clause (ii).

29 (b) CONFORMING AMENDMENTS.—

30 (1) Section 1903(m)(2) (42 U.S.C. 1396b(m)(2)) is
31 amended—

32 (A) by striking subparagraphs (C), (D), and (E);
33 and

34 (B) in subparagraph (G), by striking “clauses (i)
35 and (ii)” and inserting “clause (i)”.

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1 (2) Section 1925(b)(4)(D)(iv) (42 U.S.C. 1396r-
2 6(b)(4)(D)(iv)) is amended by striking “less than 50 per-
3 cent” and all that follows up to the period at the end.

4 **SEC. 4704. INCREASED BENEFICIARY PROTECTIONS.**

5 (a) IN GENERAL.—Section 1932, as added by section
6 4701(a), is amended by adding at the end the following:

7 “(b) BENEFICIARY PROTECTIONS.—

8 “(1) SPECIFICATION OF BENEFITS.—Each contract
9 with a managed care entity under section 1903(m) or
10 under section 1905(t)(3) shall specify the benefits the pro-
11 vision (or arrangement) for which the entity is responsible.

12 “(2) ASSURING COVERAGE TO EMERGENCY SERV-
13 ICES.—

14 “(A) IN GENERAL.—Each contract with a medic-
15 aid managed care organization under section 1903(m)
16 and each contract with a primary care case manager
17 under section 1905(t)(3) shall require the organization
18 or manager—

19 “(i) to provide coverage for emergency services
20 (as defined in subparagraph (B)) without regard to
21 prior authorization or the emergency care provid-
22 er’s contractual relationship with the organization
23 or manager, and

24 “(ii) to comply with guidelines established
25 under section 1852(d)(2) (respecting coordination
26 of post-stabilization care) in the same manner as
27 such guidelines apply to Medicare+Choice plans of-
28 fered under part C of title XVIII.

29 The requirement under clause (ii) shall first apply 30
30 days after the date of promulgation of the guidelines
31 referred to in such clause.

32 “(B) EMERGENCY SERVICES DEFINED.—In sub-
33 paragraph (A)(i), the term ‘emergency services’ means,
34 with respect to an individual enrolled with an organiza-
35 tion, covered inpatient and outpatient services that—

36 “(i) are furnished by a provider that is quali-
37 fied to furnish such services under this title, and

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1 “(ii) are needed to evaluate or stabilize an
2 emergency medical condition (as defined in sub-
3 paragraph (C)).

4 “(C) EMERGENCY MEDICAL CONDITION DE-
5 FINED.—In subparagraph (B)(ii), the term ‘emergency
6 medical condition’ means a medical condition manifest-
7 ing itself by acute symptoms of sufficient severity (in-
8 cluding severe pain) such that a prudent layperson,
9 who possesses an average knowledge of health and
10 medicine, could reasonably expect the absence of imme-
11 diate medical attention to result in—

12 “(i) placing the health of the individual (or,
13 with respect to a pregnant woman, the health of
14 the woman or her unborn child) in serious jeop-
15 ardly,

16 “(ii) serious impairment to bodily functions, or

17 “(iii) serious dysfunction of any bodily organ
18 or part.

19 “(3) PROTECTION OF ENROLLEE-PROVIDER COMMU-
20 NICATIONS.—

21 “(A) IN GENERAL.—Subject to subparagraphs (B)
22 and (C), under a contract under section 1903(m) a
23 medicaid managed care organization (in relation to an
24 individual enrolled under the contract) shall not pro-
25 hibit or otherwise restrict a covered health care profes-
26 sional (as defined in subparagraph (D)) from advising
27 such an individual who is a patient of the professional
28 about the health status of the individual or medical
29 care or treatment for the individual’s condition or dis-
30 ease, regardless of whether benefits for such care or
31 treatment are provided under the contract, if the pro-
32 fessional is acting within the lawful scope of practice.

33 “(B) CONSTRUCTION.—Subparagraph (A) shall
34 not be construed as requiring a medicaid managed care
35 organization to provide, reimburse for, or provide cov-
36 erage of, a counseling or referral service if the organi-
37 zation—

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1 “(i) objects to the provision of such service on
2 moral or religious grounds; and

3 “(ii) in the manner and through the written
4 instrumentalities such organization deems appro-
5 priate, makes available information on its policies
6 regarding such service to prospective enrollees be-
7 fore or during enrollment and to enrollees within
8 90 days after the date that the organization adopts
9 a change in policy regarding such a counseling or
10 referral service.

11 Nothing in this subparagraph shall be construed to af-
12 fect disclosure requirements under State law or under
13 the Employee Retirement Income Security Act of 1974.

14 “(C) HEALTH CARE PROFESSIONAL DEFINED.—
15 For purposes of this paragraph, the term ‘health care
16 professional’ means a physician (as defined in section
17 1861(r)) or other health care professional if coverage
18 for the professional’s services is provided under the
19 contract referred to in subparagraph (A) for the serv-
20 ices of the professional. Such term includes a podia-
21 trist, optometrist, chiropractor, psychologist, dentist,
22 physician assistant, physical or occupational therapist
23 and therapy assistant, speech-language pathologist,
24 audiologist, registered or licensed practical nurse (in-
25 cluding nurse practitioner, clinical nurse specialist, cer-
26 tified registered nurse anesthetist, and certified nurse-
27 midwife), licensed certified social worker, registered
28 respiratory therapist, and certified respiratory therapy
29 technician.

30 “(4) GRIEVANCE PROCEDURES.—Each medicaid man-
31 aged care organization shall establish an internal grievance
32 procedure under which an enrollee who is eligible for medi-
33 cal assistance under the State plan under this title, or a
34 provider on behalf of such an enrollee, may challenge the
35 denial of coverage of or payment for such assistance.

36 “(5) DEMONSTRATION OF ADEQUATE CAPACITY AND
37 SERVICES.—Each medicaid managed care organization

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1 shall provide the State and the Secretary with adequate as-
2 surances (in a time and manner determined by the Sec-
3 retary) that the organization, with respect to a service area,
4 has the capacity to serve the expected enrollment in such
5 service area, including assurances that the organization—

6 “(A) offers an appropriate range of services and
7 access to preventive and primary care services for the
8 population expected to be enrolled in such service area,
9 and

10 “(B) maintains a sufficient number, mix, and geo-
11 graphic distribution of providers of services.

12 “(6) PROTECTING ENROLLEES AGAINST LIABILITY
13 FOR PAYMENT.—Each medicaid managed care organization
14 shall provide that an individual eligible for medical assist-
15 ance under the State plan under this title who is enrolled
16 with the organization may not be held liable—

17 “(A) for the debts of the organization, in the event
18 of the organization’s insolvency,

19 “(B) for services provided to the individual—

20 “(i) in the event of the organization failing to
21 receive payment from the State for such services;
22 or

23 “(ii) in the event of a health care provider
24 with a contractual, referral, or other arrangement
25 with the organization failing to receive payment
26 from the State or the organization for such serv-
27 ices, or

28 “(C) for payments to a provider that furnishes
29 covered services under a contractual, referral, or other
30 arrangement with the organization in excess of the
31 amount that would be owed by the individual if the or-
32 ganization had directly provided the services.

33 “(7) ANTIDISCRIMINATION.—A medicaid managed
34 care organization shall not discriminate with respect to par-
35 ticipation, reimbursement, or indemnification as to any pro-
36 vider who is acting within the scope of the provider’s li-
37 cense or certification under applicable State law, solely on

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1 the basis of such license or certification. This paragraph
2 shall not be construed to prohibit an organization from in-
3 cluding providers only to the extent necessary to meet the
4 needs of the organization's enrollees or from establishing
5 any measure designed to maintain quality and control costs
6 consistent with the responsibilities of the organization.

7 “(8) COMPLIANCE WITH CERTAIN MATERNITY AND
8 MENTAL HEALTH REQUIREMENTS.—Each medicaid man-
9 aged care organization shall comply with the requirements
10 of subpart 2 of part A of title XXVII of the Public Health
11 Service Act insofar as such requirements apply and are ef-
12 fective with respect to a health insurance issuer that offers
13 group health insurance coverage.”

14 (b) PROTECTION OF ENROLLEES AGAINST BALANCE
15 BILLING THROUGH SUBCONTRACTORS.—Section 1128B(d)(1)
16 (42 U.S.C. 1320a-7b(d)(1)) is amended by inserting “(or, in
17 the case of services provided to an individual enrolled with a
18 medicaid managed care organization under title XIX under a
19 contract under section 1903(m) or under a contractual, refer-
20 ral, or other arrangement under such contract, at a rate in ex-
21 cess of the rate permitted under such contract)” before the
22 comma at the end.

23 SEC. 4705. QUALITY ASSURANCE STANDARDS.

24 (a) IN GENERAL.—Section 1932 is further amended by
25 adding at the end the following:

26 “(c) QUALITY ASSURANCE STANDARDS.—

27 “(1) QUALITY ASSESSMENT AND IMPROVEMENT
28 STRATEGY.—

29 “(A) IN GENERAL.—If a State provides for con-
30 tracts with medicaid managed care organizations under
31 section 1903(m), the State shall develop and implement
32 a quality assessment and improvement strategy consist-
33 ent with this paragraph. Such strategy shall include the
34 following:

35 “(i) ACCESS STANDARDS.—Standards for ac-
36 cess to care so that covered services are available

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1 within reasonable timeframes and in a manner that
2 ensures continuity of care and adequate primary
3 care and specialized services capacity.

4 “(ii) OTHER MEASURES.—Examination of
5 other aspects of care and service directly related to
6 the improvement of quality of care (including grievance
7 procedures and marketing and information
8 standards).

9 “(iii) MONITORING PROCEDURES.—Procedures
10 for monitoring and evaluating the quality and ap-
11 propriateness of care and services to enrollees that
12 reflect the full spectrum of populations enrolled
13 under the contract and that includes requirements
14 for provision of quality assurance data to the State
15 using the data and information set that the Sec-
16 retary has specified for use under part C of title
17 XVIII or such alternative data as the Secretary ap-
18 proves, in consultation with the State.

19 “(iv) PERIODIC REVIEW.—Regular, periodic
20 examinations of the scope and content of the strat-
21 egy.

22 “(B) STANDARDS.—The strategy developed under
23 subparagraph (A) shall be consistent with standards
24 that the Secretary first establishes within 1 year after
25 the date of the enactment of this section. Such stand-
26 ards shall not preempt any State standards that are
27 more stringent than such standards. Guidelines relating
28 to quality assurance that are applied under section
29 1915(b)(1) shall apply under this subsection until the
30 effective date of standards for quality assurance estab-
31 lished under this subparagraph.

32 “(C) MONITORING.—The Secretary shall monitor
33 the development and implementation of strategies
34 under subparagraph (A).

35 “(D) CONSULTATION.—The Secretary shall con-
36 duct activities under subparagraphs (B) and (C) in
37 consultation with the States.

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1 “(2) EXTERNAL INDEPENDENT REVIEW OF MANAGED
2 CARE ACTIVITIES.—

3 “(A) REVIEW OF CONTRACTS.—

4 “(i) IN GENERAL.—Each contract under sec-
5 tion 1903(m) with a medicaid managed care orga-
6 nization shall provide for an annual (as appro-
7 priate) external independent review conducted by a
8 qualified independent entity of the quality outcomes
9 and timeliness of, and access to, the items and
10 services for which the organization is responsible
11 under the contract. The requirement for such a re-
12 view shall not apply until after the date that the
13 Secretary establishes the identification method de-
14 scribed in clause (ii).

15 “(ii) QUALIFICATIONS OF REVIEWER.—The
16 Secretary, in consultation with the States, shall es-
17 tablish a method for the identification of entities
18 that are qualified to conduct reviews under clause
19 (i).

20 “(iii) USE OF PROTOCOLS.—The Secretary, in
21 coordination with the National Governors’ Associa-
22 tion, shall contract with an independent quality re-
23 view organization (such as the National Committee
24 for Quality Assurance) to develop the protocols to
25 be used in external independent reviews conducted
26 under this paragraph on and after January 1,
27 1999.

28 “(iv) AVAILABILITY OF RESULTS.—The results
29 of each external independent review conducted
30 under this subparagraph shall be available to par-
31 ticipating health care providers, enrollees, and po-
32 tential enrollees of the organization, except that the
33 results may not be made available in a manner that
34 discloses the identity of any individual patient.

35 “(B) NONDUPLICATION OF ACCREDITATION.—A
36 State may provide that, in the case of a medicaid man-
37 aged care organization that is accredited by a private

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1 independent entity (such as those described in section
2 1852(e)(4)) or that has an external review conducted
3 under section 1852(e)(3), the external review activities
4 conducted under subparagraph (A) with respect to the
5 organization shall not be duplicative of review activities
6 conducted as part of the accreditation process or the
7 external review conducted under such section.

8 “(C) DEEMED COMPLIANCE FOR MEDICARE MAN-
9 AGED CARE ORGANIZATIONS.—At the option of a State,
10 the requirements of subparagraph (A) shall not apply
11 with respect to a medicaid managed care organization
12 if the organization is an eligible organization with a
13 contract in effect under section 1876 or a
14 Medicare+Choice organization with a contract in effect
15 under C of title XVIII and the organization has had a
16 contract in effect under section 1903(m) at least dur-
17 ing the previous 2-year period.

