

1 **TITLE VII—MEDICAID REFORM**

2 **SEC. 7000. REFERENCES IN TITLE; TABLE OF CONTENTS.**

3 (a) **AMENDMENTS TO SOCIAL SECURITY ACT.**—Except as
4 otherwise specifically provided, whenever in this title an amend-
5 ment is expressed in terms of an amendment to or repeal of
6 a section or other provision, the reference shall be considered
7 to be made to that section or other provision of the Social Se-
8 curity Act.

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

TITLE VII—MEDICAID REFORM

Sec. 7000. References in title; table of contents.

Subtitle A—Average Per Capita Spending Limit

Sec. 7001. Limitation on expenditures recognized for purposes of Federal financial participation.

Subtitle B—Medicaid Managed Care

Sec. 7101. Permitting greater flexibility for States to enroll beneficiaries in managed care arrangements.

Sec. 7102. Removal of barriers to provision of medicaid services through managed care.

Sec. 7103. Additional requirements for medicaid managed care plans.

Sec. 7104. Preventing fraud in medicaid managed care.

Sec. 7105. Assuring adequacy of payments to medicaid managed care plans and providers.

Sec. 7106. Sanctions for noncompliance by eligible managed care providers.

Sec. 7107. Report on public health services.

Sec. 7108. Report on payments to hospitals.

Sec. 7109. Conforming amendments.

Sec. 7110. Effective date; status of waivers.

Subtitle C—Additional State Flexibility in Medicaid Acute Care Program

Sec. 7201. Permitting increased flexibility in medicaid cost-sharing.

Sec. 7202. Limits on required coverage of additional treatment services under EPSDT.

Sec. 7203. Application of standards for payment for hospitals and nursing facilities.

Sec. 7204. Making home and community-based services optional benefit not subject to waiver requirements.

Sec. 7205. Revision of requirements relating to Federally qualified health centers and rural health clinics; establishment of separate direct payment program.

Sec. 7206. Eligibility for ~~TM~~-related populations.

Sec. 7207. Repeal of certain restrictions on obstetrical and pediatric providers.

Sec. 7208. Elimination of requirement to pay for private insurance.

Sec. 7209. Elimination of obstetrical and pediatric payment rate requirements.

Sec. 7210. Requirement of exhaustion of administrative remedies before bringing action in Federal court.

Subtitle D—National Commission on Medicaid Restructuring

- Sec. 7301. Establishment of Commission.
- Sec. 7302. Duties of Commission.
- Sec. 7303. Administration.
- Sec. 7304. Authorization of appropriations.
- Sec. 7305. Termination.

Subtitle E—Restrictions on Disproportionate Share Payments

Sec. 7401. Reforming disproportionate share payments under State medic-aid programs.

Subtitle F—Fraud Reduction

- Sec. 7501. Monitoring payments for dual eligibles.
- Sec. 7502. Improved identification systems.

Subtitle G—State Plan Administration

- Sec. 7601. MMIS requirements.
- Sec. 7602. Elimination of personnel requirements.
- Sec. 7603. Elimination of requirements for cooperative agreements with health agencies.
- Sec. 7604. Elimination of requirement for annual independent review of HMO care.
- Sec. 7605. State review of mentally ill or retarded nursing facility residents upon change in physical or mental condition.
- Sec. 7606. Nurse aide training in medicare and medicaid nursing facilities subject to extended survey and under certain other conditions.
- Sec. 7607. Public process for developing State plan amendments.

Subtitle H—Provider Eligibility for PACE Projects

Sec. 7701. Provider eligibility for pace projects.

Subtitle A—Spending Limitations

SEC. 7001. LIMITATION ON EXPENDITURES RECOGNIZED FOR PURPOSES OF FEDERAL FINANCIAL PARTICIPATION.

(a) LIMITATION.—

(1) IN GENERAL.—Title XIX is amended—

(A) in section 1903(a), by striking “From” and inserting “Subject to section 1931, from”;

(B) by redesignating section 1931 as section 1932;

and

(C) by inserting after section 1930 the following

new section:

“LIMITATION ON FEDERAL FINANCIAL PARTICIPATION

“SEC. 1931. (a) LIMITATION.—

1 “(1) IN GENERAL.—Subject to subsection (c), the total
2 amount of State expenditures for medical assistance for
3 which Federal financial participation may be made under
4 section 1903(a) for quarters in a fiscal year (beginning
5 with fiscal year 1997) may not exceed the greater of—

6 “(A) the base amount specified in paragraph (2),

7 or

8 “(B) growth-adjusted amount specified in para-
9 graph (3), which is subject to an umbrella adjustment
10 under subsection (d)(5)).

11 “(2) BASE AMOUNT.—The base amount specified in
12 this paragraph is (subject to subsection (c)) the total
13 amount of State expenditures for medical assistance for
14 which Federal financial participation was made under sec-
15 tion 1903(a) for quarters in any of the following base years
16 (as selected by the State and in this section referred to as
17 the ‘base fiscal year’ for that State):

18 “(A) Fiscal year 1993.

19 “(B) Fiscal year 1994.

20 “(C) Fiscal year 1995.

21 “(3) GROWTH-ADJUSTED AMOUNT.—

22 “(A) FISCAL YEAR 1997.—The growth-adjusted
23 amount specified in this paragraph for a State for fis-
24 cal year 1997 is equal to the product of—

25 “(i) the base amount specified in paragraph
26 (2) for the State,

27 “(ii) a factor equal to 1 plus the weighted av-
28 erage enrollment growth rate (specified in para-
29 graph (4)) for the State for fiscal year 1996,

30 “(iii) a factor equal to 1 plus the weighted av-
31 erage enrollment growth rate (specified in para-
32 graph (4)) for the State for fiscal year 1997,

33 “(iv) a factor equal to 1 plus the inflation ad-
34 juster (specified in paragraph (5)) for fiscal year
35 1996, and

36 “(v) a factor equal to 1 plus the inflation ad-
37 juster for fiscal year 1997.

1 “(B) SUBSEQUENT FISCAL YEAR.—The growth-
2 adjusted amount specified in this paragraph for a State
3 for a subsequent fiscal year is equal to the product
4 of—

5 “(i) the growth-adjusted amount under this
6 paragraph for the State for the previous fiscal year,

7 “(ii) a factor equal to 1 plus the weighted av-
8 erage enrollment growth rate (specified in para-
9 graph (4)) for the State for the fiscal year, and

10 “(iii) a factor equal to 1 plus the inflation ad-
11 juster (specified in paragraph (5)) for the fiscal
12 year.

13 The growth-adjusted amount under clause (i) is subject
14 to an umbrella adjustment under subsection (d)(5).

15 “(4) WEIGHTED AVERAGE ENROLLMENT GROWTH
16 RATE.—For purposes of this subsection, the ‘weighted aver-
17 age enrollment growth rate’ for a State for a fiscal year is
18 the sum of the following:

19 “(A) The sum of the products, for each of the 4
20 categories of medicaid beneficiary (as defined in sub-
21 section (b)(7)), of (i) the percentage change in the
22 number of full-year equivalent individuals in such cat-
23 egory in the State in the fiscal year (compared to such
24 number in the previous fiscal year, or, for fiscal year
25 1996, in the base fiscal year for the State), and (ii) the
26 proportion, of the State medical assistance expenditures
27 (other than expenditures excluded under subsection (c))
28 for which Federal financial participation was provided
29 to the State in the previous fiscal year, which is attrib-
30 utable to expenditures under paragraphs (1) and (5) of
31 section 1903(a) with respect to medical assistance fur-
32 nished for individuals in such category.

33 “(B) The product of (i) the percentage change in
34 the number of full-year equivalent individuals in any of
35 the separate categories of medicaid beneficiary in the
36 State in the fiscal year (compared to such number in
37 the previous fiscal year, or, for fiscal year 1996, in the

1 base fiscal year for the State), and (ii) 100 percent
2 minus the sum of the proportions specified under
3 clause (ii) of subparagraph (A).

4 “(5) INFLATION ADJUSTER.—In this subsection, the
5 ‘inflation adjuster’ for a fiscal year is—

6 “(A) the percentage by which—

7 “(i) the Secretary’s estimate (before the begin-
8 ning of the fiscal year) of the average value of the
9 consumer price index for all urban consumers (all
10 items, U.S. city average) for months in the particu-
11 lar fiscal year, exceeds

12 “(ii) the average value of such index for
13 months in the previous fiscal year; increased by

14 “(B)(i) 4.0 percentage points for fiscal year 1996;

15 “(ii) 3.0 percentage points for fiscal year 1997;

16 “(iii) 2.0 percentage points for each of fiscal years
17 1998, 1999, and 2000; and

18 “(iv) 1.0 percentage points for each [of fiscal
19 years 2001 and 2002]/[subsequent fiscal year].

20 The Secretary shall not reestimate or recompute the infla-
21 tion adjuster for a fiscal year after the beginning of a fiscal
22 year.

23 “(6) LIMITATION ONLY ON EXPENDITURES FOR
24 WHICH FFP AVAILABLE.—This section does not apply to ex-
25 penditures for which no Federal financial participation is
26 available under this title.

27 “(b) DEFINITIONS RELATING TO CATEGORIES OF INDI-
28 VIDUALS AND MEDICAID BENEFICIARIES.—In this section:

29 “(1) NONDISABLED MEDICAID CHILD.—The term
30 ‘nondisabled medicaid child’ means an individual entitled to
31 medical assistance under the State plan under this title
32 who is not disabled (as such term is used under paragraph
33 (4)), not a QMB-related individual (as defined in para-
34 graph (5)), and is under 21 years of age.

35 “(2) NONDISABLED MEDICAID ADULTS.—The term
36 ‘nondisabled medicaid adult’ means an individual entitled
37 to medical assistance under the State plan under this title

1 who is not disabled (as such term is used under paragraph
2 (4)), not a QMB-related individual (as defined in para-
3 graph (5)), and is at least 21 years of age but under 65
4 years of age.

5 “(3) ELDERLY MEDICAID BENEFICIARY.—The term
6 ‘elderly medicaid beneficiary’ means an individual entitled
7 to medical assistance under the State plan under this title
8 who at least 65 years of age and is not a QMB-related indi-
9 vidual (as defined in paragraph (5)).

10 “(4) DISABLED MEDICAID BENEFICIARIES.—The term
11 ‘disabled medicaid beneficiary’ means an individual entitled
12 to medical assistance under the State plan under this title
13 who is entitled to such assistance on the basis of blindness
14 or disability and is not a QMB-related individual (as de-
15 fined in paragraph (5)).

16 “(5) QMB-RELATED INDIVIDUAL.—The term ‘QMB-
17 related individual’ means an individual who is eligible only
18 for benefits described in section 1902(a)(10)(E) under this
19 title as—

20 “(A) a qualified medicare beneficiary (as defined
21 in section 1905(p)(1)),

22 “(B) a qualified disabled and working individual
23 (as defined in section 1905(s)), or

24 “(C) an individual described in section
25 1902(a)(10)(E)(iii).

26 “(6) MEDICAID BENEFICIARY.—The term ‘medicaid
27 beneficiary’ means an individual enrolled in the State pro-
28 gram under this title, other than an individual described in
29 section 1902(a)(10)(G).

30 “(7) CATEGORY.—Nondisabled medicaid children, non-
31 disabled medicaid adults, elderly medicaid beneficiaries, and
32 disabled medicaid beneficiaries each constitute a separate ‘cat-
33 egory’ of medicaid beneficiaries.

34 “(c) SPECIAL RULES AND EXCEPTIONS.—For purposes of
35 this section, expenditures attributable to any of the following
36 shall not be subject to the limits established under this section

1 and shall not be taken into account in computing base amounts
2 under subsection (a)(2):

3 “(1) DSH.—Payment adjustments under section
4 1923.

5 “(2) MEDICARE COST-SHARING.—Payments for medi-
6 cal assistance described in section 1902(a)(10)(E).

7 “(3) INDIAN HEALTH PROGRAMS.—Amounts for medi-
8 cal assistance for services provided by—

9 “(A) the Indian Health Service;

10 “(B) Indian health programs operated by an In-
11 dian tribe or tribal organization pursuant to a contract,
12 grant, cooperative agreement, or compact with the In-
13 dian Health Service pursuant to the Indian Self-Deter-
14 mination Act (25 U.S.C. 450 et seq.); and

15 “(C) urban Indian health programs operated by an
16 urban Indian organization pursuant to a grant or con-
17 tract with the Indian Health Service pursuant to title
18 V of the Indian Health Care Improvement Act (25
19 U.S.C. 1601 et seq.).

20 “(4) FRAUD AND ABUSE ACTIVITIES.—Amounts paid
21 for activities of State medicaid fraud control units pursuant
22 to section 1903(a)(6).

23 “(5) SAVE.—Amounts for expenditures attributable to
24 implementation of the immigration status verification sys-
25 tem described in section 1137(d).

26 “(6) NURSING FACILITY SURVEY AND CERTIFI-
27 CATION.—Amounts paid pursuant to section 1903(a)(2)(D)
28 for State survey and certification activities pursuant to sec-
29 tion 1919(g).

30 “(7) PAYMENTS FOR GRANTS FOR UNFUNDED COSTS
31 OF RURAL HEALTH CLINICS AND FEDERALLY-QUALIFIED
32 HEALTH CENTERS.—Amounts paid pursuant to a grant
33 under section 1933.

34 “(8) CERTAIN EXPENDITURES FOR UNDOCUMENTED
35 ALIENS.—Payments for medical assistance described in sec-
36 tion 1932.

1 Nothing in this section shall be construed as applying any limitation to expenditures for the purchase and delivery of qualified
2 pediatric vaccines under section 1928.

3
4 “(d) ESTIMATIONS AND NOTICE; UMBRELLA INSURANCE
5 ADJUSTMENT FOR UNDERESTIMATES AND OVERESTIMATES IN
6 CASELOAD.—

7 “(1) IN GENERAL.—The Secretary shall—

8 “(A) establish a process for estimating the limits
9 established under subsection (a) for each State before
10 the beginning of each fiscal year and adjusting such estimates during such year; and

11
12 “(B) notifying each State of the estimates and adjustments referred to in subparagraph (A).

13
14 “(2) REPORTS.—

15 “(A) IN GENERAL.—The Secretary shall produce,
16 for each fiscal year (beginning with fiscal year 1997)
17 the following reports that specify the growth-adjusted
18 amount under subsection (a)(3) for each State for the
19 fiscal year (taking into account any umbrella adjustment under paragraph (5)):

20
21 “(i) PRELIMINARY REPORT.—A preliminary
22 report in July before the beginning of the fiscal
23 year.

24 “(ii) INTERIM REPORT.—An interim report at
25 such time during the fiscal year as permits a semi-
26 annual umbrella adjustment under paragraph (5).

27 “(iii) FINAL REPORT.—A final report not later
28 than 6 months after the end of the fiscal year.

29 “(B) CONTENTS OF REPORT.—Each such report
30 for a fiscal year shall include for each State for the fiscal year an estimate or statement of—

31
32 “(i) the weighted average enrollment growth
33 rate;

34 “(ii) the number of full-year equivalent individuals in each category of medicaid beneficiary;

35
36 “(iii) the growth-adjusted amount under subsection (a)(3); and
37

1 “(iv) the amount of any umbrella adjustment
2 under paragraph (5).

3 “(3) DETERMINATION OF NUMBER OF FULL-YEAR
4 EQUIVALENT INDIVIDUALS.—

5 “(A) STANDARD FORMULA.—

6 “(i) IN GENERAL.—For purposes of this sec-
7 tion, the number of full-year equivalent individuals
8 in each category described in subsection (b) for a
9 State for a year shall be determined, subject to
10 subparagraph (B), based on actual reports submit-
11 ted by the State to the Secretary.

12 “(ii) PART-YEAR ENROLLEES.—In the case of
13 individuals who were not enrolled under the State
14 program under this title for the entire fiscal year
15 (or are within a group of individuals for only part
16 of a fiscal year), the number shall take into ac-
17 count only the portion of the year in which they
18 were so enrolled or within such group.

19 “(B) ALTERNATIVE FORMULA FOR STATES OPER-
20 ATING UNDER WAIVERS IN BASE YEAR.—

21 “(i) IN GENERAL.—A State that, during fiscal
22 year 1995, had in effect a program under this title
23 under which individuals not otherwise eligible were
24 enrolled pursuant to waivers under section 1115
25 may elect to make the calculations required by this
26 paragraph for fiscal year 1995 in the manner speci-
27 fied in clause (ii).

28 “(ii) ASSUMPTIONS FOR PURPOSES OF ALTER-
29 NATIVE CALCULATION.—For purposes of the cal-
30 culation under this subparagraph it shall be as-
31 sumed—

32 “(I) that only individuals eligible for medi-
33 cal assistance (or who would have been eligible
34 if the State had exercised the option under sec-
35 tion 1902(r)(2)) without regard to such waivers
36 received such assistance; and

1 “(II) that notwithstanding subclause (I),
2 State expenditures for individuals eligible for
3 medical assistance only through such waivers
4 shall be taken into account for purposes of de-
5 termining what percentage of State expendi-
6 tures for each group of individuals defined in
7 subsection (b) bears to total State expenditures
8 for medical assistance in such State.

9 “(iii) DEADLINE FOR ELECTION OF OPTION.—
10 Election by a State of the option under this sub-
11 paragraph must be made not later than September
12 1996.

13 “(C) SECRETARIAL OVERSIGHT.—In order to en-
14 sure the accuracy of the numbers reported by States
15 pursuant to subparagraph (A), the Secretary may—

16 “(i) require documentation, whether on a sam-
17 ple or other basis;

18 “(ii) audit such reports (or require the per-
19 formance of independent audits); and

20 “(iii) revise the numbers so reported.

21 “(4) BASIS FOR ESTIMATIONS.—The Secretary shall
22 estimate the number of full-year equivalents before a fiscal
23 year taking into account—

24 “(A) estimates provided by the State,

25 “(B) the medicaid eligibility criteria and standards
26 under each State plan,

27 “(C) legislation enacted or pending in each State,

28 “(D) historical trends in medicaid enrollment in
29 the State, and

30 “(E) economic conditions in the State.

31 “(5) UMBRELLA ADJUSTMENT.—

32 “(A) IN GENERAL.—Based on reports provided
33 under paragraph (2), the Secretary shall provide for a
34 process for adjustment of estimated limits under this
35 section on a semi-annual basis in order to take into ac-
36 count the most current data available on actual medic-

1 aid beneficiary enrollments in the different categories
2 in each State.

3 "(B) ADJUSTMENTS.—If the actual number of
4 full-year equivalent individuals for a category in a State
5 is—

6 "(i) greater than the number of such equiva-
7 lents previously estimated, then the Secretary shall
8 increase the growth-adjusted amount under this
9 section in order to take into account the actual
10 number of full-year equivalents in that category in
11 that State (as well as the actual number of such
12 equivalents in other categories), or

13 "(ii) less than the number of such equivalents
14 previously estimated, then the Secretary shall de-
15 crease the growth-adjusted amount under this sec-
16 tion in order to take into account the actual num-
17 ber of full-year equivalents in that category in that
18 State (as well as the actual number of such equiva-
19 lents in other categories).

20 Adjustments under this subparagraph shall apply to
21 the fiscal year involved and (under the formulas pro-
22 vided under subsection (a)) for subsequent fiscal years.

23 (2) LIMITATION ON FEDERAL FINANCIAL PARTICIPA-
24 TION.—Section 1903 (42 U.S.C. 1396b) is amended by
25 adding at the end the following new subsection:

26 "(x)(1) Notwithstanding the previous provisions of this
27 section but subject to paragraph (3), the Secretary shall incur
28 no obligation after September 30, 1996, to make payments to
29 a State for State expenditures that exceed the limitation on
30 Federal financial participation specified in section 1931.

31 "(2) No payment shall be made to a State with respect
32 to an obligation incurred before October 1, 1996, unless the
33 State has submitted to the Secretary by not later than June
34 30, 1997, a claim for Federal financial participation for ex-
35 penses paid by the State with respect to such obligation.

1 “(3) Nothing in paragraph (1) shall be construed as af-
2 fecting the obligation of the Federal Government to pay claims
3 described in paragraph (2).

4 “(4) Nothing in this subsection or section 1931 shall be
5 construed as affecting the entitlement of eligible individuals to
6 medical assistance under this title.”.

7 (b) ENFORCEMENT-RELATED PROVISIONS.—

8 (1) ASSURING ACTUAL PAYMENTS TO STATES CON-
9 SISTENT WITH LIMITATION.—Section 1903(d) (42 U.S.C.
10 1396b(d)) is amended—

11 (A) in paragraph (2)(A), by striking “The Sec-
12 retary” and inserting “Subject to paragraph (7), the
13 Secretary”, and

14 (B) by adding at the end the following new para-
15 graph:

16 “(7)(A) The Secretary shall take such steps as are nec-
17 essary to assure that payments under this subsection for quar-
18 ters in a fiscal year are consistent with the payment limits es-
19 tablished under section 1931 for the fiscal year. Such steps
20 may include limiting such payments for one or more quarters
21 in a fiscal year based on—

22 “(i) an appropriate proportion of the payment limits
23 for the fiscal year involved, and

24 “(ii) numbers of individuals within each category, as
25 reported under subparagraph (B) for a recent previous
26 quarter.

27 “(B) Each State shall include, in its report filed under
28 paragraph (1)(A) for a calendar quarter—

29 “(i) the actual number of individuals within each cat-
30 egory described in section 1931(b) for the second previous
31 calendar quarter and (based on the data available) for the
32 previous calendar quarter, and

33 “(ii) an estimate of such numbers for the calendar
34 quarter involved.”.

35 (2) RESTRICTION ON AUTHORITY OF STATES TO
36 APPLY LESS RESTRICTIVE INCOME AND RESOURCE METH-
37 ODOLOGIES.—Section 1902(r)(2) (42 U.S.C. 1396a(r)(2))

1 is amended by adding at the end the following new sub-
2 paragraph:

3 “(C) Subparagraph (A) shall not apply to plan amend-
4 ments made on or after October 15, 1995.”

5 (c) CONFORMING AMENDMENT.—Section 1903(i) (42
6 U.S.C. 1396b(i)) is amended—

7 (1) by striking “or” at the end of paragraph (14),

8 (2) by striking the period at the end of paragraph (15)
9 and inserting “; or”, and

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

11 “(16) in accordance with section 1931, with respect to
12 amounts expended to the extent they exceed applicable lim-
13 its established under section 1931(a).”

14 (d) EFFECTIVE DATE.—The amendments made by this
15 section shall apply to payments for calendar quarters beginning
16 on or after October 1, 1996.

17 **Subtitle B—Medicaid Managed Care**

18 **SEC. 7101. PERMITTING GREATER FLEXIBILITY FOR** 19 **STATES TO ENROLL BENEFICIARIES IN MAN-** 20 **AGED CARE ARRANGEMENTS.**

21 (a) IN GENERAL.—Title XIX (42 U.S.C. 1396 et seq.), as
22 amended by section 7001(a), is amended—

23 (1) by redesignating section 1932 as section 1933; and

24 (2) by inserting after section 1931 the following new
25 section:

26 **“STATE OPTIONS FOR ENROLLMENT OF BENEFICIARIES IN** 27 **MANAGED CARE ARRANGEMENTS**

28 **“SEC. 1932. (a) MANDATORY ENROLLMENT.—**

29 **“(1) IN GENERAL.—Subject to the succeeding provi-**
30 **sions of this section and notwithstanding paragraphs (1),**
31 **(10)(B), and (23) of section 1902(a), a State may require**
32 **an individual eligible for medical assistance under the State**
33 **plan under this title to enroll with an eligible managed care**
34 **provider as a condition of receiving such assistance and,**
35 **with respect to assistance furnished by or under arrange-**
36 **ments with such provider, to receive such assistance**
37 **through the provider, if the following provisions are met:**

1 “(A) The provider meets the requirements of sec-
2 tion 1933.

3 “(B) The provider enters into a contract with the
4 State to provide services for the benefit of individuals
5 eligible for benefits under this title under which prepaid
6 payments to such provider are made on an actuarially
7 sound basis.

8 “(C) There is sufficient capacity among all provid-
9 ers meeting such requirements to enroll and serve the
10 individuals required to enroll with such providers.

11 “(D) The individual is not a special needs individ-
12 ual (as defined in subsection (c)).

13 “(E)(i) The State permits an individual to choose
14 an eligible managed care provider—

15 “(I) from among not less than 2 medicaid
16 managed care plans, or

17 “(II) between a medicaid managed care plan
18 and a primary care case management provider.

19 “(ii) At the option of the State, a State shall be
20 considered to meet the requirements of clause (i) in the
21 case of an individual residing in a rural area, if the
22 State—

23 “(I) requires the individual to enroll with a
24 medicaid managed care plan or primary care case
25 management provider if such plan or provider per-
26 mits the individual to receive such assistance
27 through not less than 2 providers (to the extent
28 that at least 2 providers are available to provide
29 such assistance in the area), and

30 “(II) permits the individual to obtain such as-
31 sistance from any other provider in appropriate cir-
32 cumstances (as established by the State under reg-
33 ulations of the Secretary).

34 “(F) The State provides the individual with the
35 opportunity to change enrollment among eligible man-
36 aged care providers not less than once annually and no-
37 tifies the individual of such opportunity not later than

1 60 days prior to the first date on which the individual
2 may change enrollment.

3 “(G) The State establishes a method for establish-
4 ing enrollment priorities in the case of an eligible man-
5 aged care provider that does not have sufficient capac-
6 ity to enroll all such individuals seeking enrollment
7 under which individuals already enrolled with the pro-
8 vider are given priority in continuing enrollment with
9 the provider.

10 “(H) The State establishes a default enrollment
11 process which meets the requirements described in
12 paragraph (2) and under which any such individual
13 who does not enroll with an eligible managed care pro-
14 vider during the enrollment period specified by the
15 State shall be enrolled by the State with such a pro-
16 vider in accordance with such process.

17 “(I) The State establishes the sanctions provided
18 for in section 1934.

19 “(2) DEFAULT ENROLLMENT PROCESS REQUIRE-
20 MENTS.—The default enrollment process established by a
21 State under paragraph (1)(E)(iv) shall—

22 “(A) provide that the State may not enroll individ-
23 uals with an eligible managed care provider which is
24 not in compliance with the requirements of section
25 1933; and

26 “(B) provide for an equitable distribution of indi-
27 viduals among all eligible managed care providers avail-
28 able to enroll individuals through such default enroll-
29 ment process, consistent with the enrollment capacities
30 of such providers.

31 “(b) REENROLLMENT OF INDIVIDUALS WHO REGAIN ELI-
32 GIBILITY.—

33 “(1) IN GENERAL.—If an individual eligible for medi-
34 cal assistance under a State plan under this title and en-
35 rolled with an eligible managed care provider with a con-
36 tract under subsection (a)(1)(B) ceases to be eligible for
37 such assistance for a period of not greater than 2 months,

1 the State may provide for the automatic reenrollment of
2 the individual with the provider as of the first day of the
3 month in which the individual is again eligible for such as-
4 sistance.

5 “(2) CONDITIONS.—Paragraph (1) shall only apply
6 if—

7 “(A) the month for which the individual is to be
8 reenrolled occurs during the enrollment period covered
9 by the individual’s original enrollment with the eligible
10 managed care provider;

11 “(B) the eligible managed care provider continues
12 to have a contract with the State agency under sub-
13 section (a)(1)(B) as of the first day of such month; and

14 “(C) the eligible managed care provider complies
15 with the requirements of section 1933.

16 “(3) NOTICE OF REENROLLMENT.—The State shall
17 provide timely notice to an eligible managed care provider
18 of any reenrollment of an individual under this subsection.

19 “(c) SPECIAL NEEDS INDIVIDUALS DESCRIBED.—In this
20 section, a ‘special needs individual’ means any of the following:

21 “(1) SPECIAL NEEDS CHILD.—An individual who is
22 under 19 years of age who —

23 “(A) is eligible for supplemental security income
24 under title XVI;

25 “(B) is described under section 501(a)(1)(D);

26 “(C) is a child described in section 1902(e)(3); or

27 “(D) is in foster care or is otherwise in an out-
28 of-home placement.

29 “(2) HOMELESS INDIVIDUALS.—An individual who is
30 homeless (without regard to whether the individual is a
31 member of a family), including—

32 “(A) an individual whose primary residence during
33 the night is a supervised public or private facility that
34 provides temporary living accommodations; or

35 “(B) an individual who is a resident in transitional
36 housing.

1 (2) by inserting after section 1932 the following new
2 section:

3 "ELIGIBLE MANAGED CARE PROVIDERS

4 "SEC. 1933. (a) DEFINITIONS.—In this section, the fol-
5 lowing definitions shall apply:

6 "(1) ELIGIBLE MANAGED CARE PROVIDER.—The term
7 'eligible managed care provider' means—

8 "(A) a medicaid managed care plan; or

9 "(B) a primary care case management provider.

10 "(2) MEDICAID MANAGED CARE PLAN.—The term
11 'medicaid managed care plan' means a health maintenance
12 organization, an eligible organization with a contract under
13 Section 1876, a provider sponsored network or any other
14 plan which provides or arranges for the provision of one or
15 more items and services to individuals eligible for medical
16 assistance under the State plan under this title in accord-
17 ance with a contract with the State under section
18 1932(a)(1)(B).

19 "(3) PRIMARY CARE CASE MANAGEMENT PROVIDER.—

20 "(A) IN GENERAL.—The term 'primary care case
21 management provider' means a health care provider
22 that—

23 "(i) is a physician, group of physicians, a Fed-
24 erally-qualified health center, a rural health clinic,
25 or an entity employing or having other arrange-
26 ments with physicians that provides or arranges for
27 the provision of one or more items and services to
28 individuals eligible for medical assistance under the
29 State plan under this title in accordance with a
30 contract with the State under section
31 1932(a)(1)(B);

32 "(ii) receives payment on a fee-for-service
33 basis (or, in the case of a Federally-qualified health
34 center or a rural health clinic, on a reasonable cost
35 per encounter basis) for the provision of health
36 care items and services specified in such contract
37 to enrolled individuals;

1 “(iii) receives an additional fixed fee per en-
 2 rollee for a period specified in such contract for
 3 providing case management services (including ap-
 4 proving and arranging for the provision of health
 5 care items and services specified in such contract
 6 on a referral basis) to enrolled individuals; and

7 “(iv) is not an entity that is at risk.