18 (b) INCREASED FFP FOR EXTERNAL QUALITY REVIEW
19 ORGANIZATIONS.—Section 1903(a)(3)(C) (42 U.S.C.
20 1396b(a)(3)(C)) is amended—

21 (1) by inserting “(i)” after “(C)”, and

22 (2) by adding at the end the following new clause:

23 “(ii) 75 percent of the sums expended with respect
24 to costs incurred during such quarter (as found nec-
25 essary by the Secretary for the proper and efficient ad-
26 ministration of the State plan) as are attributable to
27 the performance of independent external reviews con-
28 ducted under section 1932(c)(2); and”.

29 (c) STUDIES AND REPORTS.—

30 (1) GAO STUDY AND REPORT ON QUALITY ASSURANCE
31 AND ACCREDITATION STANDARDS.—

32 (A) STUDY.—The Comptroller General of the
33 United States shall conduct a study and analysis of the
34 quality assurance programs and accreditation stand-
35 ards applicable to managed care entities operating in
36 the private sector, or to such entities that operate
37 under contracts under the medicare program under

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1 title XVIII of the Social Security Act (42 U.S.C. 1395
2 et seq.). Such study shall determine—

3 (i) if such programs and standards include
4 consideration of the accessibility and quality of the
5 health care items and services delivered under such
6 contracts to low-income individuals; and

7 (ii) the appropriateness of applying such pro-
8 grams and standards to medicaid managed care or-
9 ganizations under section 1932(c) of such Act.

10 (B) REPORT.—The Comptroller General shall sub-
11 mit a report to the Committee on Commerce of the
12 House of Representatives and the Committee on Fi-
13 nance of the Senate on the study conducted under sub-
14 paragraph (A).

15 (2) STUDY AND REPORT ON SERVICES PROVIDED TO
16 INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS.—

17 (A) STUDY.—The Secretary of Health and Human
18 Services, in consultation with States, managed care or-
19 ganizations, the National Academy of State Health Pol-
20 icy, representatives of beneficiaries with special health
21 care needs, experts in specialized health care, and oth-
22 ers, shall conduct a study concerning safeguards (if
23 any) that may be needed to ensure that the health care
24 needs of individuals with special health care needs and
25 chronic conditions who are enrolled with medicaid man-
26 aged care organizations are adequately met.

27 (B) REPORT.—Not later than 2 years after the
28 date of the enactment of this Act, the Secretary shall
29 submit to Committees described in paragraph (1)(B) a
30 report on such study.

31 **SEC. 4706. SOLVENCY STANDARDS.**

32 Section 1903(m)(1) (42 U.S.C. 1396b(m)(1)) is amend-
33 ed—

34 (1) in subparagraph (A)(ii), by inserting “, meets the
35 requirements of subparagraph (C)(i) (if applicable),” after
36 “provision is satisfactory to the State”, and

37 (2) by adding at the end the following:

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1 “(C)(i) Subject to clause (ii), a provision meets the re-
2 quirements of this subparagraph for an organization if the or-
3 ganization meets solvency standards established by the State
4 for private health maintenance organizations or is licensed or
5 certified by the State as a risk-bearing entity.

6 “(ii) Clause (i) shall not apply to an organization if—

7 “(I) the organization is not responsible for the provi-
8 sion (directly or through arrangements with providers of
9 services) of inpatient hospital services and physicians’ serv-
10 ices;

11 “(II) the organization is a public entity;

12 “(III) the solvency of the organization is guaranteed
13 by the State; or

14 “(IV) the organization is (or is controlled by) one or
15 more Federally-qualified health centers and meets solvency
16 standards established by the State for such an organiza-
17 tion.

18 For purposes of subclause (IV), the term ‘control’ means the
19 possession, whether direct or indirect, of the power to direct or
20 cause the direction of the management and policies of the orga-
21 nization through membership, board representation, or an own-
22 ership interest equal to or greater than 50.1 percent.”.

23 **SEC. 4707. PROTECTIONS AGAINST FRAUD AND ABUSE.**

24 (a) **IN GENERAL.**—Section 1932 (42 U.S.C. 1396v) is fur-
25 ther amended by adding at the end the following:

26 “(d) **PROTECTIONS AGAINST FRAUD AND ABUSE.**—

27 “(1) **PROHIBITING AFFILIATIONS WITH INDIVIDUALS**
28 **DEBARRED BY FEDERAL AGENCIES.**—

29 “(A) **IN GENERAL.**—A managed care entity may
30 not knowingly—

31 “(i) have a person described in subparagraph
32 (C) as a director, officer, partner, or person with
33 beneficial ownership of more than 5 percent of the
34 entity’s equity, or

35 “(ii) have an employment, consulting, or other
36 agreement with a person described in such sub-
37 paragraph for the provision of items and services

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1 that are significant and material to the entity's ob-
2 ligations under its contract with the State.

3 "(B) EFFECT OF NONCOMPLIANCE.—If a State
4 finds that a managed care entity is not in compliance
5 with clause (i) or (ii) of subparagraph (A), the State—

6 "(i) shall notify the Secretary of such non-
7 compliance;

8 "(ii) may continue an existing agreement with
9 the entity unless the Secretary (in consultation
10 with the Inspector General of the Department of
11 Health and Human Services) directs otherwise; and

12 "(iii) may not renew or otherwise extend the
13 duration of an existing agreement with the entity
14 unless the Secretary (in consultation with the In-
15 spector General of the Department of Health and
16 Human Services) provides to the State and to Con-
17 gress a written statement describing compelling
18 reasons that exist for renewing or extending the
19 agreement.

20 "(C) PERSONS DESCRIBED.—A person is described
21 in this subparagraph if such person—

22 "(i) is debarred, suspended, or otherwise ex-
23 cluded from participating in procurement activities
24 under the Federal Acquisition Regulation or from
25 participating in nonprocurement activities under
26 regulations issued pursuant to Executive Order No.
27 12549 or under guidelines implementing such
28 order; or

29 "(ii) is an affiliate (as defined in such Act) of
30 a person described in clause (i).

31 "(2) RESTRICTIONS ON MARKETING.—

32 "(A) DISTRIBUTION OF MATERIALS.—

33 "(i) IN GENERAL.—A managed care entity,
34 with respect to activities under this title, may not
35 distribute directly or through any agent or inde-
36 pendent contractor marketing materials within any
37 State—

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1 “(I) without the prior approval of the
2 State, and

3 “(II) that contain false or materially mis-
4 leading information.

5 The requirement of subclause (I) shall not apply
6 with respect to a State until such date as the Sec-
7 retary specifies in consultation with such State.

8 “(ii) CONSULTATION IN REVIEW OF MARKET
9 MATERIALS.—In the process of reviewing and ap-
10 proving such materials, the State shall provide for
11 consultation with a medical care advisory commit-
12 tee.

13 “(B) SERVICE MARKET.—A managed care entity
14 shall distribute marketing materials to the entire serv-
15 ice area of such entity covered under the contract
16 under section 1903(m) or section 1903(t)(3).

17 “(C) PROHIBITION OF TIE-INS.—A managed care
18 entity, or any agency of such entity, may not seek to
19 influence an individual’s enrollment with the entity in
20 conjunction with the sale of any other insurance.

21 “(D) PROHIBITING MARKETING FRAUD.—Each
22 managed care entity shall comply with such procedures
23 and conditions as the Secretary prescribes in order to
24 ensure that, before an individual is enrolled with the
25 entity, the individual is provided accurate oral and
26 written information sufficient to make an informed de-
27 cision whether or not to enroll.

28 “(E) PROHIBITION OF ‘COLD-CALL’ MARKETING.—
29 Each managed care entity shall not, directly or indi-
30 rectly, conduct door-to-door, telephonic, or other ‘cold-
31 call’ marketing of enrollment under this title.

32 “(3) STATE CONFLICT-OF-INTEREST SAFEGUARDS IN
33 MEDICAID RISK CONTRACTING.—A medicaid managed care
34 organization may not enter into a contract with any State
35 under section 1903(m) unless the State has in effect con-
36 flict-of-interest safeguards with respect to officers and em-
37 ployees of the State with responsibilities relating to con-

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1 tracts with such organizations or to the default enrollment
2 process described in subsection (a)(4)(C)(ii) that are at
3 least as effective as the Federal safeguards provided under
4 section 27 of the Office of Federal Procurement Policy Act
5 (41 U.S.C. 423), against conflicts of interest that apply
6 with respect to Federal procurement officials with com-
7 parable responsibilities with respect to such contracts.

8 “(4) USE OF UNIQUE PHYSICIAN IDENTIFIER FOR
9 PARTICIPATING PHYSICIANS.—Each medicaid managed care
10 organization shall require each physician providing services
11 to enrollees eligible for medical assistance under the State
12 plan under this title to have a unique identifier in accord-
13 ance with the system established under section 1173(b).

14 “(e) SANCTIONS FOR NONCOMPLIANCE.—

15 “(1) USE OF INTERMEDIATE SANCTIONS BY THE
16 STATE TO ENFORCE REQUIREMENTS.—

17 “(A) IN GENERAL.—A State may not enter into or
18 renew a contract under section 1903(m) unless the
19 State has established intermediate sanctions, which
20 may include any of the types described in paragraph
21 (2), other than the termination of a contract with a
22 medicaid managed care organization, which the State
23 may impose against a medicaid managed care organiza-
24 tion with such a contract, if the organization—

25 “(i) fails substantially to provide medically
26 necessary items and services that are required
27 (under law or under such organization’s contract
28 with the State) to be provided to an enrollee cov-
29 ered under the contract;

30 “(ii) imposes premiums or charges on enrollees
31 in excess of the premiums or charges permitted
32 under this title;

33 “(iii) acts to discriminate among enrollees on
34 the basis of their health status or requirements for
35 health care services, including expulsion or refusal
36 to reenroll an individual, except as permitted by
37 this title, or engaging in any practice that would

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1 reasonably be expected to have the effect of deny-
2 ing or discouraging enrollment with the organiza-
3 tion by eligible individuals whose medical condition
4 or history indicates a need for substantial future
5 medical services;

6 “(iv) misrepresents or falsifies information
7 that is furnished—

8 “(I) to the Secretary or the State under
9 this title; or

10 “(II) to an enrollee, potential enrollee, or
11 a health care provider under such title; or

12 “(v) fails to comply with the applicable re-
13 quirements of section 1903(m)(2)(A)(x).

14 The State may also impose such intermediate sanction
15 against a managed care entity if the State determines
16 that the entity distributed directly or through any
17 agent or independent contractor marketing materials in
18 violation of subsection (d)(2)(A)(i)(II)..

19 “(B) RULE OF CONSTRUCTION.—Clause (i) of sub-
20 paragraph (A) shall not apply to the provision of abor-
21 tion services, except that a State may impose a sanc-
22 tion on any medicaid managed care organization that
23 has a contract to provide abortion services if the orga-
24 nization does not provide such services as provided for
25 under the contract.

26 “(2) INTERMEDIATE SANCTIONS.—The sanctions de-
27 scribed in this paragraph are as follows:

28 “(A) Civil money penalties as follows:

29 “(i) Except as provided in clause (ii), (iii), or
30 (iv), not more than \$25,000 for each determination
31 under paragraph (1)(A).

32 “(ii) With respect to a determination under
33 clause (iii) or (iv)(I) of paragraph (1)(A), not more
34 than \$100,000 for each such determination.

35 “(iii) With respect to a determination under
36 paragraph (1)(A)(ii), double the excess amount
37 charged in violation of such subsection (and the ex-

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1 cess amount charged shall be deducted from the
2 penalty and returned to the individual concerned).

3 “(iv) Subject to clause (ii), with respect to a
4 determination under paragraph (1)(A)(iii), \$15,000
5 for each individual not enrolled as a result of a
6 practice described in such subsection.

7 “(B) The appointment of temporary manage-
8 ment—

9 “(i) to oversee the operation of the medicaid
10 managed care organization upon a finding by the
11 State that there is continued egregious behavior by
12 the organization or there is a substantial risk to
13 the health of enrollees; or

14 “(ii) to assure the health of the organization’s
15 enrollees, if there is a need for temporary manage-
16 ment while—

17 “(I) there is an orderly termination or re-
18 organization of the organization; or

19 “(II) improvements are made to remedy
20 the violations found under paragraph (1),
21 except that temporary management under this sub-
22 paragraph may not be terminated until the State
23 has determined that the medicaid managed care or-
24 ganization has the capability to ensure that the vio-
25 lations shall not recur.

26 “(C) Permitting individuals enrolled with the man-
27 aged care entity to terminate enrollment without cause,
28 and notifying such individuals of such right to termi-
29 nate enrollment.

30 “(D) Suspension or default of all enrollment of in-
31 dividuals under this title after the date the Secretary
32 or the State notifies the entity of a determination of a
33 violation of any requirement of section 1903(m) or this
34 section.

35 “(E) Suspension of payment to the entity under
36 this title for individuals enrolled after the date the Sec-
37 retary or State notifies the entity of such a determina-

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1 tion and until the Secretary or State is satisfied that
2 the basis for such determination has been corrected
3 and is not likely to recur.

4 “(3) TREATMENT OF CHRONIC SUBSTANDARD ENTI-
5 TIES.—In the case of a medicaid managed care organiza-
6 tion which has repeatedly failed to meet the requirements
7 of section 1903(m) and this section, the State shall (re-
8 gardless of what other sanctions are provided) impose the
9 sanctions described in subparagraphs (B) and (C) of para-
10 graph (2).