8 “(B) AT RISK.—In subparagraph (A)(iv), the term
 9 ‘at risk’ means an entity that—

10 “(i) has a contract with the State under which
 11 such entity is paid a fixed amount for providing or
 12 arranging for the provision of health care items or
 13 services specified in such contract to an individual
 14 eligible for medical assistance under the State plan
 15 and enrolled with such entity, regardless of whether
 16 such items or services are furnished to such indi-
 17 vidual; and

18 “(ii) is liable for all or part of the cost of fur-
 19 nishing such items or services, regardless of wheth-
 20 er such cost exceeds such fixed payment.

21 “(b) ENROLLMENT.—

22 “(1) NONDISCRIMINATION.—An eligible managed care
 23 provider may not discriminate on the basis of health status
 24 or anticipated need for services in the enrollment,
 25 reenrollment, or disenrollment of individuals eligible to re-
 26 ceive medical assistance under a State plan under this title
 27 or by discouraging enrollment (except as permitted by this
 28 section) by eligible individuals.

29 “(2) TERMINATION OF ENROLLMENT.—

30 “(A) IN GENERAL.—An eligible managed care pro-
 31 vider shall permit an individual eligible for medical as-
 32 sistance under the State plan under this title who is en-
 33 rolled with the provider to terminate such enrollment
 34 for cause at any time, and without cause during the
 35 60-day period beginning on the date the individual re-
 36 ceives notice of enrollment, and shall notify each such

1 individual of the opportunity to terminate enrollment
2 under these conditions.

3 “(B) FRAUDULENT INDUCEMENT OR COERCION AS
4 GROUNDS FOR CAUSE.—For purposes of subparagraph
5 (A), an individual terminating enrollment with an eligi-
6 ble managed care provider on the grounds that the en-
7 rollment was based on fraudulent inducement or was
8 obtained through coercion shall be considered to termi-
9 nate such enrollment for cause.

10 “(C) NOTICE OF TERMINATION.—

11 “(i) NOTICE TO STATE.—

12 “(I) BY INDIVIDUALS.—Each individual
13 terminating enrollment with an eligible man-
14 aged care provider under subparagraph (A)
15 shall do so by providing notice of the termi-
16 nation to an office of the State agency admin-
17 istering the State plan under this title, the
18 State or local welfare agency, or an office of an
19 eligible managed care provider.

20 “(II) BY PLANS.—Any eligible managed
21 care provider which receives notice of an indi-
22 vidual’s termination of enrollment with such
23 provider through receipt of such notice at an
24 office of an eligible managed care provider shall
25 provide timely notice of the termination to the
26 State agency administering the State plan
27 under this title.

28 “(ii) NOTICE TO PLAN.—The State agency ad-
29 ministering the State plan under this title or the
30 State or local welfare agency which receives notice
31 of an individual’s termination of enrollment with an
32 eligible managed care provider under clause (i)
33 shall provide timely notice of the termination to
34 such provider.

35 “(D) REENROLLMENT.—Each State shall estab-
36 lish a process under which an individual terminating
37 enrollment under this paragraph shall be promptly en-

1 rolled with another eligible managed care provider and
2 notified of such enrollment.

3 “(3) PROVISION OF ENROLLMENT MATERIALS IN UN-
4 DERSTANDABLE FORM.—Each eligible managed care pro-
5 vider shall provide all enrollment materials in a manner
6 and form which may be easily understood by a typical adult
7 enrollee of the provider who is eligible for medical assist-
8 ance under the State plan under this title.

9 “(c) QUALITY ASSURANCE.—

10 “(1) ACCESS TO SERVICES.—Each eligible managed
11 care provider shall provide or arrange for the provision of
12 all medically necessary medical assistance under this title
13 which is specified in the contract entered into between such
14 provider and the State under section 1932(a)(1)(B) for en-
15 rollees who are eligible for medical assistance under the
16 State plan under this title.

17 “(2) TIMELY DELIVERY OF SERVICES.—Each eligible
18 managed care provider shall respond to requests from en-
19 rollees for the delivery of medical assistance in a manner
20 which —

21 “(A) makes such assistance —

22 “(i) available and accessible to each such indi-
23 vidual, within the area served by the provider, with
24 reasonable promptness and in a manner which
25 assures continuity; and

26 “(ii) when medically necessary, available and
27 accessible 24 hours a day and 7 days a week; and

28 “(B) with respect to assistance provided to such
29 an individual other than through the provider, or with-
30 out prior authorization, in the case of a primary care
31 case management provider, provides for reimbursement
32 to the individual (if applicable under the contract be-
33 tween the State and the provider) if —

34 “(i) the services were medically necessary and
35 immediately required because of an unforeseen ill-
36 ness, injury, or condition; and

1 “(ii) it was not reasonable given the cir-
 2 cumstances to obtain the services through the pro-
 3 vider, or, in the case of a primary care case man-
 4 agement provider, with prior authorization.

5 “(3) EXTERNAL INDEPENDENT REVIEW OF ELIGIBLE
 6 MANAGED CARE PROVIDER ACTIVITIES.—

7 “(A) REVIEW OF MEDICAID MANAGED CARE PLAN
 8 CONTRACT.—

9 “(i) IN GENERAL.—Except as provided in sub-
 10 paragraph (B), each medicaid managed care plan
 11 shall be subject to an annual external independent
 12 review of the quality and timeliness of, and access
 13 to, the items and services specified in such plan’s
 14 contract with the State under section
 15 1932(a)(1)(B). Such review shall specifically evalu-
 16 ate the extent to which the medicaid managed care
 17 plan provides such services in a timely manner.

18 “(ii) CONTENTS OF REVIEW.—An external
 19 independent review conducted under this paragraph
 20 shall include the following:

21 “(I) a review of the entity’s medical care,
 22 through sampling of medical records or other
 23 appropriate methods, for indications of quality
 24 of care and inappropriate utilization (including
 25 overutilization) and treatment,

26 “(II) a review of enrollee inpatient and
 27 ambulatory data, through sampling of medical
 28 records or other appropriate methods, to deter-
 29 mine trends in quality and appropriateness of
 30 care,

31 “(III) notification of the entity and the
 32 State when the review under this paragraph in-
 33 dicates inappropriate care, treatment, or utili-
 34 zation of services (including overutilization),
 35 and

36 “(IV) other activities as prescribed by the
 37 Secretary or the State.

1 “(iii) AVAILABILITY OF RESULTS.—The re-
2 sults of each external independent review conducted
3 under this subparagraph shall be available to par-
4 ticipating health care providers, enrollees, and po-
5 tential enrollees of the medicaid managed care
6 plan, except that the results may not be made
7 available in a manner that discloses the identity of
8 any individual patient.

9 “(B) DEEMED COMPLIANCE.—

10 “(i) MEDICARE PLANS.—The requirements of
11 subparagraph (A) shall not apply with respect to a
12 medicaid managed care plan if the plan is an eligi-
13 ble organization with a contract in effect under sec-
14 tion 1876.

15 “(ii) PRIVATE ACCREDITATION.—

16 “(I) IN GENERAL.—The requirements of
17 subparagraph (A) shall not apply with respect
18 to a medicaid managed care plan if —

19 “(aa) the plan is accredited by an or-
20 ganization meeting the requirements de-
21 scribed in clause (iii); and

22 “(bb) the standards and process under
23 which the plan is accredited meet such re-
24 quirements as are established under
25 subclause (II), without regard to whether
26 or not the time requirement of such
27 subclause is satisfied.

28 “(II) STANDARDS AND PROCESS.—Not
29 later than 180 days after the date of the enact-
30 ment of this Act, the Secretary shall specify re-
31 quirements for the standards and process
32 under which a medicaid managed care plan is
33 accredited by an organization meeting the re-
34 quirements of clause (iii).

35 “(iii) ACCREDITING ORGANIZATION.—An ac-
36 crediting organization meets the requirements of
37 this clause if the organization —

- 1 “(I) is a private, nonprofit organization;
- 2 “(II) exists for the primary purpose of ac-
- 3 crediting managed care plans or health care
- 4 providers; and
- 5 “(III) is independent of health care pro-
- 6 viders or associations of health care providers.
- 7 “(C) REVIEW OF PRIMARY CARE CASE MANAGE-
- 8 MENT PROVIDER CONTRACT.—Each primary care case
- 9 management provider shall be subject to an annual ex-
- 10 ternal independent review of the quality and timeliness
- 11 of, and access to, the items and services specified in the
- 12 contract entered into between the State and the pri-
- 13 mary care case management provider under section
- 14 1932(a)(1)(B).
- 15 “(4) FEDERAL MONITORING RESPONSIBILITIES.—The
- 16 Secretary shall review the external independent reviews
- 17 conducted pursuant to paragraph (3) and shall monitor the
- 18 effectiveness of the State’s monitoring and followup activi-
- 19 ties required under subparagraph (A) of paragraph (2). If
- 20 the Secretary determines that a State’s monitoring and fol-
- 21 lowup activities are not adequate to ensure that the re-
- 22 quirements of paragraph (2) are met, the Secretary shall
- 23 undertake appropriate followup activities to ensure that the
- 24 State improves its monitoring and followup activities.
- 25 “(5) PROVIDING INFORMATION ON SERVICES.—
- 26 “(A) REQUIREMENTS FOR MEDICAID MANAGED
- 27 CARE PLANS.—
- 28 “(i) INFORMATION TO THE STATE.—Each
- 29 medicaid managed care plan shall provide to the
- 30 State (at such frequency as the Secretary may re-
- 31 quire), complete and timely information concerning
- 32 the following:
- 33 “(I) The services that the plan provides to
- 34 (or arranges to be provided to) individuals eli-
- 35 gible for medical assistance under the State
- 36 plan under this title.

1 “(II) The identity, locations, qualifica-
2 tions, and availability of participating health
3 care providers.

4 “(III) The rights and responsibilities of
5 enrollees.

6 “(IV) The services provided by the plan
7 which are subject to prior authorization by the
8 plan as a condition of coverage (in accordance
9 with paragraph (6)(A)).

10 “(V) The procedures available to an en-
11 rollee and a health care provider to appeal the
12 failure of the plan to cover a service.

13 “(VI) The performance of the plan in
14 serving individuals eligible for medical assist-
15 ance under the State plan under this title.

16 “(ii) INFORMATION TO HEALTH CARE PROVID-
17 ERS, ENROLLEES, AND POTENTIAL ENROLLEES.—
18 Each medicaid managed care plan shall—

19 “(I) upon request, make the information
20 described in clause (i) available to participating
21 health care providers, enrollees, and potential
22 enrollees in the plan’s service area; and

23 “(II) provide to enrollees and potential en-
24 rollees information regarding all items and
25 services that are available to enrollees under
26 the contract between the State and the plan
27 that are covered either directly or through a
28 method of referral and prior authorization.

29 “(B) REQUIREMENTS FOR PRIMARY CARE CASE
30 MANAGEMENT PROVIDERS.—Each primary care case
31 management provider shall—

32 “(i) provide to the State (at such frequency as
33 the Secretary may require), complete and timely in-
34 formation concerning the services that the primary
35 care case management provider provides to (or ar-
36 ranges to be provided to) individuals eligible for

1 medical assistance under the State plan under this
2 title;

3 “(ii) make available to enrollees and potential
4 enrollees information concerning services available
5 to the enrollee for which prior authorization by the
6 primary care case management provider is re-
7 quired; and

8 “(iii) provide enrollees and potential enrollees
9 information regarding all items and services that
10 are available to enrollees under the contract be-
11 tween the State and the primary care case manage-
12 ment provider that are covered either directly or
13 through a method of referral and prior authoriza-
14 tion.

15 “(iv) provide assurances that such entities and
16 their professional personnel are licensed as required
17 by State law and qualified to provide case manage-
18 ment services, through methods such as ongoing
19 monitoring of compliance with applicable require-
20 ments and providing information and technical as-
21 sistance.

22 “(C) REQUIREMENTS FOR BOTH MEDICAID MAN-
23 AGED CARE PLANS AND PRIMARY CARE CASE MANAGE-
24 MENT PROVIDERS.—Each eligible managed care pro-
25 vider shall provide the State with aggregate encounter
26 data for early and periodic screening, diagnostic, and
27 treatment services under section 1905(r) furnished to
28 individuals under 21 years of age. Any such data pro-
29 vided may be audited by the State and the Secretary.

30 “(6) TIMELINESS OF PAYMENT.—An eligible managed
31 care provider shall make payment to health care providers
32 for items and services which are subject to the contract
33 under section 1931(a)(1)(B) and which are furnished to in-
34 dividuals eligible for medical assistance under the State
35 plan under this title who are enrolled with the provider on
36 a timely basis and under the claims payment procedures
37 described in section 1902(a)(37)(A), unless the health care

1 provider and the eligible managed care provider agree to an
2 alternate payment schedule.

3 “(7) ADDITIONAL QUALITY ASSURANCE REQUIRE-
4 MENTS FOR MEDICAID MANAGED CARE PLANS.—

5 “(A) CONDITIONS FOR PRIOR AUTHORIZATION.—A
6 medicaid managed care plan may require the approval
7 of medical assistance for nonemergency services before
8 the assistance is furnished to an enrollee only if the
9 system providing for such approval—

10 “(i) provides that such decisions are made in
11 a timely manner, depending upon the urgency of
12 the situation; and

13 “(ii) permits coverage of medically necessary
14 medical assistance provided to an enrollee without
15 prior authorization in the event of an emergency.

16 “(B) INTERNAL GRIEVANCE PROCEDURE.—Each
17 medicaid managed care plan shall establish an internal
18 grievance procedure under which a plan enrollee or a
19 provider on behalf of such an enrollee who is eligible
20 for medical assistance under the State plan under this
21 title may challenge the denial of coverage of or pay-
22 ment for such assistance.

23 “(C) USE OF UNIQUE PHYSICIAN IDENTIFIER FOR
24 PARTICIPATING PHYSICIANS.—Each medicaid managed
25 care plan shall require each physician providing serv-
26 ices to enrollees eligible for medical assistance under
27 the State plan under this title to have a unique identi-
28 fier in accordance with the system established under
29 section 1902(x).

30 “(D) PATIENT ENCOUNTER DATA.—

31 “(i) IN GENERAL.—Each medicaid managed
32 care plan shall maintain sufficient patient encoun-
33 ter data to identify the health care provider who
34 delivers services to patients and to otherwise enable
35 the State plan to meet the requirements of section
36 1902(a)(27). The plan shall incorporate such infor-

1 mation in the maintenance of patient encounter
2 data with respect to such health care provider.

3 “(ii) COMPLIANCE.—A medicaid managed care
4 plan shall—

5 “(I) submit the data maintained under
6 clause (i) to the State; or

7 “(II) demonstrate to the State that the
8 data complies with managed care quality assur-
9 ance guidelines established by the Secretary in
10 accordance with clause (iii).

11 “(iii) STANDARDS.—In establishing managed
12 care quality assurance guidelines under clause
13 (ii)(II), the Secretary shall consider—

14 “(I) managed care industry standards
15 for—

16 “(aa) internal quality assurance; and

17 “(bb) performance measures; and

18 “(II) any managed care quality standards
19 established by the National Association of In-
20 surance Commissioners.

21 “(d) DUE PROCESS REQUIREMENTS FOR ELIGIBLE MAN-
22 AGED CARE PROVIDERS.—

23 “(1) DENIAL OF OR UNREASONABLE DELAY IN DE-
24 TERMINING COVERAGE AS GROUNDS FOR HEARING.—If an
25 eligible managed care provider—

26 “(A) denies coverage of or payment for medical as-
27 sistance with respect to an enrollee who is eligible for
28 such assistance under the State plan under this title;
29 or

30 “(B) fails to make any eligibility or coverage de-
31 termination sought by an enrollee or, in the case of a
32 medicaid managed care plan, by a participating health
33 care provider or enrollee, in a timely manner, depend-
34 ing upon the urgency of the situation, the enrollee or
35 the health care provider furnishing such assistance to
36 the enrollee (as applicable) may obtain a hearing before
37 the State agency administering the State plan under

1 this title in accordance with section 1902(a)(3), but
2 only, with respect to a medicaid managed care plan,
3 after completion of the internal grievance procedure es-
4 tablished by the plan under subsection (c)(6)(B).

5 “(2) COMPLETION OF INTERNAL GRIEVANCE PROCE-
6 DURE.—Nothing in this subsection shall require completion
7 of an internal grievance procedure if such procedure does
8 not exist or if the procedure does not provide for timely re-
9 view of health needs considered by the enrollee’s health
10 care provider to be of an urgent nature.

11 “(e) MISCELLANEOUS.—

12 “(1) PROTECTING ENROLLEES AGAINST THE INSOL-
13 VENCY OF ELIGIBLE MANAGED CARE PROVIDERS AND
14 AGAINST THE FAILURE OF THE STATE TO PAY SUCH PRO-
15 VIDERS.—Each eligible managed care provider shall provide
16 that an individual eligible for medical assistance under the
17 State plan under this title who is enrolled with the provider
18 may not be held liable—

19 “(A) for the debts of the eligible managed care
20 provider, in the event of the provider’s insolvency;

21 “(B) for services provided to the individ-
22 ual—

23 “(i) in the event of the provider failing to re-
24 ceive payment from the State for such services; or

25 “(ii) in the event of a health care provider
26 with a contractual or other arrangement with the
27 eligible managed care provider failing to receive
28 payment from the State or the eligible managed
29 care provider for such services; or

30 “(C) for the debts of any health care provider with
31 a contractual or other arrangement with the provider
32 to provide services to the individual, in the event of the
33 insolvency of the health care provider.

34 “(2) TREATMENT OF CHILDREN WITH SPECIAL
35 HEALTH CARE NEEDS.—

1 “(A) IN GENERAL.—In the case of an enrollee of
2 an eligible managed care provider who is a child with
3 special health care needs—

4 “(i) if any medical assistance specified in the
5 contract with the State is identified in a treatment
6 plan prepared for the enrollee by a program de-
7 scribed in subparagraph (C), the eligible managed
8 care provider shall provide (or arrange to be pro-
9 vided) such assistance in accordance with the treat-
10 ment plan either—

11 “(I) by referring the enrollee to a pediatric
12 health care provider who is trained and experi-
13 enced in the provision of such assistance and
14 who has a contract with the eligible managed
15 care provider to provide such assistance; or

16 “(II) if appropriate services are not avail-
17 able through the eligible managed care pro-
18 vider, permitting such enrollee to seek appro-
19 priate specialty services from pediatric health
20 care providers outside of or apart from the eli-
21 gible managed care provider; and

22 “(ii) the eligible managed care provider shall
23 require each health care provider with whom the eli-
24 gible managed care provider has entered into an
25 agreement to provide medical assistance to enroll-
26 ees to furnish the medical assistance specified in
27 such enrollee’s treatment plan to the extent the
28 health care provider is able to carry out such treat-
29 ment plan.

30 “(B) PRIOR AUTHORIZATION.—An enrollee re-
31 ferred for treatment under subparagraph (A)(i)(I), or
32 permitted to seek treatment outside of or apart from
33 the eligible managed care provider under subparagraph
34 (A)(i)(II) shall be deemed to have obtained any prior
35 authorization required by the provider.

36 “(C) CHILD WITH SPECIAL HEALTH CARE
37 NEEDS.—For purposes of subparagraph (A), a child

1 with special health care needs is a child who is receiv-
2 ing services under—

3 “(i) a program administered under part B or
4 part H of the Individuals with Disabilities Edu-
5 cation Act;

6 “(ii) a program for children with special health
7 care needs under title V;

8 “(iii) a program under part B or part D of
9 title IV; or

10 “(iv) any other program for children with spe-
11 cial health care needs identified by the Secretary.

12 “(3) PHYSICIAN INCENTIVE PLANS.—Each medicaid
13 managed care plan shall require that any physician incen-
14 tive plan covering physicians who are participating in the
15 medicaid managed care plan shall meet the requirements of
16 section 1876(i)(8).

17 “(4) INCENTIVES FOR HIGH QUALITY ELIGIBLE MAN-
18 AGED CARE PROVIDERS.—The Secretary and the State may
19 establish a program to reward, through public recognition,
20 incentive payments, or enrollment of additional individuals
21 (or combinations of such rewards), eligible managed care
22 providers that provide the highest quality care to individ-
23 uals eligible for medical assistance under the State plan
24 under this title who are enrolled with such providers. For
25 purposes of section 1903(a)(7), proper expenses incurred
26 by a State in carrying out such a program shall be consid-
27 ered to be expenses necessary for the proper and efficient
28 administration of the State plan under this title.”

29 (d) CLARIFICATION OF APPLICATION OF FFP DENIAL
30 RULES TO PAYMENTS MADE PURSUANT TO MEDICAID MAN-
31 AGED CARE PLANS.—Section 1903(i) (42 U.S.C. 1396b(i)) is
32 amended by adding at the end the following sentence: “Para-
33 graphs (1)(A), (1)(B), (2), (5), and (12) shall apply with re-
34 spect to items or services furnished and amounts expended by
35 or through an eligible managed care provider (as defined in sec-
36 tion 1933(a)(1)) in the same manner as such paragraphs apply

1 to items or services furnished and amounts expended directly
 2 by the State.”

3 (e) CLARIFICATION OF CERTIFICATION REQUIREMENTS
 4 FOR PHYSICIANS PROVIDING SERVICES TO CHILDREN AND
 5 PREGNANT WOMEN.—Section 1903(i)(12) (42 U.S.C.
 6 1396b(i)(12)) is amended —

7 (1) in subparagraph (A)(i), to read as follows:

8 “(i) is certified in family practice or pediatrics
 9 by the medical specialty board recognized by the
 10 American Board of Medical Specialties for family
 11 practice or pediatrics or is certified in general prac-
 12 tice or pediatrics by the medical specialty board
 13 recognized by the American Osteopathic Associa-
 14 tion,”;

15 (2) in subparagraph (B)(i), to read as follows:

16 “(i) is certified in family practice or obstetrics
 17 by the medical specialty board recognized by the
 18 American Board of Medical Specialties for family
 19 practice or obstetrics or is certified in family prac-
 20 tice or obstetrics by the medical specialty board
 21 recognized by the American Osteopathic Associa-
 22 tion,”; and

23 (3) in both subparagraphs (A) and (B) —

24 (A) by striking “or” at the end of clause (v);

25 (B) by redesignating clause (vi) as clause (vii);

26 and

27 (C) by inserting after clause (v) the following new
 28 clause:

29 “(vi) delivers such services in the emergency
 30 department of a hospital participating in the State
 31 plan approved under this title, or”.

32 **SEC. 7103. ADDITIONAL REQUIREMENTS FOR MEDICAID**
 33 **MANAGED CARE PLANS.**

34 Section 1933, as added by section 7102(c)(2), is amended

35 —

36 (1) by redesignating subsections (d) and (e) as sub-
 37 sections (e) and (f), respectively; and

1 (2) by inserting after subsection (c) the following new
2 subsection:

3 “(d) ADDITIONAL REQUIREMENTS FOR MEDICAID MAN-
4 AGED CARE PLANS.—

5 “(1) DEMONSTRATION OF ADEQUATE CAPACITY AND
6 SERVICES.—

7 “(A) IN GENERAL.—Subject to subparagraph (C),
8 each medicaid managed care plan shall provide the
9 State and the Secretary with adequate assurances (as
10 determined by the Secretary) that the plan, with re-
11 spect to a service area —

12 “(i) has the capacity to serve the expected en-
13 rollment in such service area;

14 “(ii) offers an appropriate range of services
15 for the population expected to be enrolled in such
16 service area, including transportation services and
17 translation services consisting of the principal lan-
18 guages spoken in the service area;

19 “(iii) maintains sufficient numbers of provid-
20 ers of services included in the contract with the
21 State to ensure that services are available to indi-
22 viduals receiving medical assistance and enrolled in
23 the plan to the same extent that such services are
24 available to individuals enrolled in the plan who are
25 not recipients of medical assistance under the State
26 plan under this title;

27 “(iv) maintains extended hours of operation
28 with respect to primary care services that are be-
29 yond those maintained during a normal business
30 day;

31 “(v) provides preventive and primary care
32 services in locations that are readily accessible to
33 members of the community; and

34 “(vi) provides information concerning edu-
35 cational, social, health, and nutritional services of-
36 fered by other programs for which enrollees may be
37 eligible.

1 “(vii) complies with such other requirements
2 relating to access to care as the Secretary or the
3 State may impose.

4 “(B) PROOF OF ADEQUATE PRIMARY CARE CAPAC-
5 ITY AND SERVICES.—Subject to subparagraph (C), a
6 medicaid managed care plan that contracts with a rea-
7 sonable number of primary care providers (as deter-
8 mined by the Secretary) and whose primary care mem-
9 bership includes a reasonable number (as so deter-
10 mined) of the following providers will be deemed to
11 have satisfied the requirements of subparagraph (A):

12 “(i) Rural health clinics, as defined in section
13 1905(l)(1).

14 “(ii) Federally-qualified health centers, as de-
15 fined in section 1905(l)(2)(B).

16 “(iii) Clinics which are eligible to receive pay-
17 ment for services provided under title X of the
18 Public Health Service Act.

19 “(C) SUFFICIENT PROVIDERS OF SPECIALIZED
20 SERVICES.—Notwithstanding subparagraphs (A) and
21 (B), a medicaid managed care plan may not be consid-
22 ered to have satisfied the requirements of subparagraph
23 (A) if the plan does not have a sufficient number (as
24 determined by the Secretary) of providers of specialized
25 services, including perinatal and pediatric specialty
26 care, to ensure that such services are available and ac-
27 cessible.

28 “(2) WRITTEN PROVIDER PARTICIPATION AGREE-
29 MENTS FOR CERTAIN PROVIDERS.—Each medicaid man-
30 aged care plan that enters into a written provider partici-
31 pation agreement with a provider described in paragraph
32 (1)(B) shall —

33 “(A) include terms and conditions that are no
34 more restrictive than the terms and conditions that the
35 medicaid managed care plan includes in its agreements
36 with other participating providers with respect to —

1 “(i) the scope of covered services for which
2 payment is made to the provider;

3 “(ii) the assignment of enrollees by the plan to
4 the provider;

5 “(iii) the limitation on financial risk or avail-
6 ability of financial incentives to the provider;

7 “(iv) accessibility of care;

8 “(v) professional credentialing and
9 recredentialing;

10 “(vi) licensure;

11 “(vii) quality and utilization management;

12 “(viii) confidentiality of patient records;

13 “(ix) grievance procedures; and

14 “(x) indemnification arrangements between
15 the plans and providers; and

16 “(B) provide for payment to the provider on a
17 basis that is comparable to the basis on which other
18 providers are paid.”.

19 **SEC. 7104. PREVENTING FRAUD IN MEDICAID MANAGED**
20 **CARE.**

21 (a) **IN GENERAL.**—Section 1933, as added by section
22 7102(c)(2) and amended by section 7103, is amended—

23 (1) by redesignating subsection (f) as subsection (g);
24 and

25 (2) by inserting after subsection (e) the following new
26 subsection:

27 “(f) **ANTI-FRAUD PROVISIONS.**—

28 “(1) **PROVISIONS APPLICABLE TO ELIGIBLE MANAGED**
29 **CARE PROVIDERS.**—

30 “(A) **PROHIBITING AFFILIATIONS WITH INDIVID-**
31 **UALS DEBARRED BY FEDERAL AGENCIES.**—

32 “(i) **IN GENERAL.**—An eligible managed care
33 provider may not knowingly—

34 “(I) have a person described in clause (iii)
35 as a director, officer, partner, or person with
36 beneficial ownership of more than 5 percent of
37 the plan’s equity; or

1 health care program, as defined in section
2 1128(h).

3 “(B) RESTRICTIONS ON MARKETING.—

4 “(i) DISTRIBUTION OF MATERIALS.—

5 “(I) IN GENERAL.—An eligible managed
6 care provider may not distribute marketing ma-
7 terials within any State—

8 “(aa) without the prior approval of the
9 State; and

10 “(bb) that contain false or materially
11 misleading information.

12 “(II) PROHIBITION.—The State may not
13 enter into or renew a contract with an eligible
14 managed care provider for the provision of
15 services to individuals enrolled under the State
16 plan under this title if the State determines
17 that the provider intentionally distributed false
18 or materially misleading information in viola-
19 tion of subclause (I)(bb).

20 “(ii) SERVICE MARKET.—An eligible managed
21 care provider shall distribute marketing materials
22 to the entire service area of such provider.

23 “(iii) PROHIBITION OF TIE-INS.—An eligible
24 managed care provider, or any agency of such pro-
25 vider, may not seek to influence an individual’s en-
26 rollment with the provider in conjunction with the
27 sale of any other insurance.

28 “(iv) PROHIBITING MARKETING FRAUD.—
29 Each eligible managed care provider shall comply
30 with such procedures and conditions as the Sec-
31 retary prescribes in order to ensure that, before an
32 individual is enrolled with the provider, the individ-
33 ual is provided accurate and sufficient information
34 to make an informed decision whether or not to en-
35 roll.

36 “(2) PROVISIONS APPLICABLE ONLY TO MEDICAID
37 MANAGED CARE PLANS.—

1 “(A) STATE CONFLICT-OF-INTEREST SAFEGUARDS
2 IN MEDICAID RISK CONTRACTING.—A medicaid man-
3 aged care plan may not enter into a contract with any
4 State under section 1932(a)(1)(B) unless the State has
5 in effect conflict-of-interest safeguards with respect to
6 officers and employees of the State with responsibilities
7 relating to contracts with such plans or to the default
8 enrollment process described in section
9 1932(a)(1)(D)(iv) that are at least as effective as the
10 Federal safeguards provided under section 27 of the
11 Office of Federal Procurement Policy Act (41 U.S.C.
12 423), against conflicts of interest that apply with re-
13 spect to Federal procurement officials with comparable
14 responsibilities with respect to such contracts.

15 “(B) REQUIRING DISCLOSURE OF FINANCIAL IN-
16 FORMATION.—In addition to any requirements applica-
17 ble under section 1902(a)(27) or 1902(a)(35), a medic-
18 aid managed care plan shall—

19 “(i) report to the State (and to the Secretary
20 upon the Secretary’s request) such financial infor-
21 mation as the State or the Secretary may require
22 to demonstrate that—

23 “(I) the plan has the ability to bear the
24 risk of potential financial losses and otherwise
25 has a fiscally sound operation;

26 “(II) the plan uses the funds paid to it by
27 the State and the Secretary for activities con-
28 sistent with the requirements of this title and
29 the contract between the State and plan; and

30 “(III) the plan does not place an individ-
31 ual physician, physician group, or other health
32 care provider at substantial risk (as determined
33 by the Secretary) for services not provided by
34 such physician, group, or health care provider,
35 by providing adequate protection (as deter-
36 mined by the Secretary) to limit the liability of
37 such physician, group, or health care provider,

1 through measures such as stop loss insurance
2 or appropriate risk corridors;

3 “(ii) agree that the Secretary and the State
4 (or any person or organization designated by ei-
5 ther) shall have the right to audit and inspect any
6 books and records of the plan (and of any sub-
7 contractor) relating to the information reported
8 pursuant to clause (i) and any information required
9 to be furnished under section paragraphs (27) or
10 (35) of section 1902(a);

11 “(iii) make available to the Secretary and the
12 State a description of each transaction described in
13 subparagraphs (A) through (C) of section
14 1318(a)(3) of the Public Health Service Act be-
15 tween the plan and a party in interest (as defined
16 in section 1318(b) of such Act); and

17 “(iv) agree to make available to its enrollees
18 upon reasonable request —

19 “(I) the information reported pursuant to
20 clause (i); and

21 “(II) the information required to be dis-
22 closed under sections 1124 and 1126.