11 “(4) AUTHORITY TO TERMINATE CONTRACT.—

12 “(A) IN GENERAL.—In the case of a managed
13 care entity which has failed to meet the requirements
14 of this part or a contract under section 1903(m) or
15 1905(t)(3), the State shall have the authority to termi-
16 nate such contract with the entity and to enroll such
17 entity’s enrollees with other managed care entities (or
18 to permit such enrollees to receive medical assistance
19 under the State plan under this title other than
20 through a managed care entity).

21 “(B) AVAILABILITY OF HEARING PRIOR TO TERMI-
22 NATION OF CONTRACT.—A State may not terminate a
23 contract with a managed care entity under subpara-
24 graph (A) unless the entity is provided with a hearing
25 prior to the termination.

26 “(C) NOTICE AND RIGHT TO DISENROLL IN CASES
27 OF TERMINATION HEARING.—A State may—

28 “(i) notify individuals enrolled with a managed
29 care entity which is the subject of a hearing to ter-
30 minate the entity’s contract with the State of the
31 hearing, and

32 “(ii) in the case of such an entity, permit such
33 enrollees to disenroll immediately with the entity
34 without cause.

35 “(5) OTHER PROTECTIONS FOR MANAGED CARE ENTI-
36 TIES AGAINST SANCTIONS IMPOSED BY STATE.—Before im-
37 posing any sanction against a managed care entity other

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1 than termination of the entity's contract, the State shall
2 provide the entity with notice and such other due process
3 protections as the State may provide, except that a State
4 may not provide a managed care entity with a pre-termi-
5 nation hearing before imposing the sanction described in
6 paragraph (2)(B).”.

7 (b) LIMITATION ON AVAILABILITY OF FFP FOR USE OF
8 ENROLLMENT BROKERS.—Section 1903(b) (42 U.S.C.
9 1396b(b)) is amended by adding at the end the following:

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

17 “(A) The broker is independent of any such entity and
18 of any health care providers (whether or not any such pro-
19 vider participates in the State plan under this title) that
20 provide coverage of services in the same State in which the
21 broker is conducting enrollment activities.

22 “(B) No person who is an owner, employee, consult-
23 ant, or has a contract with the broker either has any direct
24 or indirect financial interest with such an entity or health
25 care provider or has been excluded from participation in
26 the program under this title or title XVIII or debarred by
27 any Federal agency, or subject to a civil money penalty
28 under this Act.”.

29 (c) APPLICATION OF DISCLOSURE REQUIREMENTS TO
30 MANAGED CARE ENTITIES.—Section 1124(a)(2)(A) (42 U.S.C.
31 1320a-3(a)(2)(A)) is amended by inserting “a managed care
32 entity, as defined in section 1932(a)(1)(B),” after “renal dis-
33 ease facility.”.

34 **SEC. 4708. IMPROVED ADMINISTRATION.**

35 (a) CHANGE IN THRESHOLD AMOUNT FOR CONTRACTS
36 REQUIRING SECRETARY'S PRIOR APPROVAL.—Section
37 1903(m)(2)(A)(iii) (42 U.S.C. 1396b(m)(2)(A)(iii)) is amended

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1 by striking "\$100,000" and inserting "\$1,000,000 for 1998
2 and, for a subsequent year, the amount established under this
3 clause for the previous year increased by the percentage in-
4 crease in the consumer price index for all urban consumers
5 over the previous year".

6 (b) PERMITTING SAME COPAYMENTS IN HEALTH MAINTEN-
7 NANCE ORGANIZATIONS AS IN FEE-FOR-SERVICE.—Section
8 1916 (42 U.S.C. 1396o) is amended—

9 (1) in subsection (a)(2)(D), by striking "or services
10 furnished" and all that follows through "enrolled,"; and

11 (2) in subsection (b)(2)(D), by striking "or (at the op-
12 tion" and all that follows through "enrolled,".

13 (c) ASSURING TIMELINESS OF PROVIDER PAYMENTS.—
14 Section 1932 is further amended by adding at the end the fol-
15 lowing:

16 "(f) TIMELINESS OF PAYMENT.—A contract under section
17 1903(m) with a medicaid managed care organization shall pro-
18 vide that the organization shall make payment to health care
19 providers for items and services which are subject to the con-
20 tract and that are furnished to individuals eligible for medical
21 assistance under the State plan under this title who are en-
22 rolled with the organization on a timely basis consistent with
23 the claims payment procedures described in section
24 1902(a)(37)(A), unless the health care provider and the organi-
25 zation agree to an alternate payment schedule."

26 (d) CLARIFICATION OF APPLICATION OF FFP DENIAL
27 RULES TO PAYMENTS MADE PURSUANT TO MANAGED CARE
28 ENTITIES.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended
29 by adding at the end the following new sentence: "Paragraphs
30 (1), (2), (16), (17), and (18) shall apply with respect to items
31 or services furnished and amounts expended by or through a
32 managed care entity (as defined in section 1932(a)(1)(B)) in
33 the same manner as such paragraphs apply to items or services
34 furnished and amounts expended directly by the State."

35 **SEC. 4709. 6-MONTH GUARANTEED ELIGIBILITY FOR ALL**
36 **INDIVIDUALS ENROLLED IN MANAGED CARE.**

37 Section 1902(e)(2) (42 U.S.C. 1396a(e)(2)) is amended—

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1 (1) by striking "who is enrolled" and all that follows
2 through "section 1903(m)(2)(A)" and inserting "who is en-
3 rolled with a medicaid managed care organization (as de-
4 fined in section 1903(m)(1)(A)), with a primary care case
5 manager (as defined in section 1905(t)),"; and

6 (2) by inserting before the period "or by or through
7 the case manager".

8 **SEC. 4710. EFFECTIVE DATES.**

9 (a) **GENERAL EFFECTIVE DATE.**—Except as otherwise
10 provided in this chapter and section 4759, the amendments
11 made by this chapter shall take effect on the date of the enact-
12 ment of this Act and shall apply to contracts entered into or
13 renewed on or after October 1, 1997.

14 (b) **SPECIFIC EFFECTIVE DATES.**—Subject to subsection
15 (c) and section 4759—

16 (1) **PCCM OPTION.**—The amendments made by sec-
17 tion 4702 shall apply to primary care case management
18 services furnished on or after October 1, 1997.

19 (2) **75:25 RULE.**—The amendments made by section
20 4703 apply to contracts under section 1903(m) of the So-
21 cial Security Act (42 U.S.C. 1396b(m)) on and after June
22 20, 1997.

23 (3) **QUALITY STANDARDS.**—Section 1932(c)(1) of the
24 Social Security Act, as added by section 4705(a), shall take
25 effect on January 1, 1999.

26 (4) **SOLVENCY STANDARDS.**—

27 (A) **IN GENERAL.**—The amendments made by sec-
28 tion 4706 shall apply to contracts entered into or re-
29 newed on or after October 1, 1998.

30 (B) **TRANSITION RULE.**—In the case of an organi-
31 zation that as of the date of the enactment of this Act
32 has entered into a contract under section 1903(m) of
33 the Social Security Act with a State for the provision
34 of medical assistance under title XIX of such Act under
35 which the organization assumes full financial risk and
36 is receiving capitation payments, the amendment made
37 by section 4706 shall not apply to such organization

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1 until 3 years after the date of the enactment of this
2 Act.

3 (5) **SANCTIONS FOR NONCOMPLIANCE.**—Section
4 1932(e) of the Social Security Act, as added by section
5 4707(a), shall apply to contracts entered into or renewed
6 on or after April 1, 1998.

7 (6) **LIMITATION ON FFP FOR ENROLLMENT BRO-**
8 **KERS.**—The amendment made by section 4707(b) shall
9 apply to amounts expended on or after October 1, 1997.

10 (7) **6-MONTH GUARANTEED ELIGIBILITY.**—The
11 amendments made by section 4709 shall take effect on Oc-
12 tober 1, 1997.

13 (c) **NONAPPLICATION TO WAIVERS.**—Nothing in this chap-
14 ter (or the amendments made by this chapter) shall be con-
15 strued as affecting the terms and conditions of any waiver, or
16 the authority of the Secretary of Health and Human Services
17 with respect to any such waiver, under section 1115 or 1915
18 of the Social Security Act (42 U.S.C. 1315, 1396n).

19 **CHAPTER 2—FLEXIBILITY IN PAYMENT OF**
20 **PROVIDERS**

21 **SEC. 4711. FLEXIBILITY IN PAYMENT METHODS FOR**
22 **HOSPITAL, NURSING FACILITY, ICF/MR, AND**
23 **HOME HEALTH SERVICES.**

24 (a) **REPEAL OF BOREN REQUIREMENTS.**—Section
25 1902(a)(13) (42 U.S.C. 1396a(a)(13)) is amended—

26 (1) by striking all that precedes subparagraph (D) and
27 inserting the following:

28 “(13) provide—

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

33 “(i) proposed rates, the methodologies underly-
34 ing the establishment of such rates, and justifica-
35 tions for the proposed rates are published,

36 “(ii) providers, beneficiaries and their rep-
37 resentatives, and other concerned State residents

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1 are given a reasonable opportunity for review and
2 comment on the proposed rates, methodologies, and
3 justifications,

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

7 “(iv) in the case of hospitals, such rates take
8 into account (in a manner consistent with section
9 1923) the situation of hospitals which serve a dis-
10 proportionate number of low-income patients with
11 special needs;”;

12 (2) by redesignating subparagraphs (D) and (E) as
13 subparagraphs (B) and (C), respectively;

14 (3) in subparagraph (B), as so redesignated, by add-
15 ing “and” at the end;

16 (4) in subparagraph (C), as so redesignated, by strik-
17 ing “and” at the end; and

18 (5) by striking subparagraph (F).

19 (b) STUDY AND REPORT.—

20 (1) STUDY.—The Secretary of Health and Human
21 Services shall study the effect on access to, and the quality
22 of, services provided to beneficiaries of the rate-setting
23 methods used by States pursuant to section 1902(a)(13)(A)
24 of the Social Security Act (42 U.S.C. 1396a(a)(13)(A)), as
25 amended by subsection (a).

26 (2) REPORT.—Not later than 4 years after the date of
27 the enactment of this Act, the Secretary of Health and
28 Human Services shall submit a report to the appropriate
29 committees of Congress on the conclusions of the study
30 conducted under paragraph (1), together with any rec-
31 ommendations for legislation as a result of such conclu-
32 sions.

33 (c) CONFORMING AMENDMENTS.—

34 (1) Section 1905(o)(3) (42 U.S.C. 1396d(o)(3)) is
35 amended by striking “amount described in section
36 1902(a)(13)(D)” and inserting “amount determined in sec-
37 tion 1902(a)(13)(B)”.

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1 (2) Section 1923 (42 U.S.C. 1396r-4) is amended, in
2 subsections (a)(1) and (e)(1), by striking "1902(a)(13)(A)"
3 each place it appears and inserting "1902(a)(13)(A)(iv)".

4 (d) EFFECTIVE DATE.—This section shall take effect on
5 the date of the enactment of this Act and the amendments
6 made by subsections (a) and (c) shall apply to payment for
7 items and services furnished on or after October 1, 1997.

8 **SEC. 4712. PAYMENT FOR CENTER AND CLINIC SERV-**
9 **ICES.**

10 (a) PHASE-OUT OF PAYMENT BASED ON REASONABLE
11 COSTS.—Section 1902(a)(13)(C) (42 U.S.C. 1396a(a)(13)(C)),
12 as redesignated by section 4711(a)(2), is amended by inserting
13 "(or 95 percent for services furnished during fiscal year 2000,
14 90 percent for services furnished during fiscal year 2001, 85
15 percent for services furnished during fiscal year 2002, or 70
16 percent for services furnished during fiscal year 2003)" after
17 "100 percent".

18 (b) TRANSITIONAL SUPPLEMENTAL PAYMENT FOR SERV-
19 ICES FURNISHED UNDER CERTAIN MANAGED CARE CON-
20 TRACTS.—

21 (1) IN GENERAL.—Section 1902(a)(13)(C) (42 U.S.C.
22 1396a(a)(13)(C)), as so redesignated, is further amended—

23 (A) by inserting "(i)" after "(C)", and

24 (B) by inserting before the semicolon at the end
25 the following: "and (ii) in carrying out clause (i) in the
26 case of services furnished by a Federally-qualified
27 health center or a rural health clinic pursuant to a con-
28 tract between the center and an organization under
29 section 1903(m), for payment to the center or clinic at
30 least quarterly by the State of a supplemental payment
31 equal to the amount (if any) by which the amount de-
32 termined under clause (i) exceeds the amount of the
33 payments provided under such contract".

34 (2) CONFORMING AMENDMENT TO MANAGED CARE
35 CONTRACT REQUIREMENT.—Clause (ix) of section
36 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) is amended to
37 read as follows:

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1 “(ix) such contract provides, in the case of an entity
2 that has entered into a contract for the provision of serv-
3 ices with a Federally-qualified health center or a rural
4 health clinic, that the entity shall provide payment that is
5 not less than the level and amount of payment which the
6 entity would make for the services if the services were fur-
7 nished by a provider which is not a Federally-qualified
8 health center or a rural health clinic;”.