23 “(C) ADEQUATE PROVISION AGAINST RISK OF IN-
24 SOLVENCY.—

25 “(i) ESTABLISHMENT OF STANDARDS.—The
26 Secretary shall establish standards, including ap-
27 propriate equity standards, under which each med-
28 icaid managed care plan shall make adequate provi-
29 sion against the risk of insolvency.

30 “(ii) CONSIDERATION OF OTHER STAND-
31 ARDS.—In establishing the standards described in
32 clause (i), the Secretary shall consider solvency
33 standards applicable to eligible organizations with a
34 risk-sharing contract under section 1876.

35 (iii) MODEL CONTRACT ON SOLVENCY.—At the
36 earliest practicable time after the date of enact-
37 ment of this section, the Secretary shall issue

1 guidelines and regulations concerning solvency
2 standards for risk contracting entities and sub-
3 contractors of such risk contracting entities. Such
4 guidelines and regulations shall take into account
5 characteristics that may differ among risk contract-
6 ing entities including whether such an entity is at
7 risk for inpatient hospital services.

8 “(D) **REQUIRING REPORT ON NET EARNINGS AND**
9 **ADDITIONAL BENEFITS.**—Each medicaid managed care
10 plan shall submit a report to the State and the Sec-
11 retary not later than 12 months after the close of a
12 contract year containing —

13 “(i) the most recent audited financial state-
14 ment of the plan’s net earnings, in accordance with
15 guidelines established by the Secretary in consulta-
16 tion with the States, and consistent with generally
17 accepted accounting principles; and

18 “(ii) a description of any benefits that are in
19 addition to the benefits required to be provided
20 under the contract that were provided during the
21 contract year to members enrolled with the plan
22 and entitled to medical assistance under the State
23 plan under this title.”.

24 **SEC. 7105. ASSURING ADEQUACY OF PAYMENTS TO MED-**
25 **ICAID MANAGED CARE PLANS AND PROVID-**
26 **ERS.**

27 Title XIX of the Social Security Act, as amended by sec-
28 tions 7001, 7101(a), and 7102(e), is further amended—

29 (1) by redesignating section 1934 as section 1935; and

30 (2) by inserting after section 1933 the following new

31 section:

32 “**ASSURING ADEQUACY OF PAYMENTS TO MEDICAID MANAGED**
33 **CARE PLANS AND PROVIDERS**

34 “**SEC. 1934.** As a condition of approval of a State plan
35 under this title, a State shall—

36 “(1) find, determine, and make assurances satisfactory
37 to the Secretary that—

1 “(A) the rates it pays medicaid managed care
2 plans for individuals eligible under the State plan are
3 reasonable and adequate to assure access to services
4 meeting professionally recognized quality standards,
5 taking into account—

6 “(i) the items and services to which the rate
7 applies,

8 “(ii) the eligible population, and

9 “(iii) the rate the State pays providers for
10 such items and services; and

11 “(B) the methodology used to adjust the rate ade-
12 quately reflects the varying risks associated with indi-
13 viduals actually enrolling in each medicaid managed
14 care plan; and

15 “(2) report to the Secretary, at least annually, on—

16 “(A) the rates the States pays to medicaid man-
17 aged care plans, and

18 “(B) the rates medicaid managed care plans pay
19 for hospital services (and such other information as
20 medicaid managed care plans are required to submit to
21 the State pursuant to section 1933(c)(5)(E).”.

22 **SEC. 7106. SANCTIONS FOR NONCOMPLIANCE BY ELIGI-**
23 **BLE MANAGED CARE PROVIDERS.**

24 (a) **SANCTIONS DESCRIBED.**—Title XIX the Social Secu-
25 rity Act (42 U.S.C. 1396 et seq.), as amended by sections
26 7001(a), 7101(a), 7102(c), and 7105, is further amended—

27 (1) by redesignating section 1935 as section 1936; and

28 (2) by inserting after section 1934 the following new
29 section:

30 **“SANCTIONS FOR NONCOMPLIANCE BY ELIGIBLE MANAGED**
31 **CARE PROVIDERS**

32 **“SEC. 1935. (a) USE OF INTERMEDIATE SANCTIONS BY**
33 **THE STATE TO ENFORCE REQUIREMENTS.**—Each State shall
34 establish intermediate sanctions, which may include any of the
35 types described in subsection (b) other than the termination of
36 a contract with an eligible managed care provider, which the

1 State may impose against an eligible managed care provider
2 with a contract under section 1932(a)(1)(B) if the provider —

3 “(1) fails substantially to provide medically necessary
4 items and services that are required (under law or under
5 such provider's contract with the State) to be provided to
6 an enrollee covered under the contract, if the failure has
7 adversely affected (or has a substantial likelihood of ad-
8 versely affecting) the enrollee;

9 “(2) imposes premiums on enrollees in excess of the
10 premiums permitted under this title;

11 “(3) acts to discriminate among enrollees on the basis
12 of their health status or requirements for health care serv-
13 ices, including expulsion or refusal to reenroll an individual,
14 except as permitted by sections 1932 and 1933, or engag-
15 ing in any practice that would reasonably be expected to
16 have the effect of denying or discouraging enrollment with
17 the provider by eligible individuals whose medical condition
18 or history indicates a need for substantial future medical
19 services;

20 “(4) misrepresents or falsifies information that is fur-
21 nished

22 “(A) to the Secretary or the State under section
23 1932 or 1933; or

24 “(B) to an enrollee, potential enrollee, or a health
25 care provider under such sections; or

26 “(5) fails to comply with the requirements of section
27 1876(i)(8).

28 “(b) INTERMEDIATE SANCTIONS.—The sanctions de-
29 scribed in this subsection are as follows:

30 “(1) Civil money penalties as follows:

31 “(A) Except as provided in subparagraph (B), (C),
32 or (D), not more than \$25,000 for each determination
33 under subsection (a).

34 “(B) With respect to a determination under para-
35 graph (3) or (4)(A) of subsection (a), not more than
36 \$100,000 for each such determination.

1 “(C) With respect to a determination under sub-
2 section (a)(2), double the excess amount charged in vio-
3 lation of such subsection (and the excess amount
4 charged shall be deducted from the penalty and re-
5 turned to the individual concerned).

6 “(D) Subject to subparagraph (B), with respect to
7 a determination under subsection (a)(3), \$15,000 for
8 each individual not enrolled as a result of a practice de-
9 scribed in such subsection.

10 “(2) The appointment of temporary management to
11 oversee the operation of the eligible managed care provider
12 and to assure the health of the provider’s enrollees, if there
13 is a need for temporary management while—

14 “(A) there is an orderly termination or reorganiza-
15 tion of the eligible managed care provider; or

16 “(B) improvements are made to remedy the viola-
17 tions found under subsection (a), except that temporary
18 management under this paragraph may not be termi-
19 nated until the State has determined that the eligible
20 managed care provider has the capability to ensure that
21 the violations shall not recur.

22 “(3) Permitting individuals enrolled with the eligible
23 managed care provider to terminate enrollment without
24 cause, and notifying such individuals of such right to termi-
25 nate enrollment.

26 “(c) TREATMENT OF CHRONIC SUBSTANDARD PROVID-
27 ERS.—In the case of an eligible managed care provider which
28 has repeatedly failed to meet the requirements of section 1932
29 or 1933, the State shall (regardless of what other sanctions are
30 provided) impose the sanctions described in paragraphs (2) and
31 (3) of subsection (b).

32 “(d) AUTHORITY TO TERMINATE CONTRACT.—In the case
33 of an eligible managed care provider which has failed to meet
34 the requirements of section 1932 or 1933, the State shall have
35 the authority to terminate its contract with such provider under
36 section 1932(a)(1)(B) and to enroll such provider’s enrollees
37 with other eligible managed care providers (or to permit such

1 enrollees to receive medical assistance under the State plan
2 under this title other than through an eligible managed care
3 provider).

4 “(e) AVAILABILITY OF SANCTIONS TO THE SECRETARY.—

5 “(1) INTERMEDIATE SANCTIONS.—In addition to the
6 sanctions described in paragraph (2) and any other sanc-
7 tions available under law, the Secretary may provide for
8 any of the sanctions described in subsection (b) if the Sec-
9 retary determines that—

10 “(A) an eligible managed care provider with a con-
11 tract under section 1932(a)(1)(B) fails to meet any of
12 the requirements of section 1932 or 1933; and

13 “(B) the State has failed to act appropriately to
14 address such failure.

15 “(2) DENIAL OF PAYMENTS TO THE STATE.—The Sec-
16 retary may deny payments to the State for medical assist-
17 ance furnished under the contract under section
18 1932(a)(1)(B) for individuals enrolled after the date the
19 Secretary notifies an eligible managed care provider of a
20 determination under subsection (a) and until the Secretary
21 is satisfied that the basis for such determination has been
22 corrected and is not likely to recur.

23 “(f) DUE PROCESS FOR ELIGIBLE MANAGED CARE PRO-
24 VIDERS.—

25 “(1) AVAILABILITY OF HEARING PRIOR TO TERMI-
26 NATION OF CONTRACT.—A State may not terminate a con-
27 tract with an eligible managed care provider under section
28 1932(a)(1)(B) unless the provider is provided with a hear-
29 ing prior to the termination.

30 “(2) NOTICE TO ENROLLEES OF TERMINATION HEAR-
31 ING.—A State shall notify all individuals enrolled with an
32 eligible managed care provider which is the subject of a
33 hearing to terminate the provider’s contract with the State
34 of the hearing and that the enrollees may immediately
35 disenroll with the provider for cause.

36 “(3) OTHER PROTECTIONS FOR ELIGIBLE MANAGED
37 CARE PROVIDERS AGAINST SANCTIONS IMPOSED BY

1 STATE.—Before imposing any sanction against an eligible
2 managed care provider other than termination of the pro-
3 vider's contract, the State shall provide the provider with
4 notice and such other due process protections as the State
5 may provide, except that a State may not provide an eligi-
6 ble managed care provider with a pretermination hearing
7 before imposing the sanction described in subsection (b)(2).

8 “(4) IMPOSITION OF CIVIL MONETARY PENALTIES BY
9 SECRETARY.—The provisions of section 1128A (other than
10 subsections (a) and (b)) shall apply with respect to a civil
11 money penalty imposed by the Secretary under subsection
12 (b)(1) in the same manner as such provisions apply to a
13 penalty or proceeding under section 1128A.”

14 (b) CONFORMING AMENDMENT RELATING TO TERMI-
15 NATION OF ENROLLMENT FOR CAUSE.—Section
16 1933(b)(2)(B), as inserted by section 7102(c), is amended by
17 inserting after “coercion” the following: “, or pursuant to the
18 imposition against the eligible managed care provider of the
19 sanction described in section 1935(b)(3),”.

20 **SEC. 7107. REPORT ON PUBLIC HEALTH SERVICES.**

21 (a) IN GENERAL.—Not later than January 1, 1997, the
22 Secretary of Health and Human Services (in this subtitle re-
23 ferred to as the “Secretary”) shall report to the Committee on
24 Finance of the Senate and the Committee on Commerce of the
25 House of Representatives on the effect of risk contracting enti-
26 ties (as defined in section 1932(a)(3) of the Social Security
27 Act) and primary care case management entities (as defined in
28 section 1932(a)(1) of such Act) on the delivery of and payment
29 for the services listed in subsection (f)(2)(C)(ii) of section 1932
30 of such Act.

31 (b) CONTENTS OF REPORT.—The report referred to in
32 subsection (a) shall include—

33 (1) information on the extent to which enrollees with
34 risk contracting entities and primary care case manage-
35 ment programs seek services at local health departments,
36 public hospitals, and other facilities that provide care with-
37 out regard to a patient's ability to pay;

1 (2) information on the extent to which the facilities
2 described in paragraph (1) provide services to enrollees
3 with risk contracting entities and primary care case man-
4 agement programs without receiving payment;

5 (3) information on the effectiveness of systems imple-
6 mented by facilities described in paragraph (1) for educat-
7 ing such enrollees on services that are available through the
8 risk contracting entities or primary care case management
9 programs with which such enrollees are enrolled;

10 (4) to the extent possible, identification of the types of
11 services most frequently sought by such enrollees at such
12 facilities; and

13 (5) recommendations about how to ensure the timely
14 delivery of the services listed in subsection (f)(2)(C)(ii) of
15 section 1931 of the Social Security Act to enrollees of risk
16 contracting entities and primary care case management en-
17 tities and how to ensure that local health departments,
18 public hospitals, and other facilities are adequately com-
19 pensated for the provision of such services to such enroll-
20 ees.

21 **SEC. 7108. REPORT ON PAYMENTS TO HOSPITALS.**

22 (a) **IN GENERAL.**—Not later than October 1 of each year,
23 beginning with October 1, 1996, the Secretary and the Comp-
24 troller General shall analyze and submit a report to the Com-
25 mittee on Finance of the Senate and the Committee on Com-
26 merce of the House of Representatives on rates paid for hos-
27 pital services under coordinated care programs described in sec-
28 tion 1932 of the Social Security Act.

29 (b) **CONTENTS OF REPORT.**—The information in the re-
30 port described in subsection (a) shall—

31 (1) be organized by State, type of hospital, type of
32 service, and

33 (2) include a comparison of rates paid for hospital
34 services under coordinated care programs with rates paid
35 for hospital services furnished to individuals who are enti-
36 tled to benefits under a State plan under title XIX of the

1 Social Security Act and are not enrolled in such coordi-
2 nated care programs.

3 (c) REPORTS BY STATES.—Each State shall transmit to
4 the Secretary, at such time and in such manner as the Sec-
5 retary determines appropriate, the information on hospital
6 rates submitted to such State under section 1932(b)(3)(P) of
7 such Act.

8 **SEC. 7109. CONFORMING AMENDMENTS.**

9 (a) EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES
10 FROM PARTICIPATION IN PROGRAM.—Section 1128(b)(6)(C)
11 (42 U.S.C. 1320a-7(b)(6)(C)) is amended—

12 (1) in clause (i), by striking “a health maintenance or-
13 ganization (as defined in section 1903(m))” and inserting
14 “an eligible managed care provider, as defined in section
15 1933(a)(1),”; and

16 (2) in clause (ii), by inserting “section 1115 or” after
17 “approved under”.

18 (b) STATE PLAN REQUIREMENTS.—Section 1902 (42
19 U.S.C. 1396a) is amended—

20 (1) in subsection (a)(30)(C), by striking “section
21 1903(m)” and inserting “section 1932(a)(1)(B)”; and

22 (2) in subsection (a)(57), by striking “hospice pro-
23 gram, or health maintenance organization (as defined in
24 section 1903(m)(1)(A))” and inserting “or hospice pro-
25 gram”;

26 (3) in subsection (e)(2)(A), by striking “or with an en-
27 tity described in paragraph (2)(B)(iii), (2)(E), (2)(G), or

28 (6) of section 1903(m) under a contract described in
29 section 1903(m)(2)(A);

30 (4) in subsection (p)(2)—

31 (A) by striking “a health maintenance organiza-
32 tion (as defined in section 1903(m))” and inserting “an
33 eligible managed care provider, as defined in section
34 1933(a)(1),”;

35 (B) by striking “an organization” and inserting “a
36 provider”; and

1 (C) by striking "any organization" and inserting
2 "any provider"; and

3 (5) in subsection (w)(1), by striking "sections
4 1903(m)(1)(A) and" and inserting "section".

5 (c) PAYMENT TO STATES.—Section 1903(w)(7)(A)(viii)
6 (42 U.S.C. 1396b(w)(7)(A)(viii)) is amended to read as follows:

7 "(viii) Services of an eligible managed care
8 provider with a contract under section
9 1932(a)(1)(B)."

10 (d) USE OF ENROLLMENT FEES AND OTHER CHARGES.—
11 Section 1916 (42 U.S.C. 1396o) is amended in subsections
12 (a)(2)(D) and (b)(2)(D) by striking "a health maintenance or-
13 ganization (as defined in section 1903(m))" and inserting "an
14 eligible managed care provider, as defined in section
15 1933(a)(1)," each place it appears.

16 (e) EXTENSION OF ELIGIBILITY FOR MEDICAL ASSIST-
17 ANCE.—Section 1925(b)(4)(D)(iv) (42 U.S.C. 1396r-
18 6(b)(4)(D)(iv)) is amended to read as follows:

19 "(iv) ENROLLMENT WITH ELIGIBLE MANAGED
20 CARE PROVIDER.—Enrollment of the caretaker rel-
21 ative and dependent children with an eligible man-
22 aged care provider, as defined in section
23 1933(a)(1), less than 50 percent of the membership
24 (enrolled on a prepaid basis) of which consists of
25 individuals who are eligible to receive benefits
26 under this title (other than because of the option
27 offered under this clause). The option of enrollment
28 under this clause is in addition to, and not in lieu
29 of, any enrollment option that the State might offer
30 under subparagraph (A)(i) with respect to receiving
31 services through an eligible managed care provider
32 in accordance with sections 1932, 1933, and
33 1934."

34 (f) ASSURING ADEQUATE PAYMENT LEVELS FOR OBSTET-
35 RICAL AND PEDIATRIC SERVICES.—Section 1926(a) (42 U.S.C.
36 1396r-7(a)) is amended in paragraphs (1) and (2) by striking
37 "health maintenance organizations under section 1903(m)" and

1 inserting "eligible managed care providers under contracts en-
2 tered into under section 1932(a)(1)(B)" each place it appears.

3 (g) PAYMENT FOR COVERED OUTPATIENT DRUGS.—Sec-
4 tion 1927(j)(1) (42 U.S.C. 1396r-8(j)(1)) is amended by strik-
5 ing "****Health Maintenance Organizations, including those or-
6 ganizations that contract under section 1903(m)," and insert-
7 ing "health maintenance organizations and medicaid managed
8 care plans, as defined in section 1933(a)(2),".

9 (h) DEMONSTRATION PROJECTS TO STUDY EFFECT OF
10 ALLOWING STATES TO EXTEND MEDICAID COVERAGE FOR
11 CERTAIN FAMILIES.—Section 4745(a)(5)(A) of the Omnibus
12 Budget Reconciliation Act of 1990 (42 U.S.C. 1396a note) is
13 amended by striking "(except section 1903(m))" and inserting
14 "(except sections 1932, 1933, and 1934)".

15 **SEC. 7110. EFFECTIVE DATE; STATUS OF WAIVERS.**

16 (a) EFFECTIVE DATE.—Except as provided in subsection
17 (b), the amendments made by this subtitle shall apply to medi-
18 cal assistance furnished—

19 (1) during quarters beginning on or after October 1,
20 1996; or

21 (2) in the case of assistance furnished under a con-
22 tract described in section 7102(b), during quarters begin-
23 ning after the earlier of—

24 (A) the date of the expiration of the contract; or

25 (B) the expiration of the 1-year period which be-
26 gins on the date of the enactment of this Act.

27 (b) APPLICATION TO WAIVERS.—

28 (1) EXISTING WAIVERS.—If any waiver granted to a
29 State under section 1115 or 1915 of the Social Security
30 Act (42 U.S.C. 1315, 1396n) or otherwise which relates to
31 the provision of medical assistance under a State plan
32 under title XIX of the such Act (42 U.S.C. 1396 et seq.),
33 is in effect or approved by the Secretary of Health and
34 Human Services as of the applicable effective date de-
35 scribed in subsection (a), the amendments made by this
36 subtitle shall not apply with respect to the State before the
37 expiration (determined without regard to any extensions) of

1 the waiver to the extent such amendments are inconsistent
2 with the terms of the waiver.

3 (2) SECRETARIAL EVALUATION AND REPORT FOR EX-
4 ISTING WAIVERS AND EXTENSIONS.—

5 (A) PRIOR TO APPROVAL.—On and after the appli-
6 cable effective date described in subsection (a), the Sec-
7 retary, prior to extending any waiver granted under
8 section 1115 or 1915 of the Social Security Act (42
9 U.S.C. 1315, 1396n) or otherwise which relates to the
10 provision of medical assistance under a State plan
11 under title XIX of the such Act (42 U.S.C. 1396 et
12 seq.), shall—

13 (i) conduct an evaluation of—

14 (I) the waivers existing under such sec-
15 tions or other provision of law as of the date
16 of the enactment of this Act; and

17 (II) any applications pending, as of the
18 date of the enactment of this Act, for exten-
19 sions of waivers under such sections or other
20 provision of law; and

21 (ii) submit a report to the Congress rec-
22 ommending whether the extension of a waiver
23 under such sections or provision of law should be
24 conditioned on the State submitting the request for
25 an extension complying with the provisions of sec-
26 tions 1932, 1933, and 1934 of the Social Security
27 Act (as added by this subtitle).

28 (B) DEEMED APPROVAL.—If the Congress has not
29 enacted legislation based on a report submitted under
30 subparagraph (A)(ii) within 120 days after the date
31 such report is submitted to the Congress, the rec-
32 ommendations contained in such report shall be deemed
33 to be approved by the Congress.

1 **Subtitle C—Additional State Flexibil-**
2 **ity in Medicaid Acute Care Pro-**
3 **gram**

4 **SEC. 7201. PERMITTING INCREASED FLEXIBILITY IN**
5 **MEDICAID COST-SHARING.**

6 (a) **IN GENERAL.**—Subsections (a)(3) and (b)(3) of sec-
7 tion 1916 (42 U.S.C. 1396o) are amended by striking every-
8 thing that follows “other care and services” and inserting the
9 following: “will be established pursuant to a public schedule of
10 charges and will be adjusted to reflect the income, resources,
11 and family size of the individual provided the item or service.”.

12 (b) **EFFECTIVE DATE.**—The amendments made by sub-
13 section (a) shall apply to items and services furnished on or
14 after the first day of the first calendar quarter beginning after
15 the date of the enactment of this Act.

16 **SEC. 7202. LIMITS ON REQUIRED COVERAGE OF ADDI-**
17 **TIONAL TREATMENT SERVICES UNDER**
18 **EPSDT.**

19 (a) **REGULATIONS.**—The Secretary of Health and Human
20 Services shall define, by regulation promulgated after consulta-
21 tion with States and organizations representing health care
22 providers, those treatment services (in addition to those other-
23 wise covered under a State plan under title XIX of the Social
24 Security Act) that must be covered under section 1905(r)(5) of
25 such Act.

26 (b) **CONSTRUCTION.**—Nothing in subsection (a) shall be
27 construed as limiting the scope of such treatment services a
28 State may cover under such section.

29 **SEC. 7203. APPLICATION OF STANDARDS FOR PAYMENT**
30 **FOR HOSPITALS AND NURSING FACILITIES.**

31 (a) **IN GENERAL.**—Section 1902 (42 U.S.C. 1396a) is
32 amended—

33 (1) in subsection (a)(13)(A), by striking “makes as-
34 surances satisfactory to the Secretary” and inserting “cer-
35 tifies to the Secretary under subsection (a)(3)”; and

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

1 “(aa)(1) The provisions of this subsection shall apply in
2 the determination of compliance of States with the require-
3 ments of subsection (a)(13)(A) relating to rates of payment for
4 hospital services and nursing facility services.

5 “(2)(A) Not later than 1 year after the date of the enact-
6 ment of this subsection, the Secretary shall promulgate regula-
7 tions specifying the standards for determining whether, under
8 subsection (a)(13)(A), rates of payment for hospital services
9 and nursing facility services are reasonable and adequate to
10 meet the costs which must be incurred by efficiently and eco-
11 nomically operated facilities in order to provide care and serv-
12 ices in conformity with applicable State and Federal laws, regu-
13 lations, and quality and safety standards and to assure that in-
14 dividuals eligible for medical assistance have reasonable access
15 (taking into account geographic location and reasonable travel
16 time) to inpatient hospital services of adequate quality. Such
17 regulations also shall specify procedures for applying such
18 standards under this subsection.

19 “(B) Such regulations shall be promulgated in consulta-
20 tion with State officials and administrators of hospitals and
21 nursing facilities.

22 “(3) In order to meet the requirement of subsection
23 (a)(13)(A) with respect to such payment rates for periods be-
24 ginning on or after such date (after the date regulations are
25 first promulgated under paragraph (2)) as the Secretary speci-
26 fies, each State shall submit a certification that its payment
27 rates comply with such regulations. Such certification shall be
28 accompanied by such information as the Secretary may require
29 under regulations promulgated under such paragraph.

30 “(4) The Secretary shall review such certification to deter-
31 mine whether the payment rates, as so certified, are in compli-
32 ance with such regulations. The Secretary shall determine,
33 within 120 days after the date of such certification, whether
34 such rates comply with such regulations.

35 “(5) A State, hospital, nursing facility, or other party that
36 is adversely affected by such determination may petition the
37 Secretary for a hearing regarding the determination.

1 “(6) If the Secretary has failed to make a timely deter-
2 mination under this subsection or has made such a determina-
3 tion that is adverse to such a party, the party may bring an
4 action described in section 702 of title 5, United States Code
5 to require the making or changing of such a determination. In
6 such an action, the judicial scope of review is that specified
7 under section 706 of title 5, United States Code.”.

8 **SEC. 7204. MAKING HOME AND COMMUNITY-BASED**
9 **SERVICES OPTIONAL BENEFIT NOT SUBJECT**
10 **TO WAIVER REQUIREMENTS.**

11 (a) **TREATMENT AS MEDICAL ASSISTANCE.—**

12 (1) **IN GENERAL.—**Section 1905(a) (42 U.S.C.
13 1396d(a)) is amended by striking paragraphs (22) and
14 (23) and inserting the following:

15 “(22) home and community-based services (in accord-
16 ance with section 1909));”.

17 (2) **TERMINATION OF CURRENT WAIVER AUTHOR-**
18 **ITY.—**Section 1915(c) (42 U.S.C. 1396n(c)) is amended by
19 adding at the end the following new paragraph:

20 “(11) The Secretary may not grant or extend a waiver
21 under this subsection with respect to any medical assistance
22 furnished on or after October 1, 2000.”.

23 (b) **REQUIREMENTS FOR SERVICES DESCRIBED.—**Title
24 **XIX** is amended by inserting after the section 1908 added by
25 section 13623(b) of the Omnibus Budget Reconciliation Act of
26 1993 the following new section:

27 **“REQUIREMENTS FOR HOME AND COMMUNITY-BASED SERVICES**

28 **“SEC. 1909. (a) IN GENERAL.—**A State plan under this
29 title may include as ‘medical assistance’ under the plan pay-
30 ment for part or all of the cost of home and community-based
31 services without regard to the requirements of section
32 1902(a)(1) (relating to statewideness), section 1902(a)(10)(B)
33 (relating to comparability), and section 1902(a)(10)(C)(i)(III)
34 (relating to income and resource rules applicable in the commu-
35 nity) if the State meets the following requirements:

36 “(1) The services meet standards established by the
37 Secretary (in cooperation with the States) through regula-

1 tions which assure that individuals to whom the services
2 are furnished are protected from neglect, physical and sexual
3 abuse, financial exploitation, inappropriate involuntary
4 restraint, and the provision of services by unqualified personnel
5 or in substandard settings.

6 “(2) The State informs individuals under the State
7 plan who are determined to be likely to require the level of
8 care provided in a hospital, nursing facility, or intermediate
9 care facility for the mentally retarded of the availability of
10 home and community-based services under the plan (at the
11 option of the individual) as an alternative to the provision
12 of inpatient hospital services, nursing facility services, or
13 services in an intermediate care facility for the mentally
14 retarded.

15 “(3) The State will provide to the Secretary annually,
16 consistent with a data collection plan designed by the Secretary,
17 information on the impact of the inclusion of home
18 and community-based services as medical assistance under
19 the State plan on the type and amount of medical assistance
20 provided under the plan and on the health and welfare
21 of recipients.

22 “(b) OPTIONAL APPLICATION OF ALTERNATIVE PERSONAL
23 NEEDS ALLOWANCE AND PROTECTIONS FOR COMMUNITY SPOUSES.—A State
24 including home and community-based services as medical assistance
25 under its State plan may—

26 “(1) for purposes of post-eligibility treatment of income,
27 provide for the disregard of a greater amount for the
28 maintenance needs of an individual receiving such services
29 than amounts disregarded with respect to an institutionalized
30 individual under similar circumstances, and

31 “(2) for purposes of section 1924, treat an individual
32 receiving such services as an individual described in section
33 1924(h)(1)(A).

34 “(c) OPTIONAL LIMIT ON INDIVIDUALS PROVIDED SERVICES.—A State
35 including home and community-based services as medical assistance
36 under its State plan may limit the individuals provided such
37 services to individuals with respect to

1 whom the State has determined that there is a reasonable ex-
2 pectation that the amount of medical assistance provided with
3 respect to the individual for such services will not exceed the
4 amount of such medical assistance provided for such individual
5 under the plan if the individual were institutionalized.

6 “(d) HOME AND COMMUNITY-BASED SERVICES DE-
7 FINED.—

8 “(1) IN GENERAL.—In this section, the term ‘home
9 and community-based services’ means items and services
10 (other than room and board) approved by the Secretary
11 which are provided pursuant to a written plan of care to
12 individuals with respect to whom there has been a deter-
13 mination that but for the provision of such services the in-
14 dividuals would require the level of care provided in a hos-
15 pital or a nursing facility or intermediate care facility for
16 the mentally retarded the cost of which could be reim-
17 bursed under the State plan.

18 “(2) TREATMENT OF ROOM AND BOARD.—For pur-
19 poses of paragraph (1), the term ‘room and board’ shall
20 not include an amount established under a method deter-
21 mined by the State to reflect the portion of costs of rent
22 and food attributable to an unrelated personal caregiver
23 who is residing in the same household with an individual
24 who, but for the assistance of such caregiver, would require
25 admission to a hospital, nursing facility, or intermediate
26 care facility for the mentally retarded.”

27 (c) PROVIDING FRAUD CONTROL UNITS WITH AUTHOR-
28 ITY TO REVIEW COMPLAINTS REGARDING HOME AND COMMU-
29 NITY-BASED SERVICES.—Section 1903(q)(4) (42 U.S.C.
30 1396b(q)(4)) is amended by inserting after “facilities” the fol-
31 lowing: “and providers of home and community-based services”.