9 (3) **EFFECTIVE DATE.**—The amendments made by
10 this subsection shall apply to services furnished on or after
11 October 1, 1997.

12 (c) **END OF TRANSITIONAL PAYMENT RULES.**—Effective
13 for services furnished on or after October 1, 2003—

14 (1) subparagraph (C) of section 1902(a)(13) (42
15 U.S.C. 1396a(a)(13)), as so redesignated, is repealed, and

16 (2) clause (ix) of section 1903(m)(2)(A) (42 U.S.C.
17 1396b(m)(2)(A)) is repealed.

18 (d) **FLEXIBILITY IN COVERAGE OF NON-FREESTANDING
19 LOOK-ALIKES.**—

20 (1) **IN GENERAL.**—Section 1905(l)(2)(B)(iii) (42
21 U.S.C. 1396d(l)(2)(B)(iii)) is amended by inserting “in-
22 cluding requirements of the Secretary that an entity may
23 not be owned, controlled, or operated by another entity,”
24 after “such a grant,”.

25 (2) **EFFECTIVE DATE.**—The amendment made by
26 paragraph (1) shall apply to services furnished on or after
27 the date of the enactment of this Act.

28 **SEC. 4713. ELIMINATION OF OBSTETRICAL AND PEDI-
29 ATRIC PAYMENT RATE REQUIREMENTS.**

30 (a) **IN GENERAL.**—Section 1926 (42 U.S.C. 1396r-7) is
31 repealed.

32 (b) **EFFECTIVE DATE.**—The repeal made by subsection
33 (a) shall apply to services furnished on or after October 1,
34 1997.

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1 SEC. 4714. MEDICAID PAYMENT RATES FOR CERTAIN
2 MEDICARE COST-SHARING.

3 (a) CLARIFICATION REGARDING STATE LIABILITY FOR
4 MEDICARE COST-SHARING.—

5 (1) IN GENERAL.—Section 1902(n) (42 U.S.C.
6 1396a(n)) is amended—

7 (A) by inserting “(1)” after “(n)”, and

8 (B) by adding at the end the following:

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

17 “(3) In the case in which a State’s payment for medicare
18 cost-sharing for a qualified medicare beneficiary with respect to
19 an item or service is reduced or eliminated through the applica-
20 tion of paragraph (2)—

21 “(A) for purposes of applying any limitation under
22 title XVIII on the amount that the beneficiary may be
23 billed or charged for the service, the amount of payment
24 made under title XVIII plus the amount of payment (if
25 any) under the State plan shall be considered to be pay-
26 ment in full for the service;

27 “(B) the beneficiary shall not have any legal liability
28 to make payment to a provider or to an organization de-
29 scribed in section 1903(m)(1)(A) for the service; and

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

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

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1 (2) CONFORMING CLARIFICATION.—Section
2 1905(p)(3) (42 U.S.C. 1396d(p)(3)) is amended by insert-
3 ing “(subject to section 1902(n)(2))” after “means”.

4 (b) LIMITATION ON MEDICARE PROVIDERS.—

5 (1) PROVIDER AGREEMENTS.—Section 1866(a)(1)(A)
6 (42 U.S.C. 1395cc(a)(1)(A)) is amended—

7 (A) by inserting “(i)” after “(A)”, and

8 (B) by inserting before the comma at the end the
9 following: “, and (ii) not to impose any charge that is
10 prohibited under section 1902(n)(3)”.

11 (2) NONPARTICIPATING PROVIDERS.—Section
12 1848(g)(3)(A) (42 U.S.C. 1395w-4(g)(3)(A)) is amended
13 by inserting before the period at the end the following:
14 “and the provisions of section 1902(n)(3)(A) apply to fur-
15 ther limit permissible charges under this section”.

16 (c) EFFECTIVE DATE.—The amendments made by this
17 section shall apply to payment for (and with respect to provider
18 agreements with respect to) items and services furnished on or
19 after the date of the enactment of this Act. The amendments
20 made by subsection (a) shall also apply to payment by a State
21 for items and services furnished before such date if such pay-
22 ment is the subject of a law suit that is based on the provisions
23 of sections 1902(n) and 1905(p) of the Social Security Act and
24 that is pending as of, or is initiated after, the date of the en-
25 actment of this Act.

26 SEC. 4715. TREATMENT OF VETERANS' PENSIONS
27 UNDER MEDICAID.

28 (a) POST-ELIGIBILITY TREATMENT.—Section 1902(r)(1)
29 (42 U.S.C. 1396a(r)(1)) is amended—

30 (1) by inserting “(A)” after “(r)(1)”,

31 (2) by inserting “, the treatment described in subpara-
32 graph (B) shall apply,” after “under such a waiver”;

33 (3) by striking “and,” and inserting “, and”; and

34 (4) by adding at the end the following:

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

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

5 “(II) resides in a State veterans home with respect to
6 which the Secretary of Veterans Affairs makes per diem
7 payments for nursing home care pursuant to section
8 1741(a) of title 38, United States Code,
9 any such pension payment, including any payment made due to
10 the need for aid and attendance, or for unreimbursed medical
11 expenses, that is in excess of \$90 per month shall be counted
12 as income only for the purpose of applying such excess payment
13 to the State veterans home’s cost of providing nursing home
14 care to the veteran.

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

19 (b) EFFECTIVE DATE.—The amendments made by this
20 section shall apply on and after October 1, 1997.

21 **CHAPTER 3—FEDERAL PAYMENTS TO STATES**
22 **SEC. 4721. REFORMING DISPROPORTIONATE SHARE**
23 **PAYMENTS UNDER STATE MEDICAID PRO-**
24 **GRAMS.**

25 (a) ADJUSTMENT OF STATE DSH ALLOTMENTS.—

26 (1) IN GENERAL.—Section 1923(f) (42 U.S.C. 1396r-
27 4(f)) is amended to read as follows:

28 “(f) LIMITATION ON FEDERAL FINANCIAL PARTICIPA-
29 TION.—

30 “(1) IN GENERAL.—Payment under section 1903(a)
31 shall not be made to a State with respect to any payment
32 adjustment made under this section for hospitals in a State
33 for quarters in a fiscal year in excess of the disproportion-
34 ate share hospital (in this subsection referred to as ‘DSH’)
35 allotment for the State for the fiscal year, as specified in
36 paragraphs (2) and (3).

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1 “(2) STATE DSH ALLOTMENTS FOR FISCAL YEARS 1998
2 THROUGH 2002.—The DSH allotment for a State for each
3 fiscal year during the period beginning with fiscal year
4 1998 and ending with fiscal year 2002 is determined in ac-
5 cordance 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	1,086	1,068	986	931	877
Colorado	93	85	79	74	74
Connecticut	200	194	164	160	160
Delaware	4	4	4	4	4
District of Columbia	23	23	23	23	23
Florida	207	203	197	188	180
Georgia	253	248	241	228	216
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	796	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	16	16	16
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	5	5	5
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	766	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	0	0

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

8 “(A) IN GENERAL.—The DSH allotment for any
9 State for fiscal year 2003 and each succeeding fiscal
10 year is equal to the DSH allotment for the State for
11 the preceding fiscal year under paragraph (2) or this

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1 paragraph, increased, subject to subparagraph (B), by
2 the percentage change in the consumer price index for
3 all urban consumers (all items; U.S. city average), for
4 the previous fiscal year.

5 “(B) LIMITATION.—The DSH allotment for a
6 State shall not be increased under subparagraph (A)
7 for a fiscal year to the extent that such an increase
8 would result in the DSH allotment for the year exceed-
9 ing the greater of—

10 “(i) the DSH allotment for the previous year,

11 or

12 “(ii) 12 percent of the total amount of expend-
13 itures under the State plan for medical assistance
14 during the fiscal year.

15 “(4) DEFINITION OF STATE.— In this subsection, the
16 term ‘State’ means the 50 States and the District of Co-
17 lumbia.”

18 (2) EFFECTIVE DATE.—The amendment made by
19 paragraph (1) shall apply to payment adjustments attrib-
20 utable to DSH allotments for fiscal years beginning with
21 fiscal year 1998.

22 (b) LIMITATION ON PAYMENTS TO INSTITUTIONS FOR
23 MENTAL DISEASES.—Section 1923 of the Social Security Act
24 (42 U.S.C. 1396r-4) is amended by adding at the end the fol-
25 lowing:

26 “(h) LIMITATION ON CERTAIN STATE DSH EXPENDI-
27 TURES.—

28 “(1) IN GENERAL.—Payment under section 1903(a)
29 shall not be made to a State with respect to any payment
30 adjustments made under this section for quarters in a fis-
31 cal year (beginning with fiscal year 1998) to institutions
32 for mental diseases or other mental health facilities, to the
33 extent the aggregate of such adjustments in the fiscal year
34 exceeds the lesser of the following:

35 “(A) 1995 IMD DSH PAYMENT ADJUSTMENTS.—

36 The total State DSH expenditures that are attributable
37 to fiscal year 1995 for payments to institutions for

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1 mental diseases and other mental health facilities
2 (based on reporting data specified by the State on
3 HCFA Form 64 as mental health DSH, and as ap-
4 proved by the Secretary).

5 “(B) APPLICABLE PERCENTAGE OF 1995 TOTAL
6 DSH PAYMENT ALLOTMENT.—The amount of such pay-
7 ment adjustments which are equal to the applicable
8 percentage of the Federal share of payment adjust-
9 ments made to hospitals in the State under subsection
10 (c) that are attributable to the 1995 DSH allotment
11 for the State for payments to institutions for mental
12 diseases and other mental health facilities (based on re-
13 porting data specified by the State on HCFA Form 64
14 as mental health DSH, and as approved by the Sec-
15 retary).

16 “(2) APPLICABLE PERCENTAGE.—

17 “(A) IN GENERAL.—For purposes of paragraph
18 (1), the applicable percentage with respect to—

19 “(i) each of fiscal years 1998, 1999, and
20 2000, is the percentage determined under subpara-
21 graph (B); or

22 “(ii) a succeeding fiscal year is the lesser of
23 the percentage determined under subparagraph (B)
24 or the following percentage:

25 “(I) For fiscal year 2001, 50 percent.

26 “(II) For fiscal year 2002, 40 percent.

27 “(III) For each succeeding fiscal year, 33
28 percent.

29 “(B) 1995 PERCENTAGE.—The percentage deter-
30 mined under this subparagraph is the ratio (determined
31 as a percentage) of—

32 “(i) the Federal share of payment adjustments
33 made to hospitals in the State under subsection (c)
34 that are attributable to the 1995 DSH allotment
35 for the State (as reported by the State not later
36 than January 1, 1997, on HCFA Form 64, and as
37 approved by the Secretary) for payments to institu-

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1 tions for mental diseases and other mental health
2 facilities, to

3 “(ii) the State 1995 DSH spending amount.

4 “(C) STATE 1995 DSH SPENDING AMOUNT.—For
5 purposes of subparagraph (B)(ii), the ‘State 1995
6 DSH spending amount’, with respect to a State, is the
7 Federal medical assistance percentage (for fiscal year
8 1995) of the payment adjustments made under sub-
9 section (c) under the State plan that are attributable
10 to the fiscal year 1995 DSH allotment for the State (as
11 reported by the State not later than January 1, 1997,
12 on HCFA Form 64, and as approved by the Sec-
13 retary).”.

14 (c) DESCRIPTION OF TARGETING PAYMENTS.—Section
15 1923(a)(2) (42 U.S.C. 1396r-4(a)(2)) is amended by adding at
16 the end the following:

17 “(D) A State plan under this title shall not be consid-
18 ered to meet the requirements of section
19 1902(a)(13)(A)(iv) (insofar as it requires payments to hos-
20 pitals to take into account the situation of hospitals that
21 serve a disproportionate number of low-income patients
22 with special needs), as of October 1, 1998, unless the State
23 has submitted to the Secretary by such date a description
24 of the methodology used by the State to identify and to
25 make payments to disproportionate share hospitals, includ-
26 ing children’s hospitals, on the basis of the proportion of
27 low-income and medicaid patients served by such hospitals.
28 The State shall provide an annual report to the Secretary
29 describing the disproportionate share payments to each
30 such disproportionate share hospital.”.

31 (d) DIRECT PAYMENT BY STATE FOR MANAGED CARE
32 ENROLLEES.—Section 1923 (42 U.S.C. 1396r-4) is amended
33 by adding at the end the following:

34 “(i) REQUIREMENT FOR DIRECT PAYMENT.—

35 “(1) IN GENERAL.—No payment may be made under
36 section 1903(a)(1) with respect to a payment adjustment
37 made under this section, for services furnished by a hos-

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1 pital on or after October 1, 1997, with respect to individ-
2 uals eligible for medical assistance under the State plan
3 who are enrolled with a managed care entity (as defined in
4 section 1932(a)(1)(B)) or under any other managed care
5 arrangement unless a payment, equal to the amount of the
6 payment adjustment—

7 “(A) is made directly to the hospital by the State;

8 and

9 “(B) is not used to determine the amount of a
10 prepaid capitation payment under the State plan to the
11 entity or arrangement with respect to such individuals.

12 “(2) EXCEPTION FOR CURRENT ARRANGEMENTS.—

13 Paragraph (1) shall not apply to a payment adjustment
14 provided pursuant to a payment arrangement in effect on
15 July 1, 1997.”.

16 (e) TRANSITION RULE.—Effective July 1, 1997, section
17 1923(g)(2)(A) of the Social Security Act (42 U.S.C. 1396r-
18 4(g)(2)(A)) shall be applied to the State of California as
19 though—

20 (1) “(or that begins on or after July 1, 1997, and be-
21 fore July 1, 1999)” were inserted in such section after
22 “January 1, 1995,”; and

23 (2) “(or 175 percent in the case of a State fiscal year
24 that begins on or after July 1, 1997, and before July 1,
25 1999)” were inserted in such section after “200 percent”.

26 **SEC. 4722. TREATMENT OF STATE TAXES IMPOSED ON**
27 **CERTAIN HOSPITALS.**

28 (a) EXCEPTION FROM TAX DOES NOT DISQUALIFY AS
29 BROAD-BASED TAX.—Section 1903(w)(3) (42 U.S.C.
30 1396b(w)(3)) is amended—

31 (1) in subparagraph (B), by striking “and (E)” and
32 inserting “(E), and (F)”;

33 (2) by adding at the end the following:

34 “(F) In no case shall a tax not qualify as a broad-based
35 health care related tax under this paragraph because it does
36 not apply to a hospital that is described in section 501(c)(3)
37 of the Internal Revenue Code of 1986 and exempt from tax-

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1 ation under section 501(a) of such Code and that does not ac-
2 cept payment under the State plan under this title or under
3 title XVIII”.

4 (b) REDUCTION IN FEDERAL FINANCIAL PARTICIPATION
5 IN CASE OF IMPOSITION OF TAX.—Section 1903(b) (42 U.S.C.
6 1396b(b)), as amended by section 4707(b), is amended by add-
7 ing at the end the following:

8 “(5) Notwithstanding the preceding provisions of this sec-
9 tion, the amount determined under subsection (a)(1) for any
10 State shall be decreased in a quarter by the amount of any
11 health care related taxes (described in section 1902(w)(3)(A))
12 that are imposed on a hospital described in subsection
13 (w)(3)(F) in that quarter.”.

14 (c) WAIVER OF CERTAIN PROVIDER TAX PROVISIONS.—
15 Notwithstanding any other provision of law, taxes, fees, or as-
16 sessments, as defined in section 1903(w)(3)(A) of the Social
17 Security Act (42 U.S.C. 1396b(w)(3)(A)), that were collected
18 by the State of New York from a health care provider before
19 June 1, 1997, and for which a waiver of the provisions of sub-
20 paragraph (B) or (C) of section 1903(w)(3) of such Act has
21 been applied for, or that would, but for this subsection require
22 that such a waiver be applied for, in accordance with subpara-
23 graph (E) of such section, and, (if so applied for) upon which
24 action by the Secretary of Health and Human Services (includ-
25 ing any judicial review of any such proceeding) has not been
26 completed as of July 23, 1997, are deemed to be permissible
27 health care related taxes and in compliance with the require-
28 ments of subparagraphs (B) and (C) of section 1903(w)(3) of
29 such Act.

30 (d) EFFECTIVE DATE.—The amendments made by sub-
31 section (a) shall apply to taxes imposed before, on, or after the
32 date of the enactment of this Act and the amendment made by
33 subsection (b) shall apply to taxes imposed on or after such
34 date.

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1 **SEC. 4723. ADDITIONAL FUNDING FOR STATE EMER-**
2 **GENCY HEALTH SERVICES FURNISHED TO**
3 **UNDOCUMENTED ALIENS.**

4 **(a) TOTAL AMOUNT AVAILABLE FOR ALLOTMENT.—**There
5 are available for allotments under this section for each of the
6 4 consecutive fiscal years (beginning with fiscal year 1998)
7 \$25,000,000 for payments to certain States under this section.

8 **(b) STATE ALLOTMENT AMOUNT.—**

9 **(1) IN GENERAL.—**The Secretary of Health and
10 Human Services shall compute an allotment for each fiscal
11 year beginning with fiscal year 1998 and ending with fiscal
12 year 2001 for each of the 12 States with the highest num-
13 ber of undocumented aliens. The amount of such allotment
14 for each such State for a fiscal year shall bear the same
15 ratio to the total amount available for allotments under
16 subsection (a) for the fiscal year as the ratio of the number
17 of undocumented aliens in the State in the fiscal year bears
18 to the total of such numbers for all such States for such
19 fiscal year. The amount of allotment to a State provided
20 under this paragraph for a fiscal year that is not paid out
21 under subsection (c) shall be available for payment during
22 the subsequent fiscal year.

23 **(2) DETERMINATION.—**For purposes of paragraph (1),
24 the number of undocumented aliens in a State under this
25 section shall be determined based on estimates of the resi-
26 dent illegal alien population residing in each State prepared
27 by the Statistics Division of the Immigration and Natu-
28 ralization Service as of October 1992 (or as of such later
29 date if such date is at least 1 year before the beginning of
30 the fiscal year involved).

31 **(c) USE OF FUNDS.—**From the allotments made under
32 subsection (b), the Secretary shall pay to each State amounts
33 the State demonstrates were paid by the State (or by a political
34 subdivision of the State) for emergency health services fur-
35 nished to undocumented aliens.

36 **(d) STATE DEFINED.—**For purposes of this section, the
37 term "State" includes the District of Columbia.

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1 (e) STATE ENTITLEMENT.—This section constitutes budg-
2 et authority in advance of appropriations Acts and represents
3 the obligation of the Federal Government to provide for the
4 payment to States of amounts provided under this section.

5 SEC. 4724. ELIMINATION OF WASTE, FRAUD, AND ABUSE.

6 (a) BAN ON SPENDING FOR NONHEALTH RELATED
7 ITEMS.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended—

8 (1) in paragraphs (2) and (16), by striking the period
9 at the end and inserting “; or”;

10 (2) in paragraphs (10)(B), (11), and (13), by adding
11 “or” at the end; and

12 (3) by inserting after paragraph (16), the following:

13 “(17) with respect to any amount expended for roads,
14 bridges, stadiums, or any other item or service not covered
15 under a State plan under this title.”.

16 (b) SURETY BOND REQUIREMENT FOR HOME HEALTH
17 AGENCIES.—

18 (1) IN GENERAL.—Section 1903(i) (42 U.S.C.
19 1396b(i)), as amended by subsection (a), is amended—

20 (1) in paragraph (17), by striking the period at the
21 end and inserting “; or”; and

22 (2) by inserting after paragraph (17), the following:

23 “(18) with respect to any amount expended for home
24 health care services provided by an agency or organization
25 unless the agency or organization provides the State agency
26 on a continuing basis a surety bond in a form specified by
27 the Secretary under paragraph (7) of section 1861(o) and
28 in an amount that is not less than \$50,000 or such com-
29 parable surety bond as the Secretary may permit under the
30 last sentence of such section.”.

31 (2) EFFECTIVE DATE.—The amendments made by
32 paragraph (1) shall apply to home health care services fur-
33 nished on or after January 1, 1998.

34 (c) CONFLICT OF INTEREST SAFEGUARDS.—

35 (1) IN GENERAL.—Section 1902(a)(4)(C) (42 U.S.C.
36 1396a(a)(4)(C)) is amended—

37 (A) by striking “and (C)” and inserting “(C)”;

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1 (B) by striking "local officer or employee" and in-
2 sserting "local officer, employee, or independent contrac-
3 tor";

4 (C) by striking "such an officer or employee" the
5 first 2 places it appears and inserting "such an officer,
6 employee, or contractor"; and

7 (D) by inserting before the semicolon the follow-
8 ing: ", and (D) that each State or local officer, em-
9 ployee, or independent contractor who is responsible for
10 selecting, awarding, or otherwise obtaining items and
11 services under the State plan shall be subject to safe-
12 guards against conflicts of interest that are at least as
13 stringent as the safeguards that apply under section 27
14 of the Office of Federal Procurement Policy Act (41
15 U.S.C. 423) to persons described in subsection (a)(2)
16 of such section of that Act".

17 (2) EFFECTIVE DATE.—The amendments made by
18 paragraph (1) shall take effect on January 1, 1998.

19 (d) AUTHORITY TO REFUSE TO ENTER INTO MEDICAID
20 AGREEMENTS WITH INDIVIDUALS OR ENTITIES CONVICTED OF
21 FELONIES.—Section 1902(a)(23) (42 U.S.C. 1396(a)) is
22 amended—

23 (1) by striking "except as provided in subsection (g)
24 and in section 1915 and except in the case of Puerto Rico,
25 the Virgin Islands, and Guam,"; and

26 (2) by inserting before the semicolon at the end the
27 following: ", except as provided in subsection (g) and in
28 section 1915, except that this paragraph shall not apply in
29 the case of Puerto Rico, the Virgin Islands, and Guam, and
30 except that nothing in this paragraph shall be construed as
31 requiring a State to provide medical assistance for such
32 services furnished by a person or entity convicted of a fel-
33 ony under Federal or State law for an offense which the
34 State agency determines is inconsistent with the best inter-
35 ests of beneficiaries under the State plan".

36 (e) MONITORING PAYMENTS FOR DUAL ELIGIBLES.—The
37 Administrator of the Health Care Financing Administration

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1 shall develop mechanisms to improve the monitoring of, and to
2 prevent, inappropriate payments under the medicaid program
3 under title XIX of the Social Security Act (42 U.S.C. 1396 et
4 seq.) in the case of individuals who are dually eligible for bene-
5 fits under such program and under the medicare program
6 under title XVIII of such Act (42 U.S.C. 1395 et seq.).

7 (f) BENEFICIARY AND PROGRAM PROTECTION AGAINST
8 WASTE, FRAUD, AND ABUSE.—Section 1902(a) (42 U.S.C.
9 1396a(a)) is amended—

10 (1) by striking “and” at the end of paragraph (62);

11 (2) by striking the period at the end of paragraph (63)

12 and inserting “; and”; and

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

14 “(64) provide, not later than 1 year after the date of
15 the enactment of this paragraph, a mechanism to receive
16 reports from beneficiaries and others and compile data con-
17 cerning alleged instances of waste, fraud, and abuse relat-
18 ing to the operation of this title;”.

19 (g) DISCLOSURE OF INFORMATION AND SURETY BOND
20 REQUIREMENT FOR SUPPLIERS OF DURABLE MEDICAL EQUIP-
21 MENT.—

22 (1) REQUIREMENT.—Section 1902(a) (42 U.S.C.
23 1396a(a)), as amended by subsection (f), is amended—

24 (A) by striking “and” at the end of paragraph
25 (63);

26 (B) by striking the period at the end of paragraph
27 (64) and inserting “; and”; and

28 (C) by inserting after paragraph (64) the follow-
29 ing:

30 “(65) provide that the State shall issue provider num-
31 bers for all suppliers of medical assistance consisting of du-
32 rable medical equipment, as defined in section 1861(n), and
33 the State shall not issue or renew such a supplier number
34 for any such supplier unless—

35 “(A)(i) full and complete information as to the
36 identity of each person with an ownership or control in-
37 terest (as defined in section 1124(a)(3)) in the supplier

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1 or in any subcontractor (as defined by the Secretary in
2 regulations) in which the supplier directly or indirectly
3 has a 5 percent or more ownership interest; and

4 “(ii) to the extent determined to be feasible under
5 regulations of the Secretary, the name of any disclosing
6 entity (as defined in section 1124(a)(2)) with respect to
7 which a person with such an ownership or control inter-
8 est in the supplier is a person with such an ownership
9 or control interest in the disclosing entity; and

10 “(B) a surety bond in a form specified by the Sec-
11 retary under section 1834(a)(16)(B) and in an amount
12 that is not less than \$50,000 or such comparable sur-
13 ety bond as the Secretary may permit under the second
14 sentence of such section.”

15 (2) **EFFECTIVE DATE.**—The amendments made by
16 paragraph (1) shall apply to suppliers of medical assistance
17 consisting of durable medical equipment furnished on or
18 after January 1, 1998.

19 **SEC. 4725. INCREASED FMAPS.**

20 (a) **ALASKA.**—Notwithstanding the first sentence of sec-
21 tion 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)),
22 the Federal medical assistance percentage determined under
23 such sentence for Alaska shall be 59.8 percent but only with
24 respect to—

25 (1) items and services furnished under a State plan
26 under title XIX or under a State child health plan under
27 title XXI of such Act during fiscal years 1998, 1999, and
28 2000;

29 (2) payments made on a capitation or other risk-basis
30 under such titles for coverage occurring during such period;
31 and

32 (3) payments under title XIX of such Act attributable
33 to DSH allotments for such State determined under section
34 1923(f) of such Act (42 U.S.C. 1396r-4(f)) for such fiscal
35 years.

36 (b) **DISTRICT OF COLUMBIA.**—

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1 (1) IN GENERAL.—The first sentence of section
2 1905(b) (42 U.S.C. 1396d(b)) is amended—

3 (A) by striking “and (2)” and inserting “, (2)”,
4 and

5 (B) by inserting before the period at the end the
6 following: “, and (3) for purposes of this title and title
7 XXI, the Federal medical assistance percentage for the
8 District of Columbia shall be 70 percent”.