32 (d) REPEAL OF CURRENT DEMONSTRATIONS.—

33 (1) IN GENERAL.—Title XIX is amended by striking
34 sections 1929 and 1930.

35 (2) CONFORMING AMENDMENT.—Section 1902(a)(13)
36 (42 U.S.C. 1396a(a)(13)(F)) is amended—

1 (A) by adding "and" at the end of subparagraph
2 (D), and

3 (B) by striking subparagraph (F).

4 (3) EFFECTIVE DATE.—The amendments made by
5 this subsection shall apply with respect to quarters begin-
6 ning on or after October 1, 1996.

7 (e) CONFORMING AMENDMENTS.—(1) Section
8 1902(a)(10)(A)(ii)(VI) (42 U.S.C. 1396a(a)(10)(A)(ii)(VI)) is
9 amended—

10 (A) by inserting "section 1909 or" after "described
11 in", and

12 (B) by striking "pursuant" and inserting "under the
13 State plan in accordance with section 1909 or pursuant".

14 (2) Section 1902(r)(1) (42 U.S.C. 1396a(r)(1)) is amend-
15 ed—

16 (A) by striking "1902(a)(17) and 1924(d)(1)(D)" and
17 inserting "1902(a)(17), 1909(b), and 1924(d)(1)(D)", and

18 (B) by striking "institutionalized or" and inserting
19 "institutionalized, receiving home and community-based
20 services in accordance with section 1909, or".

21 (3) Section 1915(d) (42 U.S.C. 1396n(d)) is amended—

22 (A) in the third sentence of paragraph (3), by insert-
23 ing before the period the following: "or pursuant to section
24 1909(b)", and

25 (B) in paragraph (5)(C)(i), by inserting after "para-
26 graph (4)," the following: "services covered under the State
27 plan in accordance with section 1909,".

28 (4) Section 1917(c)(1)(C)(i)(III) (42 U.S.C.
29 1396p(c)(1)(C)(i)(III)) is amended by inserting after "fur-
30 nished" the following: "under the State plan in accordance with
31 section 1909 or".

32 (f) EFFECTIVE DATE.—Except as provided in subsection
33 (d)(3), the amendments made by this section shall apply with
34 respect to quarters beginning on or after the effective date of
35 the regulations established by the Secretary of Health and
36 Human Services pursuant to section 1909(a)(1) of the Social

1 Security Act (as added by subsection (b)) regarding standards
2 for home and community-based services.

3 **SEC. 7205. REVISION OF REQUIREMENTS RELATING TO**
4 **FEDERALLY QUALIFIED HEALTH CENTERS**
5 **AND RURAL HEALTH CLINICS; ESTABLISH-**
6 **MENT OF SEPARATE DIRECT PAYMENT PRO-**
7 **GRAM.**

8 (a) **LIMITATION OF CURRENT REQUIREMENTS TO FACILI-**
9 **TIES OF INDIAN TRIBES.—**

10 (1) **PAYMENT RULES.—**Section 1902(a)(13)¹ (42
11 U.S.C. 1396a(a)(13)) is amended by inserting “furnished
12 by an Indian tribe or tribal organization described in the
13 last sentence of section 1905(b)” after “under the plan”.

14 (2) **COVERAGE REQUIREMENT.—**Section 1905(a) (42
15 U.S.C. 1396d(a)) is amended—

16 (A) in paragraph (2)(B), by inserting “if furnished
17 in a facility of an Indian tribe or tribal organization de-
18 scribed in the last sentence of section 1905(b)” after
19 “included in the plan”;

20 (B) in paragraph (2)(C), by inserting “if furnished
21 in a facility of such an Indian tribe or tribal organiza-
22 tion” after “included in the plan”; and

23 (C) in paragraph (9)—

24 (i) by inserting “(A)” after “(9)”, and

25 (ii) by inserting before the semicolon at the
26 end the following: “(B) consistent with State law
27 permitting such services, rural health clinic services
28 (as defined in subsection (1)(1)) and any other am-
29 bulatory services which are offered by a rural
30 health clinic (as defined in subsection (1)(1)) and
31 which are otherwise included in the plan and which
32 are not described in paragraph (3)(B), and (C)
33 Federally-qualified health center services (as de-
34 fined in subsection (1)(2)) and any other ambula-
35 tory services offered by a Federally-qualified health
36 center and which are otherwise included in the plan
37 and which are not described in paragraph (3)(C)”.

1 (3) EFFECTIVE DATE.—The amendments made by
2 this subsection shall apply to services furnished on or after
3 October 1, 1996.

4 (b) GRANT PROGRAM FOR UNFUNDED COSTS OF RURAL
5 HEALTH CLINICS AND FEDERALLY-QUALIFIED HEALTH CEN-
6 TERS.—Title XIX, as amended by sections 7001(a), 7101(a),
7 7102(c), 7105, and 7106(a), is further amended by
8 redesignating section 1936 as section 1937 and by inserting
9 after section 1935 the following new section:

10 "GRANTS FOR UNFUNDED COSTS OF RURAL HEALTH CLINICS
11 AND FEDERALLY-QUALIFIED HEALTH CENTERS

12 "SEC. 1936. (a) GRANT PROGRAM FOR UNFUNDED POR-
13 TION OF REASONABLE COSTS INCURRED UNDER STATE
14 PLANS.—The Secretary shall make a grant under this section
15 to each public or private nonprofit rural health clinic and public
16 or private nonprofit Federally-qualified health center for fiscal
17 year 1997 and each subsequent fiscal year. The Secretary shall
18 make payments for such grants in advance, in such install-
19 ments as the Secretary finds appropriate and adjusted to take
20 into account any overpayments or underpayments in grants
21 previously made under this section.

22 "(b) AMOUNT OF GRANT.—Subject to subsection (d), the
23 amount of the grant made under this section to a Federally-
24 qualified health center or rural health clinic for a year is equal
25 to the Secretary's estimate of the difference between—

26 "(1) the total amount of costs projected to be incurred
27 by the center or clinic for the year in providing health care
28 and related services; and

29 "(2) the total amount (exclusive of the grant under
30 this section) projected to be received by the center or clinic
31 for the year as payment for providing health care and relat-
32 ed services.

33 "(c) DIRECT SPENDING.—

34 "(1) IN GENERAL.—For carrying out this section
35 there are hereby appropriated, out of any money in the
36 Treasury not otherwise appropriated, the following amounts
37 (as applicable to the fiscal year involved):

1 “(A) For fiscal year 1997, \$500,000,000.

2 “(B) For fiscal years 1998 and each subsequent
3 fiscal year, the amount determined under this sub-
4 section for the previous fiscal year multiplied by the na-
5 tional medicaid rural health clinic and Federally-quali-
6 fied health center rate of growth, as determined under
7 paragraph (2), for such fiscal year.

8 “(B) For fiscal years 1998 and each subsequent
9 fiscal year—

10 “(2) NATIONAL MEDICAID RURAL HEALTH CLINIC AND
11 FEDERALLY-QUALIFIED HEALTH CENTER RATE OF
12 GROWTH.—At the beginning of each fiscal year, the Sec-
13 retary shall determine for the preceding fiscal year a na-
14 tional medicaid rural health clinic and Federally-qualified
15 health center rate of growth for Federal payments made
16 under this title to all States with a State plan approved
17 under this title (or operating a medicaid program under a
18 waiver of the requirements of this title) based on—

19 “(A) the percentage increase in payments made
20 under this title that occurred during such fiscal year;
21 and

22 “(B) the annual percentage increase that occurred
23 during such year in the populations served by Federally
24 qualified health centers and rural health clinics eligible
25 for a grant under this section.

26 “(d) ENTITLEMENT STATUS OF GRANTS.—

27 “(1) IN GENERAL.—Effective on and after October 1,
28 1996, the requirement established in subsection (a) for the
29 Secretary (relating to making a grant)—

30 “(A) is an entitlement in a public or private non-
31 profit Federally qualified health center and a public or
32 private nonprofit rural health clinic on behalf of indi-
33 viduals served by the center or clinic (but is not an en-
34 titlement in any such individual); and

35 “(B) represents the obligation of the Federal Gov-
36 ernment, subject to paragraph (2), to make a grant
37 under subsection (a) to the center or clinic in the

1 amount determined for the clinic or center under sub-
2 section (b).

3 “(2) CAPPED ENTITLEMENT.—The entitlement estab-
4 lished in paragraph (1) is subject to the extent of the
5 amount appropriated in subsection (c) for the fiscal year.

6 “(3) PRO RATA REDUCTIONS UNDER CAP AMOUNT.—
7 If the Secretary determines that the budget authority pro-
8 vided in subsection (c) for a fiscal year is insufficient to
9 provide the total of all amounts under subsection (b) for
10 the year, the Secretary shall reduce each amount deter-
11 mined under subsection (b) for the year on a pro rata basis
12 to the extent necessary for the grants under this section to
13 be provided in an aggregate amount equal to the budget
14 authority available under subsection (c) for the year.”

15 **SEC. 7206. ELIGIBILITY FOR TANF-RELATED POPU-**
16 **LATIONS.**

17 (a) **HOLDHARMLESS FOR CURRENT AFDC POPU-**
18 **LATIONS.**—For purposes of applying title XIX of the Social Se-
19 curity Act on and after [the effective date of the AFDC
20 changes], an individual who on the date before date was eligi-
21 ble for medical assistance under such title on the basis of re-
22 ceiving aid or assistance under part A of title IV of such Act
23 (or other basis relating to the previous receipt of such aid)
24 shall be deemed to continue to remain eligible for such medical
25 assistance until such date as such aid or assistance (or eligi-
26 bility) would have been terminated under the law in effect on
27 the date of the enactment of this Act.

28 (b) **REPEAL OF SUNSET ON TRANSITIONAL WORK PROVI-**
29 **SIONS.**—Subsection (f) of section 1925 (42 U.S.C. 1396r-6(f))
30 is repealed.

31 **SEC. 7207. REPEAL OF CERTAIN RESTRICTIONS ON OB-**
32 **STETRICAL AND PEDIATRIC PROVIDERS.**

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

35 (b) **EFFECTIVE DATE.**—The amendment made by section
36 (a) shall take effect on October 1, 1996.

1 **SEC. 7208. ELIMINATION OF REQUIREMENT TO PAY FOR**
 2 **PRIVATE INSURANCE.**

3 (a) **REPEAL OF STATE PLAN PROVISION.**—Section
 4 1902(a)(25) (42 U.S.C. 1396a(a)(25)) is amended—

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

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

8 (b) **REPEAL OF ENROLLMENT REQUIREMENTS.**—Section
 9 1906 (42 U.S.C. 1396e) is repealed.

10 (c) **REINSTATEMENT OF STATE OPTION.**—Section 1905(a)
 11 (42 U.S.C. 1396d(a)) is amended in the matter preceding
 12 clause (i) by inserting “(including, at State option, through
 13 purchase or payment of enrollee costs of health insurance)”
 14 after “The term ‘medical assistance’ means payment”.

15 (d) **EFFECTIVE DATE.**—The amendments made by this
 16 section shall take effect on October 1, 1996.

17 **SEC. 7209. ELIMINATION OF OBSTETRICAL AND PEDI-**
 18 **ATRIC PAYMENT RATE REQUIREMENTS.**

19 Section 1926 (42 U.S.C. 1396r-7) is repealed.

20 **SEC. 7210. REQUIREMENT OF EXHAUSTION OF ADMINIS-**
 21 **TRATIVE REMEDIES BEFORE BRINGING AC-**
 22 **TION IN FEDERAL COURT.**

23 (a) **IN GENERAL.**—Section 1902 (42 U.S.C. 1396a) is
 24 amended by adding at the end the following new subsection:

25 “(aa)(1) Except as provided in this subsection, prior to
 26 commencing in Federal court an action arising under this
 27 title—

28 “(A) an individual must exhaust an administrative
 29 process established by the State consistent with paragraph
 30 (4), and

31 “(B) a provider must exhaust any administrative proc-
 32 ess established by the State.

33 “(2) Paragraph (1)(A) shall not apply to an action
 34 brought—

35 “(A) for the enforcement of requirements under sub-
 36 section (a)(10)(D) (relating to qualified medicare bene-
 37 ficiaries) and section 1905(p) (relating to medicare cost-
 38 sharing);

1 “(B) for the enforcement of section 1919 (relating to
2 nursing home standards);

3 “(C) for the enforcement of section 1924 (relating to
4 prevention of spousal impoverishment); or

5 “(D) by an individual who is a veteran (as defined in
6 section 101(2) of title 38, United States Code) or a spouse,
7 widow, or widower of such a veteran.

8 “(3) Paragraph (1) shall not apply to an action brought
9 in a case in which—

10 “(A) a delay in provision of services during the admin-
11 istrative process may result in serious impairment to the
12 health of, or irreparable injury to, the individual;

13 “(B) the responsible officer in the administrative proc-
14 ess lacks authority to provide for the relief requested; or

15 “(C) compliance with the exhaustion requirement of
16 such paragraph would be futile and there is otherwise no
17 adequate remedy at law.

18 “(4) An administrative process is consistent with this
19 paragraph only if—

20 “(A) it provides for fair hearings consistent with the
21 requirements of subsection 1902(a)(3) and subpart E of
22 part 431 of title 42, Code of Federal Regulations (as in ef-
23 fect as of January 1, 1996), and

24 “(B) it does not restrict the rights of beneficiaries to
25 such a hearing because they are enrolled in an entity con-
26 tracting on a risk basis under section 1903(m) or in an en-
27 tity contracting with a State under section 1915(b) or sec-
28 tion 1115.

29 Subparagraph (B) shall not be construed as preventing a State
30 from providing for a fair hearing through such an entity so
31 long as such hearing meets the requirements of subparagraph
32 (A).”.

33 (b) EFFECTIVE DATE.—The amendment made by sub-
34 section (a) shall apply to actions commenced on or after Octo-
35 ber 1, 1996.

1 **Subtitle D—National Commission on**
2 **Medicaid Restructuring**

3 **SEC. 7301. ESTABLISHMENT OF COMMISSION.**

4 (a) **IN GENERAL.**—There is hereby established the Na-
5 tional Commission on Medicaid Restructuring (in this subtitle
6 referred to as the “Commission”).

7 (b) **COMPOSITION.**—The Commission shall be composed as
8 follows:

9 (1) **2 FEDERAL OFFICIALS.**—The President shall ap-
10 point 2 Federal officials, one of whom the President shall
11 designate as chairperson of the Commission.

12 (2) **4 MEMBERS OF CONGRESS.**—(A) The Speaker of
13 the House of Representatives shall appoint one Member of
14 the House as a member.

15 (B) The minority leader of the House of Representa-
16 tives shall appoint one Member of the House as a member.

17 (C) The majority leader of the Senate shall appoint
18 one Member of the Senate as a member.

19 (D) The minority leader of the Senate shall appoint
20 one Member of the Senate as a member.

21 (3) **6 STATE GOVERNMENT REPRESENTATIVES.**—(A)
22 The majority leaders of the House of Representatives and
23 the Senate shall jointly appoint 3 individuals who are gov-
24 ernors, State legislators, or State medicaid officials.

25 (B) The minority leaders of the House of Representa-
26 tives and the Senate shall jointly appoint 3 individuals who
27 are governors, State legislators, or State medicaid officials.