9 (2) EFFECTIVE DATE.—The amendments made by
10 paragraph (1) shall apply to—

11 (A) items and services furnished on or after Octo-
12 ber 1, 1997;

13 (B) payments made on a capitation or other risk-
14 basis for coverage occurring on or after such date; and

15 (C) payments attributable to DSH allotments for
16 such States determined under section 1923(f) of such
17 Act (42 U.S.C. 1396r-4(f)) for fiscal years beginning
18 with fiscal year 1998.

19 SEC. 4726. INCREASE IN PAYMENT LIMITATION FOR
20 TERRITORIES.

21 Section 1108 (42 U.S.C. 1308) is amended—

22 (1) in subsection (f), by striking “The” and inserting
23 “Subject to subsection (g), the”; and

24 (2) by adding at the end the following:

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

27 “(1) FISCAL YEAR 1998.—With respect to fiscal year
28 1998, the amounts otherwise determined for Puerto Rico,
29 the Virgin Islands, Guam, the Northern Mariana Islands,
30 and American Samoa under subsection (f) for such fiscal
31 year shall be increased by the following amounts:

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

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

34 “(C) For Guam, \$750,000.

35 “(D) For the Northern Mariana Islands,
36 \$500,000.

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

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1 “(2) FISCAL YEAR 1999 AND THEREAFTER.—Notwith-
2 standing subsection (f), with respect to fiscal year 1999
3 and any fiscal year thereafter, the total amount certified by
4 the Secretary under title XIX for payment to—

5 “(A) Puerto Rico shall not exceed the sum of the
6 amount provided in this subsection for the preceding
7 fiscal year increased by the percentage increase in the
8 medical care component of the Consumer Price Index
9 for all urban consumers (as published by the Bureau
10 of Labor Statistics) for the 12-month period ending in
11 March preceding the beginning of the fiscal year,
12 rounded to the nearest \$100,000;

13 “(B) the Virgin Islands shall not exceed the sum
14 of the amount provided in this subsection for the pre-
15 ceding fiscal year increased by the percentage increase
16 referred to in subparagraph (A), rounded to the nearest
17 \$10,000;

18 “(C) Guam shall not exceed the sum of the
19 amount provided in this subsection for the preceding
20 fiscal year increased by the percentage increase re-
21 ferred to in subparagraph (A), rounded to the nearest
22 \$10,000;

23 “(D) the Northern Mariana Islands shall not ex-
24 ceed the sum of the amount provided in this subsection
25 for the preceding fiscal year increased by the percent-
26 age increase referred to in subparagraph (A), rounded
27 to the nearest \$10,000; and

28 “(E) American Samoa shall not exceed the sum of
29 the amount provided in this subsection for the preced-
30 ing fiscal year increased by the percentage increase re-
31 ferred to in subparagraph (A), rounded to the nearest
32 \$10,000.”.

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CHAPTER 4—ELIGIBILITY

1
2 **SEC. 4731. STATE OPTION OF CONTINUOUS ELIGIBILITY**
3 **FOR 12 MONTHS; CLARIFICATION OF STATE**
4 **OPTION TO COVER CHILDREN.**

5 (a) **CONTINUOUS ELIGIBILITY OPTION.**—Section 1902(e)
6 (42 U.S.C. 1396a(e)) is amended by adding at the end the fol-
7 lowing new paragraph:

8 “(12) At the option of the State, the plan may provide
9 that an individual who is under an age specified by the State
10 (not to exceed 19 years of age) and who is determined to be
11 eligible for benefits under a State plan approved under this title
12 under subsection (a)(10)(A) shall remain eligible for those ben-
13 efits until the earlier of—

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

16 “(B) the time that the individual exceeds that age.”.

17 (b) **CLARIFICATION OF STATE OPTION TO COVER ALL**
18 **CHILDREN UNDER 19 YEARS OF AGE.**—Section 1902(l)(1)(D)
19 (42 U.S.C. 1396a(l)(1)(D)) is amended by inserting “(or, at
20 the option of a State, after any earlier date)” after “children
21 born after September 30, 1983”.

22 (c) **EFFECTIVE DATE.**—The amendments made by this
23 section shall apply to medical assistance for items and services
24 furnished on or after October 1, 1997.

25 **SEC. 4732. PAYMENT OF PART B PREMIUMS.**

26 (a) **ELIGIBILITY.**—Section 1902(a)(10)(E) (42 U.S.C.
27 1396a(a)(10)(E)) is amended—

28 (1) by striking “and” at the end of clause (ii); and

29 (2) by inserting after clause (iii) the following:

30 “(iv) subject to sections 1933 and 1905(p)(4), for
31 making medical assistance available (but only for pre-
32 miums payable with respect to months during the pe-
33 riod beginning with January 1998, and ending with
34 December 2002)—

35 “(I) for medicare cost-sharing described in
36 section 1905(p)(3)(A)(ii) for individuals who would
37 be qualified medicare beneficiaries described in sec-

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1 tion 1905(p)(1) but for the fact that their income
2 exceeds the income level established by the State
3 under section 1905(p)(2) and is at least 120 per-
4 cent, but less than 135 percent, of the official pov-
5 erty line (referred to in such section) for a family
6 of the size involved and who are not otherwise eligi-
7 ble for medical assistance under the State plan,
8 and

9 “(II) for the portion of medicare cost-sharing
10 described in section 1905(p)(3)(A)(ii) that is at-
11 tributable to the operation of the amendments
12 made by (and subsection (e)(3) of) section 4611 of
13 the Balanced Budget Act of 1997 for individuals
14 who would be described in subclause (I) if ‘135 per-
15 cent’ and ‘175 percent’ were substituted for ‘120
16 percent’ and ‘135 percent’ respectively; and”.

17 (b) CONFORMING AMENDMENT.—Section 1905(b) (42
18 U.S.C. 1396d(b)) is amended by striking “The term” and in-
19 serting “Subject to section 1933(d), the term”.

20 (c) TERMS AND CONDITIONS OF COVERAGE.—Title XIX
21 (42 U.S.C. 1395 et seq.), as amended by section 4701(a), is
22 amended by redesignating section 1933 as section 1934 and by
23 inserting after section 1932 the following new section:

24 “STATE COVERAGE OF MEDICARE COST-SHARING FOR
25 ADDITIONAL LOW-INCOME MEDICARE BENEFICIARIES

26 “SEC. 1933. (a) IN GENERAL.—A State plan under this
27 title shall provide, under section 1902(a)(10)(E)(iv) and subject
28 to the succeeding provisions of this section and through a plan
29 amendment, for medical assistance for payment of the cost of
30 medicare cost-sharing described in such section on behalf of all
31 individuals described in such section (in this section referred to
32 as ‘qualifying individuals’) who are selected to receive such as-
33 sistance under subsection (b).

34 “(b) SELECTION OF QUALIFYING INDIVIDUALS.—A State
35 shall select qualifying individuals, and provide such individuals
36 with assistance, under this section consistent with the follow-
37 ing:

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1 “(1) ALL QUALIFYING INDIVIDUALS MAY APPLY.—The
2 State shall permit all qualifying individuals to apply for as-
3 sistance during a calendar year.

4 “(2) SELECTION ON FIRST-COME, FIRST-SERVED
5 BASIS.—

6 “(A) IN GENERAL.—For each calendar year (be-
7 ginning with 1998), from (and to the extent of) the
8 amount of the allocation under subsection (c) for the
9 State for the fiscal year ending in such calendar year,
10 the State shall select qualifying individuals who apply
11 for the assistance in the order in which they apply.

12 “(B) CARRYOVER.—For calendar years after
13 1998, the State shall give preference to individuals who
14 were provided such assistance (or other assistance de-
15 scribed in section 1902(a)(10)(E)) in the last month of
16 the previous year and who continue to be (or become)
17 qualifying individuals.

18 “(3) LIMIT ON NUMBER OF INDIVIDUALS BASED ON
19 ALLOCATION.—The State shall limit the number of qualify-
20 ing individuals selected with respect to assistance in a cal-
21 endar year so that the aggregate amount of such assistance
22 provided to such individuals in such year is estimated to be
23 equal to (but not exceed) the State’s allocation under sub-
24 section (c) for the fiscal year ending in such calendar year.

25 “(4) RECEIPT OF ASSISTANCE DURING DURATION OF
26 YEAR.—If a qualifying individual is selected to receive as-
27 sistance under this section for a month in year, the individ-
28 ual is entitled to receive such assistance for the remainder
29 of the year if the individual continues to be a qualifying in-
30 dividual. The fact that an individual is selected to receive
31 assistance under this section at any time during a year
32 does not entitle the individual to continued assistance for
33 any succeeding year.

34 “(c) ALLOCATION.—

35 “(1) TOTAL ALLOCATION.—The total amount available
36 for allocation under this section for—

37 “(A) fiscal year 1998 is \$200,000,000;

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1 “(B) fiscal year 1999 is \$250,000,000;

2 “(C) fiscal year 2000 is \$300,000,000;

3 “(D) fiscal year 2001 is \$350,000,000; and

4 “(E) fiscal year 2002 is \$400,000,000.

5 “(2) ALLOCATION TO STATES.—The Secretary shall
6 provide for the allocation of the total amount described in
7 paragraph (1) for a fiscal year, among the States that exe-
8 cuted a plan amendment in accordance with subsection (a),
9 based upon the Secretary’s estimate of the ratio of—

10 “(A) an amount equal to the sum of—

11 “(i) twice the total number of individuals de-
12 scribed in section 1902(a)(10)(E)(iv)(I) in the
13 State, and

14 “(ii) the total number of individuals described
15 in section 1902(a)(10)(E)(iv)(II) in the State; to

16 “(B) the sum of the amounts computed under sub-
17 paragraph (A) for all eligible States.

18 “(d) APPLICABLE FMAP.—With respect to assistance de-
19 scribed in section 1902(a)(10)(E)(iv) furnished in a State for
20 calendar quarters in a calendar year —

21 “(1) to the extent that such assistance does not exceed
22 the State’s allocation under subsection (c) for the fiscal
23 year ending in the calendar year, the Federal medical as-
24 sistance percentage shall be equal to 100 percent; and

25 “(2) to the extent that such assistance exceeds such
26 allocation, the Federal medical assistance percentage is 0
27 percent.

28 “(e) LIMITATION ON ENTITLEMENT.—Except as specifi-
29 cally provided under this section, nothing in this title shall be
30 construed as establishing any entitlement of individuals de-
31 scribed in section 1902(a)(10)(E)(iv) to assistance described in
32 such section.

33 “(f) COVERAGE OF COSTS THROUGH PART B OF THE
34 MEDICARE PROGRAM.—For each fiscal year, the Secretary
35 shall provide for the transfer from the Federal Supplementary
36 Medical Insurance Trust Fund under section 1841 to the ap-
37 propriate account in the Treasury that provides for payments

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1 under section 1903(a) with respect to medical assistance pro-
2 vided under this section, of an amount equivalent to the total
3 of the amount of payments made under such section that is at-
4 tributable to this section and such transfer shall be treated as
5 an expenditure from such Trust Fund for purposes of section
6 1839.”.

7 **SEC. 4733. STATE OPTION TO PERMIT WORKERS WITH**
8 **DISABILITIES TO BUY INTO MEDICAID.**

9 Section 1902(a)(10)(A)(ii) (42 U.S.C.
10 1396a(a)(10)(A)(ii)) is amended—

- 11 (1) in subclause (XI), by striking “or” at the end;
12 (2) in subclause (XII), by adding “or” at the end; and
13 (3) by adding at the end the following:

14 “(XIII) who are in families whose income
15 is less than 250 percent of the income official
16 poverty line (as defined by the Office of Man-
17 agement and Budget, and revised annually in
18 accordance with section 673(2) of the Omnibus
19 Budget Reconciliation Act of 1981) applicable
20 to a family of the size involved, and who but
21 for earnings in excess of the limit established
22 under section 1905(q)(2)(B), would be consid-
23 ered to be receiving supplemental security in-
24 come (subject, notwithstanding section 1916, to
25 payment of premiums or other cost-sharing
26 charges (set on a sliding scale based on in-
27 come) that the State may determine);”.

28 **SEC. 4734. PENALTY FOR FRAUDULENT ELIGIBILITY.**

29 Section 1128B(a) (42 U.S.C. 1320a-7b(a)), as amended
30 by section 217 of the Health Insurance Portability and Ac-
31 countability Act of 1996 (Public Law 104-191; 110 Stat.
32 2008), is amended—

- 33 (1) by striking paragraph (6) and inserting the follow-
34 ing:

35 “(6) for a fee knowingly and willfully counsels or as-
36 sists an individual to dispose of assets (including by any
37 transfer in trust) in order for the individual to become eli-

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1 gible for medical assistance under a State plan under title
2 XIX, if disposing of the assets results in the imposition of
3 a period of ineligibility for such assistance under section
4 1917(c);” and

5 (2) in clause (ii) of the matter following such para-
6 graph, by striking “failure, or conversion by any other per-
7 son” and inserting “failure, conversion, or provision of
8 counsel or assistance by any other person”.

9 **SEC. 4735. TREATMENT OF CERTAIN SETTLEMENT PAY-**
10 **MENTS.**

11 (a) **IN GENERAL.**—Notwithstanding any other provision of
12 law, the payments described in subsection (b) shall not be con-
13 sidered income or resources in determining eligibility for, or the
14 amount of benefits under, a State plan of medical assistance
15 approved under title XIX of the Social Security Act.

16 (b) **PAYMENTS DESCRIBED.**—The payments described in
17 this subsection are—

18 (1) payments made from any fund established pursu-
19 ant to a class settlement in the case of Susan Walker v.
20 Bayer Corporation, et al., 96-C-5024 (N.D. Ill.); and

21 (2) payments made pursuant to a release of all claims
22 in a case—

23 (A) that is entered into in lieu of the class settle-
24 ment referred to in paragraph (1); and

25 (B) that is signed by all affected parties in such
26 case on or before the later of—

27 (i) December 31, 1997, or

28 (ii) the date that is 270 days after the date on
29 which such release is first sent to the persons (or
30 the legal representative of such persons) to whom
31 the payment is to be made.

32 **CHAPTER 5—BENEFITS**

33 **SEC. 4741. ELIMINATION OF REQUIREMENT TO PAY FOR**
34 **PRIVATE INSURANCE.**

35 (a) **REPEAL OF STATE PLAN PROVISION.**—Section
36 1902(a)(25) (42 U.S.C. 1396a(a)(25)) is amended—

37 (1) by striking subparagraph (G); and

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1 (2) by redesignating subparagraphs (H) and (I) as
2 subparagraphs (G) and (H), respectively.

3 (b) MAKING PROVISION OPTIONAL.—Section 1906 (42
4 U.S.C. 1396e) is amended—

5 (1) in subsection (a)—

6 (A) by striking “For purposes of section
7 1902(a)(25)(G) and subject to subsection (d), each”
8 and inserting “Each”;

9 (B) in paragraph (1), by striking “shall” and in-
10 sserting “may”; and

11 (C) in paragraph (2), by striking “shall” and in-
12 sserting “may”; and

13 (2) by striking subsection (d).

14 (c) EFFECTIVE DATE.—The amendments made by this
15 section shall take effect on the date of the enactment of this
16 Act.

17 **SEC. 4742. PHYSICIAN QUALIFICATION REQUIREMENTS.**

18 (a) IN GENERAL.—Section 1903(i) (42 U.S.C. 1396b(i))
19 is amended by striking paragraph (12).

20 (b) EFFECTIVE DATE.—The amendment made by sub-
21 section (a) shall apply to services furnished on or after the date
22 of the enactment of this Act.

23 **SEC. 4743. ELIMINATION OF REQUIREMENT OF PRIOR**
24 **INSTITUTIONALIZATION WITH RESPECT TO**
25 **HABILITATION SERVICES FURNISHED**
26 **UNDER A WAIVER FOR HOME OR COMMU-**
27 **NITY-BASED SERVICES.**

28 (a) IN GENERAL.—Section 1915(c)(5) (42 U.S.C.
29 1396n(e)(5)) is amended, in the matter preceding subpara-
30 graph (A), by striking “, with respect to individuals who receive
31 such services after discharge from a nursing facility or inter-
32 mediate care facility for the mentally retarded”.

33 (b) EFFECTIVE DATE.—The amendment made by sub-
34 section (a) apply to services furnished on or after October 1,
35 1997.

36 **SEC. 4744. STUDY AND REPORT ON EPSDT BENEFIT.**

37 (a) STUDY.—

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1 (1) IN GENERAL.—The Secretary of Health and
2 Human Services, in consultation with Governors, directors
3 of State medicaid programs, the American Academy of Ac-
4 tuaries, and representatives of appropriate provider and
5 beneficiary organizations, shall conduct a study of the pro-
6 vision of early and periodic screening, diagnostic, and treat-
7 ment services under the medicaid program under title XIX
8 of the Social Security Act in accordance with the require-
9 ments of section 1905(r) of such Act (42 U.S.C. 1396d(r)).

10 (2) REQUIRED CONTENTS.—The study conducted
11 under paragraph (1) shall include examination of the actu-
12 arial value of the provision of such services under the med-
13 icaid program and an examination of the portions of such
14 actuarial value that are attributable to paragraph (5) of
15 section 1905(r) of such Act and to the second sentence of
16 such section.

17 (b) REPORT.—Not later than 12 months after the date of
18 the enactment of this Act, the Secretary of Health and Human
19 Services shall submit a report to Congress on the results of the
20 study conducted under subsection (a).

21 **CHAPTER 6—ADMINISTRATION AND**
22 **MISCELLANEOUS**

23 **SEC. 4751. ELIMINATION OF DUPLICATIVE INSPECTION**
24 **OF CARE REQUIREMENTS FOR ICFS/MR AND**
25 **MENTAL HOSPITALS.**

26 (a) MENTAL HOSPITALS.—Section 1902(a)(26) (42
27 U.S.C. 1396a(a)(26)) is amended—

28 (1) by striking “provide—

29 “(A) with respect to each patient” and inserting
30 “provide, with respect to each patient”; and

31 (2) by striking subparagraphs (B) and (C).

32 (b) ICFS/MR.—Section 1902(a)(31) (42 U.S.C.
33 1396a(a)(31)) is amended—

34 (1) by striking “provide—

35 “(A) with respect to each patient” and inserting
36 “provide, with respect to each patient”; and

37 (2) by striking subparagraphs (B) and (C).

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1 (c) **EFFECTIVE DATE.**—The amendments made by this
2 section take effect on the date of the enactment of this Act.
3 **SEC. 4752. ALTERNATIVE SANCTIONS FOR NONCOMPLI-**
4 **ANT ICFS/MR.**

5 (a) **IN GENERAL.**—Section 1902(i)(1)(B) (42 U.S.C.
6 1396a(i)(1)(B)) is amended by striking “provide” and inserting
7 “establish alternative remedies if the State demonstrates to the
8 Secretary’s satisfaction that the alternative remedies are effec-
9 tive in deterring noncompliance and correcting deficiencies, and
10 may provide”.

11 (b) **EFFECTIVE DATE.**—The amendment made by sub-
12 section (a) takes effect on the date of the enactment of this
13 Act.

14 **SEC. 4753. MODIFICATION OF MMIS REQUIREMENTS.**

15 (a) **IN GENERAL.**—Section 1903(r) (42 U.S.C. 1396b(r))
16 is amended—

17 (1) by striking all that precedes paragraph (5) and in-
18 serting the following:

19 “(r)(1) In order to receive payments under subsection (a)
20 for use of automated data systems in administration of the
21 State plan under this title, a State must have in operation
22 mechanized claims processing and information retrieval systems
23 that meet the requirements of this subsection and that the Sec-
24 retary has found—

25 “(A) are adequate to provide efficient, economical, and
26 effective administration of such State plan;

27 “(B) are compatible with the claims processing and in-
28 formation retrieval systems used in the administration of
29 title XVIII, and for this purpose—

30 “(i) have a uniform identification coding sys-
31 tem for providers, other payees, and beneficiaries
32 under this title or title XVIII;

33 “(ii) provide liaison between States and car-
34 riers and intermediaries with agreements under
35 title XVIII to facilitate timely exchange of appro-
36 priate data; and

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1 “(iii) provide for exchange of data between the
2 States and the Secretary with respect to persons
3 sanctioned under this title or title XVIII;

4 “(C) are capable of providing accurate and timely
5 data;

6 “(D) are complying with the applicable provisions of
7 part C of title XI;

8 “(E) are designed to receive provider claims in stand-
9 ard formats to the extent specified by the Secretary; and

10 “(F) effective for claims filed on or after January 1,
11 1999, provide for electronic transmission of claims data in
12 the format specified by the Secretary and consistent with
13 the Medicaid Statistical Information System (MSIS) (in-
14 cluding detailed individual enrollee encounter data and
15 other information that the Secretary may find necessary).”;

16 (2) in paragraph (5)—

17 (A) by striking subparagraph (B);

18 (B) by striking all that precedes clause (i) and in-
19 serting the following:

20 “(2) In order to meet the requirements of this paragraph,
21 mechanized claims processing and information retrieval systems
22 must meet the following requirements:”;

23 (C) in clause (iii), by striking “under paragraph
24 (6)”; and

25 (D) by redesignating clauses (i) through (iii) as
26 paragraphs (A) through (C); and

27 (3) by striking paragraphs (6), (7), and (8).

28 (b) CONFORMING AMENDMENTS.—Section
29 1902(a)(25)(A)(ii) (42 U.S.C. 1396a(a)(25)(A)(ii)) is amended
30 by striking all that follows “shall” and inserting the following:
31 “be integrated with, and be monitored as a part of the Sec-
32 retary’s review of, the State’s mechanized claims processing
33 and information retrieval systems required under section
34 1903(r);”.

35 (c) EFFECTIVE DATE.—Except as otherwise specifically
36 provided, the amendments made by this section shall take ef-
37 fect on January 1, 1998.

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1 **SEC. 4754. FACILITATING IMPOSITION OF STATE ALTER-**
2 **NATIVE REMEDIES ON NONCOMPLIANT**
3 **NURSING FACILITIES.**

4 (a) **IN GENERAL.**—Section 1919(h)(3)(D) (42 U.S.C.
5 1396r(h)(3)(D)) is amended—

6 (1) by inserting “and” at the end of clause (i);

7 (2) by striking “, and” at the end of clause (ii) and
8 inserting a period; and

9 (3) by striking clause (iii).

10 (b) **EFFECTIVE DATE.**—The amendments made by sub-
11 section (a) take effect on the date of the enactment of this Act.

12 **SEC. 4755. REMOVAL OF NAME FROM NURSE AIDE REG-**
13 **ISTRY.**

14 (a) **MEDICARE.**—Section 1819(g)(1) (42 U.S.C. 1395i-
15 3(g)(1)) is amended—

16 (1) by redesignating subparagraph (D) as subpara-
17 graph (E), and

18 (2) by inserting after subparagraph (C) the following:

19 “(D) **REMOVAL OF NAME FROM NURSE AIDE REG-**
20 **ISTRY.**—

21 “(i) **IN GENERAL.**—In the case of a finding of
22 neglect under subparagraph (C), the State shall es-
23 tablish a procedure to permit a nurse aide to peti-
24 tion the State to have his or her name removed
25 from the registry upon a determination by the
26 State that—

27 “(I) the employment and personal history
28 of the nurse aide does not reflect a pattern of
29 abusive behavior or neglect; and

30 “(II) the neglect involved in the original
31 finding was a singular occurrence.

32 “(ii) **TIMING OF DETERMINATION.**—In no case
33 shall a determination on a petition submitted under
34 clause (i) be made prior to the expiration of the 1-
35 year period beginning on the date on which the
36 name of the petitioner was added to the registry
37 under subparagraph (C).”

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1 (b) **MEDICAID.**—Section 1919(g)(1) (42 U.S.C.
2 1396r(g)(1)) is amended—

3 (1) by redesignating subparagraph (D) as subpara-
4 graph (E), and

5 (2) by inserting after subparagraph (C) the following:

6 “(D) REMOVAL OF NAME FROM NURSE AIDE REG-
7 ISTRY.—

8 “(i) **IN GENERAL.**—In the case of a finding of
9 neglect under subparagraph (C), the State shall es-
10 tablish a procedure to permit a nurse aide to peti-
11 tion the State to have his or her name removed
12 from the registry upon a determination by the
13 State that—

14 “(I) the employment and personal history
15 of the nurse aide does not reflect a pattern of
16 abusive behavior or neglect; and

17 “(II) the neglect involved in the original
18 finding was a singular occurrence.

19 “(ii) **TIMING OF DETERMINATION.**—In no case
20 shall a determination on a petition submitted under
21 clause (i) be made prior to the expiration of the 1-
22 year period beginning on the date on which the
23 name of the petitioner was added to the registry
24 under subparagraph (C).”.

25 (c) **RETROACTIVE REVIEW.**—The procedures developed by
26 a State under the amendments made by subsection (a) and (b)
27 shall permit an individual to petition for a review of any find-
28 ing made by a State under section 1819(g)(1)(C) or
29 1919(g)(1)(C) of the Social Security Act (42 U.S.C. 1395i-
30 3(g)(1)(C) or 1396r(g)(1)(C)) after January 1, 1995.

31 **SEC. 4756. MEDICALLY ACCEPTED INDICATION.**

32 Section 1927(g)(1)(B)(i) (42 U.S.C. 1396r-8(g)(1)(B)(i))
33 is amended—

34 (1) by striking “and” at the end of subclause (II),

35 (2) by redesignating subclause (III) as subclause (IV),

36 and

37 (3) by inserting after subclause (II) the following:

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1 “(III) the DRUGDEX Information Sys-
2 tem; and”.

3 **SEC. 4757. CONTINUATION OF STATE-WIDE SECTION 1115**
4 **MEDICAID WAIVERS.**

5 (a) **IN GENERAL.**—Section 1115 (42 U.S.C. 1315) is
6 amended by adding at the end the following new subsection:

7 “(e)(1) The provisions of this subsection shall apply to the
8 extension of any State-wide comprehensive demonstration
9 project (in this subsection referred to as ‘waiver project’) for
10 which a waiver of compliance with requirements of title XIX is
11 granted under subsection (a).

12 “(2) During the 6-month period ending 1 year before the
13 date the waiver under subsection (a) with respect to a waiver
14 project would otherwise expire, the chief executive officer of the
15 State which is operating the project may submit to the Sec-
16 retary a written request for an extension, of up to 3 years, of
17 the project.

18 “(3) If the Secretary fails to respond to the request within
19 6 months after the date it is submitted, the request is deemed
20 to have been granted.

21 “(4) If such a request is granted, the deadline for submit-
22 tal of a final report under the waiver project is deemed to have
23 been extended until the date that is 1 year after the date the
24 waiver project would otherwise have expired.

25 “(5) The Secretary shall release an evaluation of each
26 such project not later than 1 year after the date of receipt of
27 the final report.

28 “(6) Subject to paragraphs (4) and (7), the extension of
29 a waiver project under this subsection shall be on the same
30 terms and conditions (including applicable terms and conditions
31 relating to quality and access of services, budget neutrality,
32 data and reporting requirements, and special population protec-
33 tions) that applied to the project before its extension under this
34 subsection.

35 “(7) If an original condition of approval of a waiver
36 project was that Federal expenditures under the project not ex-
37 ceed the Federal expenditures that would otherwise have been

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1 made, the Secretary shall take such steps as may be necessary
2 to ensure that, in the extension of the project under this sub-
3 section, such condition continues to be met. In applying the
4 previous sentence, the Secretary shall take into account the
5 Secretary's best estimate of rates of change in expenditures at
6 the time of the extension."

7 (b) **EFFECTIVE DATE.**—The amendment made by sub-
8 section (a) shall apply to demonstration projects initially ap-
9 proved before, on, or after the date of the enactment of this
10 Act.

11 **SEC. 4758. EXTENSION OF MORATORIUM.**

12 Section 6408(a)(3) of the Omnibus Budget Reconciliation
13 Act of 1989, as amended by section 13642 of the Omnibus
14 Budget Reconciliation Act of 1993, is amended by striking
15 "December 31, 1995" and inserting "December 31, 2002".

16 **SEC. 4759. EXTENSION OF EFFECTIVE DATE FOR STATE**
17 **LAW AMENDMENT.**

18 In the case of a State plan under title XIX of the Social
19 Security Act which the Secretary of Health and Human Serv-
20 ices determines requires State legislation in order for the plan
21 to meet the additional requirements imposed by the amend-
22 ments made by a provision of this subtitle, the State plan shall
23 not be regarded as failing to comply with the requirements of
24 such title solely on the basis of its failure to meet these addi-
25 tional requirements before the first day of the first calendar
26 quarter beginning after the close of the first regular session of
27 the State legislature that begins after the date of the enact-
28 ment of this Act. For purposes of the previous sentence, in the
29 case of a State that has a 2-year legislative session, each year
30 of the session is considered to be a separate regular session of
31 the State legislature.

Impact on Children

The Republican Medicaid Plan may affect the health benefits of up to 18 million children:

No Guarantee of Coverage:

- No entitlement for certain groups of children.
 - Under current law, Medicaid coverage for children age 12-18 under 100% FL is being phased in. Under the Republican proposal coverage of this population is optional for the States -- if States decide to cover these children they only receive coverage for mandatory services.
- Medicaid populations will have to compete for Medicaid dollars -- children will lose to lobbyists, interest groups and advocates representing the elderly and the disabled.
 - Children represent over 49% of current Medicaid beneficiaries, however, 83% of Medicaid dollars are spent on services for adults, the elderly and the disabled.

Cuts up to \$250 billion by 2002

- The Republican cut in Federal Medicaid spending is \$72 billion, however, the total (Federal and State) reduction in spending could reach \$250 billion over six years.
- Under Republican proposals, State matching requirements are reduced, therefore, the amount a State would have to spend in order to receive its full Federal allotment is less than what they currently have to spend.
- States would be allowed to spend less on children than they currently do.
 - The reduction in state spending may mean the elimination of coverage of optional groups of children. States may choose to only cover the mandatory eligible groups.
 - The reduction in State spending may mean a reduction in services for children -- most likely a reduction in optional services such as speech, hearing and language services

Minimal Benefits Package

- Mandatory benefits are reduced under the Republican proposal.
- The Vaccines for Children program is eliminated under the Republican proposal. Low income parents are going to have to overcome cost and delivery system barriers in order to get their children immunized.

- States define the amount and frequency of medical services and benefits children receive.
- There is no requirement on States to treat illnesses and conditions discovered during preventive health screens and exams.
- Follow-up treatment is mandated only for vision, hearing, and dental services. Right now children are guaranteed coverage for services medically necessary to treat an illness or condition discovered during health screens and exams.

Cuts in Optional Benefits

- There are no defined optional benefits under the Republican proposal.
- Current optional benefits used extensively by Medicaid eligible children include personal care services that allow children to stay at home with their families rather than in institutions; speech, hearing and language disorder services which assist with child development and education; physical therapy services which aids mobility; etc.
- The elimination of the current treatment requirement coupled with the lack of defined optional benefits means that some children may not receive comprehensive health benefits.

Redefining Disability may Result in Cuts to Disabled Children

- States have the option to define disability - this could result in fifty different definitions of disability.
- This discretion allows States to deny benefits to certain disabled populations currently receiving Medicaid benefits. Over 4 percent of the children on Medicaid are disabled.
- Medicaid is the primary source of payment for medical services for children with disabilities.
 - These children and their families stand the most to lose under the Republican proposal. Their conditions demand intensive health care services - usually the most expensive to provide.
 - If states are forced to provide medical care under a block grant, coverage for the most expensive services, particularly services provided in a home setting, would be reduced.
 - Medicaid covers 90 percent of all children with HIV and AIDS.

CBO Estimate of President's Budget Plan for Medicaid

(By fiscal year, in billions of dollars)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	1998-2002
SAVINGS											
Per Capita Cap Savings	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Disproportionate Share Hospital (DSH) Savings	-0.3	-2.1	-3.8	-4.7	-5.6	-6.6	-7.7	-8.9	-10.2	-11.6	-16.6
Pools											
Federally Qualified Health Centers	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Transition Pool	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
MEDICAID GROSS SAVINGS	-0.3	-2.1	-3.8	-4.7	-5.6	-6.6	-7.7	-8.9	-10.2	-11.6	-16.6
Other											
Puerto Rico Increase	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3
Working Disabled	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Raise DC FMAP to 70%	0.1	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.9
Eliminate Vaccine Excise Tax	-0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1
SUBTOTAL	0.1	0.2	0.2	0.3	0.3	0.3	0.3	0.4	0.4	0.4	1.1
Interactions											
Medicare Part B Premium Increase	0.0	0.1	0.2	0.2	0.4	0.6	0.8	1.1	1.3	1.6	0.9
TOTAL INVESTMENTS	-0.2	-1.8	-3.4	-4.2	-4.9	-5.7	-6.5	-7.5	-8.5	-9.6	-14.5

THE WHITE HOUSE

WASHINGTON

September 23, 1996

MEMORANDUM TO THE PRESIDENT

FROM: Carol Rasco  and Chris Jennings 

SUBJECT: Decline in the Medicaid Growth Rate and Baseline

Largely unnoticed, Medicaid baseline reductions have made a significant contribution to the decline in the Federal deficit. In fact, in their recently-released budget outlook report that reduced the 1996 Federal deficit to \$116 billion, the Congressional Budget Office (CBO) stated that "the largest single re-estimate is a (1 year) \$4 billion reduction in Medicaid outlays." The reduction in expenditures has produced an aggregate Medicaid growth rate of 3 percent between 1995 and 1996, the lowest growth rate in over 20 years. This translates into an astounding 1 to 2 percent per capita (or per person) increase in spending -- well below the 20-year average annual Medicaid per capita growth rate of 11 percent.

Since you unveiled your balanced budget last year, the CBO Medicaid baseline has declined by \$52 billion. The comparable reduction in the Administration Medicaid baseline is about \$20 billion; (it is less because OMB started with a lower spending base, has been assuming lower growth rates, and has integrated more accurate economic assumptions all along.) This trend will continue as we fully expect this winter's baseline adjustments (off both the CBO and OMB baselines) to produce tens of billions of dollars of additional savings. As a result, without enacting a single Medicaid cut, you will preside over a program whose CBO baseline (after this winter's adjustment) will have been reduced in the budget window by as much as (if not more than) \$80 billion since 1995, and more than \$50 billion off of the OMB baseline during that same period.

Many factors have contributed to the decline in the Medicaid baseline. They include: (1) increased utilization of managed care and other cost-cutting initiatives implemented by the states; (2) an improved economy with much lower inflation; and (3) reduced use of "creative" Disproportionate Share and provider donation financing mechanisms by states.

The fact that Medicaid's growth has slowed so rapidly is good news. It mirrors the positive news about health care inflation in the private sector you occasionally cite. However, we must be cautious about heralding it too much because it tends to undermine our criticism of the magnitude of the Republicans' Medicare cuts. For example, we appropriately criticized the Republicans' Medicare cuts, but their proposal (at the time of the veto) would have allowed for a 4.9 percent per person growth rate -- above what the 1995 to 1996 per capita Medicaid growth rate was by 2 to 3 percentage points. In short, when we highlight the success of the private and Medicaid sectors in constraining costs, we risk someone charging that we are being inconsistent in not suggesting that Medicare be held to the same standard.

Most health economists are dubious that last year's low growth rate can be extended for a prolonged period. They believe that much of the savings represent a one-time constriction of excess capacity and inefficiency in the health care system. Moreover, because of historically high health inflation (recall the 11 percent average per capita over the last 20 years), CBO and OMB estimators are extremely weary of lowering their projected Medicaid growth rates, particularly in the out-years. While they may lower their budget window per capita growth rates from 7 percent to 6 percent or at most 5 percent (which is probably the range that they will assume private sector growth rates will be), the estimators will not lower their projected growth rates to anywhere near last year's unofficial Medicaid per capita number of between 1 and 2 percent.

Regardless of the final projections, it is clear that our current Medicaid 5 percent per capita cap proposal will not score significant savings off the downsized CBO Medicaid 5 to 6 percent average per capita baseline. If we do need or want additional savings, we will need to tighten up the allowable average growth rates to probably no more than 4 percent over the budget window. The primary outstanding question is: Can this program sustain this level of constraint without undermining the care it provides to its population?

Clearly, medical and general health inflation have significantly moderated. Very few health care analysts would have projected two years ago that health inflation would be running as low as it is. If current trends are sustained, holding the Medicaid program to a 4 percent average per capita growth rate is conceivable.

Having said this, since Medicaid would have to grow 20-30 percent below what will likely be the revised CBO average private sector per capita rate (of 5-6 percent), we probably could not get many health care economists to validate such a low, sustained growth rate. This is particularly the case because of the increasing numbers of high-cost elderly and disabled populations served by Medicaid.

More importantly, we might re-open the door to another serious block grant debate, since states would be more likely than ever to reject such reductions in Federal support without the elimination of virtually all Federal strings. Coverage expansion through or with Medicaid would have to be put off for a while, since no or few states would have the appetite and the resources to take it on. And lastly, reducing Federal financing might place overwhelming pressures on the states to demand that their waivers (old or new) be exempted from changes in financing. If this occurred, we would have even a greater rush to grant and grandfather-in politically-charged state waiver applicants. If this happened, Medicaid savings would be much more difficult to achieve.

We still believe that the Medicaid flexibility reforms you have proposed can achieve savings for the states (and the Federal Government) and are good policy. Moreover, we probably could get some limited savings from a slightly tighter per capita cap, as well as some additional contributions from DSH. Having said this, as we continue to witness billions of dollars of additional Medicaid baseline reductions help lower the deficit, we may want to start lowering our expectations of how much savings we can or should include in our next budget proposal.

December 20, 1996

MEMORANDUM TO HILLARY RODHAM CLINTON

FROM: Chris Jennings 
RE: Medicaid and Health Care Investments

At your request, I have enclosed a copy of the Medicaid/Health Care Investments presentation given to the President this morning. A final decision has not yet been made, but it appears that the President believes Medicaid savings should be lower than the number Frank Raines has been carrying in the budget tables (\$30 billion in five years, \$17 billion in FY 02).

During the meeting, the President indicated his willingness to retain the per capita cap as long as it does not achieve savings off the baseline until FY 01 or FY 02. This will likely result in \$3 to \$10 billion in per capita cap savings over five years. Additionally, the President expressed his concern about making severe cuts in Disproportionate Share Hospital (DSH) payments and, as a result, may be more comfortable with our more moderate DSH savings proposal (about \$10 billion over five years). This would leave our total Medicaid savings numbers to about \$10 billion in FY 02 and \$20 billion over five years.

Personally, I believe the Medicaid number should be no more than \$8 billion in FY 02 and \$15 billion over five years to avoid implementing either a politically unpopular and excessively tight per capita cap or severe DSH savings. In short, this approach would provide us flexibility to work out an agreement with the governors on the best way to achieve needed savings. This would help us invest the governors in our efforts to expand health care coverage to children.

As for the children's initiatives, the President seemed very interested in all the options offered and, in particular, package B on page 9 of the enclosed document. (As you will note, package B drops the last year financing of the workers in between jobs option). To pay for this package and cover an additional 5 million children, it would likely require \$3.5 billion in FY 02 and \$12 billion over 5 years. As always, competing demands with other priorities pose the challenge to finding these dollars.

Lastly, the Vice President continues to raise the possibility of moving the SPECTRUM sale from FY 03 to FY 02 to generate additional resources to reduce the impact of cuts and allow for increased domestic investments. This may be the best option to ensure an adequate kids package and to achieve a more moderate Medicaid savings number (and achieve a balanced budget in 2002).

If you have any questions, please call me.