28 (4) **6 EXPERTS.**—(A) The majority leaders of the
29 House of Representatives and the Senate shall jointly ap-
30 point 4 individuals who are not officials of the Federal or
31 State governments and who have expertise in a health-re-
32 lated field, such as medicine, public health, or delivery and
33 financing of health care services.

34 (B) The President shall appoint 2 individuals who are
35 not officials of the Federal or State governments and who
36 have expertise in a health-related field, such as medicine,

1 public health, or delivery and financing of health care serv-
2 ices.

3 (c) INITIAL APPOINTMENT.—Members of the Commission
4 shall first be appointed by not later than 60 days after the date
5 of the enactment of this Act.

6 (d) COMPENSATION AND EXPENSES.—

7 (1) COMPENSATION.—Each member of the Commis-
8 sion shall serve without compensation.

9 (2) TRAVEL EXPENSES.—Members of the Commission
10 shall be allowed travel expenses, including per diem in lieu
11 of subsistence, at rates authorized for employees of agen-
12 cies under subchapter I of chapter 57 of title 5, United
13 States Code, while away from their homes or regular places
14 of business in the performance of services for the Commis-
15 sion.

16 **SEC. 7302. DUTIES OF COMMISSION.**

17 (a) STUDY OF MEDICAID PROGRAM.—

18 (1) IN GENERAL.—The Commission shall study and
19 make recommendations to the Congress, the President, and
20 the Secretary regarding the need for changes (in addition
21 to the changes effected under this title) in the laws and
22 regulations regarding the medicaid program under title
23 XIX of the Social Security Act.

24 (2) SPECIFIC CONCERNS.—The Commission shall spe-
25 cifically address each of the following:

26 (A) Changes needed to ensure adequate access to
27 health care for low-income individuals.

28 (B) Promotion of quality care.

29 (C) Deterrence of fraud and abuse.

30 (D) Providing States with additional flexibility in
31 implementing their medicaid plans.

32 (E) Methods of containing Federal and State
33 costs.

34 (b) REPORTS.—

35 (1) FIRST REPORT.—The Commission shall issue a
36 first report to Congress by not later than December 31,
37 1996.

1 (2) SUBSEQUENT REPORTS.—The Commission shall
2 issue subsequent reports to Congress by not later than De-
3 cember 31, 1997, and December 31, 1998.

4 **SEC. 7303. ADMINISTRATION.**

5 (a) APPOINTMENT OF STAFF.—

6 (1) EXECUTIVE DIRECTOR.—The Commission shall
7 have an Executive Director who shall be appointed by the
8 Chairperson with the approval of the Commission. The Ex-
9 ecutive Director shall be paid at a rate not to exceed the
10 rate of basic pay payable for level III of the Executive
11 Schedule.

12 (2) STAFF.—With the approval of the Commission,
13 the Executive Director may appoint and determine the
14 compensation of such staff as may be necessary to carry
15 out the duties of the Commission. Such appointments and
16 compensation may be made without regard to the provi-
17 sions of title 5, United States Code, that govern appoint-
18 ments in the competitive services, and the provisions of
19 chapter 51 and subchapter III of chapter 53 of such title
20 that relate to classifications and the General Schedule pay
21 rates.

22 (3) CONSULTANTS.—The Commission may procure
23 such temporary and intermittent services of consultants
24 under section 3109(b) of title 5, United States Code, as the
25 Commission determines to be necessary to carry out the
26 duties of the Commission.

27 (b) PROVISION OF ADMINISTRATIVE SUPPORT SERVICES
28 BY HHS.—Upon the request of the Commission, the Secretary
29 of Health and Human Services shall provide to the Commission
30 on a reimbursable basis such administrative support services as
31 the Commission may request.

32 **SEC. 7304. AUTHORIZATION OF APPROPRIATIONS.**

33 There are authorized to be appropriated to carry out this
34 subtitle \$3,000,000 for fiscal year 1996, \$4,000,000 for each
35 of fiscal years 1997 and 1998, and \$2,000,000 for fiscal year
36 1999.

1 SEC. 7305. TERMINATION.

2 The Commission shall terminate on December 31, 1998.

3 **Subtitle E—Restrictions on**
4 **Disproportionate Share Payments**5 SEC. 7401. REFORMING DISPROPORTIONATE SHARE
6 PAYMENTS UNDER STATE MEDICAID PRO-
7 GRAMS.8 (a) TARGETING PAYMENTS.—Section 1923 (42
9 U.S.C.1396r-3) is amended—

10 (1) in subsection (a)(1)—

11 (A) by redesignating subparagraphs (A) and (B)
12 as clauses (i) and (ii),

13 (B) by striking “(1)” and inserting “(1)(A)”,

14 (C) in clause (i) (as so redesignated) by striking
15 “(b)(1)” and inserting “(b)(1)(A)”, and

16 (D) by adding at the end the following:

17 “(B) A State plan under this title shall not be considered
18 to meet the requirement of section 1902(a)(13)(A) (insofar as
19 it requires payments to hospitals to take into account the situa-
20 tion of hospitals that serve a disproportionate number of low-
21 income patients with special needs), as of July 1, 1997, unless
22 the State has submitted to the Secretary, by not later than
23 such date, an amendment to such plan that utilizes the defini-
24 tion of such hospitals specified in subsection (b)(1)(B) in lieu
25 of the definition established by the State under subparagraph
26 (a)(i).”;

27 (2) in subsection (a)(2)(A)—

28 (A) by inserting “(i)” after “(2)(A)”,

29 (B) by striking “paragraph (1)” and inserting
30 “paragraph (1)(A)(i)”, and

31 (C) by adding at the end the following:

32 “(ii) In order to be considered to have met such require-
33 ment of section 1902(a)(13)(A) as of July 1, 1997, the State
34 must submit to the Secretary by not later than April 1, 1997,
35 the State plan amendment described in paragraph (1)(B), con-
36 sistent with subsection (c), effective for inpatient hospital serv-
37 ices furnished on or after July 1, 1997.”;

- 1 (3) in subsection (b)—
- 2 (A) in the heading, by striking “HOSPITALS
- 3 DEEMED DISPROPORTIONATE SHARE” and inserting
- 4 “DISPROPORTIONATE SHARE HOSPITALS”,
- 5 (B) in paragraph (1)—
- 6 (i) by redesignating subparagraphs (A) and
- 7 (B) as clauses (i) and (ii),
- 8 (ii) by striking “(1) For purposes of sub-
- 9 section (a)(1)” and inserting “(1)(A) For purposes
- 10 of subsection (a)(1)(A)”, and
- 11 (iii) by adding at the end the following:
- 12 “(B) For purposes of subsection (a)(1)(B), a hospital that
- 13 meets the requirements of subsection (d) is a disproportionate
- 14 share hospital only if—
- 15 “(i) in the case of a hospital that is not described in
- 16 subsection (d)(2)(A)(i), the hospital’s low-income utilization
- 17 rate (as defined in paragraph (3)) exceeds 25 percent; or
- 18 “(ii) in the case of a hospital that is described in sub-
- 19 section (d)(2)(A)(i)—
- 20 “(I) the hospital meets the requirement of clause
- 21 (i), or
- 22 “(II) the hospital’s medicaid inpatient utilization
- 23 rate (as defined in paragraph (2)) exceeds 20 per-
- 24 cent.”;
- 25 (C) in paragraph (2) by striking “(1)(A)” and in-
- 26 sserting “(1)”,
- 27 (D) in paragraph (3) by striking “(1)(B)” and in-
- 28 sserting “(1)”, and
- 29 (E) by striking paragraph (4);
- 30 (4) in subsection (c)—
- 31 (A) in paragraph (2), by striking “subparagraph
- 32 (A) or (B) of subsection (b)(1)” and inserting “clause
- 33 (i) or (ii) of subsection (b)(1)(A)”,
- 34 (B) by striking paragraph (3), and
- 35 (C) in the matter following paragraph (3)—
- 36 (i) by striking “(1)(B)” each place it appears
- 37 and inserting “(1)(A)(ii)”, and

1 (ii) by striking "(2)(A)" each place it appears
2 and inserting "(2)(A)(i)"; and

3 (5) in subsection (e)—

4 (A) in paragraph (1)(C), by striking "meets the
5 requirement of subsection (d)(3)" and inserting "makes
6 payments under this section only to hospitals described
7 in subsection (b)(1)(B)", and

8 (B) in paragraph (2)—

9 (i) by inserting "and" at the end of subpara-
10 graph (B), and

11 (ii) by striking subparagraph (C).

12 (b) DIRECT PAYMENT BY STATE.—Section 1923(a) (42
13 U.S.C. 1396r-4(a)), as amended by subsection (a), is further
14 amended—

15 (1) in paragraph (1), by adding at the end the follow-
16 ing

17 "(C) A State plan under this title shall not be considered
18 to meet the requirement of section 1902(a)(13)(A) (insofar as
19 it requires payments to hospitals to take into account the situa-
20 tion of hospitals that serve a disproportionate number of low-
21 income patients with special needs), as of July 1, 1997, unless
22 the State provides that any payments made under this section
23 with respect to individuals who are—

24 "(i) entitled to benefits under the State plan, and

25 "(ii) enrolled with a health maintenance organization
26 or other managed care plan,

27 are, at the option of the hospital, made directly to such hospital
28 by the State."; and

29 (2) in paragraph (2)(A)(ii), by striking "amendment
30 described in paragraph (1)(B)" and inserting "amendments
31 described in subparagraphs (B) and (C) of paragraph (1)".

32 (c) ADJUSTMENT TO NATIONAL DSH LIMIT; STATE AL-
33 LOCATIONS.—Subsection (f) of section 1923 (42 U.S.C. 1396r-
34 4) is amended to read as follows:

35 "(f) LIMITATION ON FEDERAL FINANCIAL PARTICIPA-
36 TION.—

37 "(1) IN GENERAL.—

1 “(A) APPLICATION OF STATE-SPECIFIC LIMITS ON
2 FEDERAL FINANCIAL PARTICIPATION.—Payment under
3 section 1903(a) shall not be made to a State with re-
4 spect to any payment adjustment made under this sec-
5 tion for hospitals in a State (as defined in paragraph
6 (4)(B)) for quarters in a fiscal year in excess of the
7 State disproportionate share hospital (in this sub-
8 section referred to as ‘DSH’) payment limit for the
9 year (as specified in paragraph (2)).

10 “(B) NATIONAL DSH PAYMENT LIMIT.—The na-
11 tional DSH payment limit for—

12 “(i) fiscal year 1997, is \$____,000,000,

13 “(ii) fiscal year 1998, is \$____,000,000,

14 “(iii) fiscal year 1999, is \$____,000,000, and

15 “(iv) fiscal year 2000 and each succeeding fis-
16 cal year is \$____,000,000.

17 “(C) PUBLICATION OF STATE DSH PAYMENT LIM-
18 ITS.—Before the beginning of each fiscal year, the Sec-
19 retary shall, consistent with section 1903(d), estimate
20 and publish the State DSH payment limit for each
21 State for the year.

22 “(2) DETERMINATION OF STATE DSH PAYMENT LIM-
23 ITS.—

24 “(A) IN GENERAL.—The State DSH payment
25 limit—

26 “(i) for each of fiscal years 1997, 1998, and
27 1999, is the amount determined under subpara-
28 graph (D); and

29 “(ii) for fiscal year 2000 and each succeeding
30 fiscal year is equal to—

31 “(I) subject to subparagraph (B)(ii), the
32 State’s share (as determined under subpara-
33 graph (B)) of the national DSH payment limit
34 for the fiscal year established under paragraph
35 (1)(B), or

36 “(II) 25 percent of payments to the State
37 under this section for fiscal year 1995,

1 whichever is greater.

2 “(B) STATE SHARE.—

3 “(i) IN GENERAL.—For purposes of subpara-
4 graph (A), subject to clause (ii), the ‘State share’
5 is equal to the ratio of—

6 “(I) the total number low-income patient
7 days (as defined in subparagraph (C)) for all
8 hospitals described in subsection (b)(1)(B) in
9 the State for the fiscal year, to

10 “(II) the total number of such low-income
11 patient days for all such hospitals for all States
12 for the fiscal year.

13 The Secretary shall determine the State share
14 based on the Secretary’s best estimate of patient
15 days and hospitals.

16 “(ii) ADJUSTMENT FOR FLOOR.—The amount
17 described in subparagraph (A)(ii)(I) for each State
18 shall be reduced for a fiscal year by such pro-rata
19 amount as may be necessary so that the total of
20 the State DSH payment limits under subparagraph
21 (A)(ii) for a fiscal year does not exceed the national
22 DSH payment limit under paragraph (1)(B) for
23 that fiscal year.

24 “(C) LOW-INCOME PATIENT DAY.—

25 “(i) IN GENERAL.—For purposes of this para-
26 graph, the term ‘low-income patient day’ means,
27 for a hospital, a patient day (as defined in clause
28 (ii)) attributable to an individual who either is eligi-
29 ble for medical assistance under the State plan or
30 has no health insurance (or other source of third
31 party coverage) for services furnished by the hos-
32 pital.

33 “(ii) PATIENT DAYS DEFINED.—For purposes
34 of this subparagraph, the term ‘patient day’ in-
35 cludes each day in which—

36 “(I) an individual (including a new-born)
37 is an inpatient in the hospital, whether or not

1 the individual is in a specialized ward and
2 whether or not the individual remains in the
3 hospital for lack of suitable placement else-
4 where, and

5 “(II) an individual makes one or more out-
6 patient visits to the hospital.

7 “(D) DETERMINATION OF STATE DSH PAYMENT
8 LIMITS DURING TRANSITION PERIOD.—

9 “(i) IN GENERAL.—For each of fiscal years
10 1997, 1998, and 1999, the State DSH payment
11 limit is an amount equal to the sum of—

12 “(I) an amount of the national DSH pay-
13 ment limit for such fiscal year equal to a per-
14 centage (specified in clause (ii)) of payments to
15 the State under this section for fiscal year
16 1995, plus

17 “(II) a share of the balance of the national
18 DSH payment limit for such fiscal year, after
19 allotment to all States pursuant to subclause
20 (I), determined in accordance with subpara-
21 graph (B).

22 “(ii) APPLICABLE PERCENTAGES.—For pur-
23 poses of clause (i), the applicable percentage speci-
24 fied in this subclause is—

25 “(I) 75 percent for fiscal year 1997,

26 “(II) 50 percent for fiscal year 1998, and

27 “(II) 25 percent for fiscal year 1999.

28 “(3) STATE DEFINED.—In this subsection, the term
29 ‘State’ means only the 50 States and the District of Co-
30 lumbia, but does not include any State whose entire pro-
31 gram under this title is operated under a waiver granted
32 under section 1115.”

33 (2) EFFECTIVE DATE.—The amendments made by
34 paragraph (1) shall apply to fiscal years beginning with fis-
35 cal year 1997.

36 (d) ANNUAL REPORT.—Not later than 90 days after the
37 end of the fiscal year in which a State first makes payment ad-

1 justment pursuant to section 1923 of the Social Security Act,
2 as amended by subsections (a), (b), and (c) of this Act, and
3 annually thereafter, the State shall submit to the Secretary of
4 Health and Human Services, and make available to the public,
5 a report on expenditures for the disproportionate share pro-
6 gram under such section in such fiscal year, based on such in-
7 formation as the Secretary of Health and Human Services may
8 specify, to insure the financial integrity of such funds and to
9 ascertain the accessibility of services at entities participating in
10 such program. Such report shall include—

11 (1) a list of each of the disproportionate share entities
12 receiving a payment adjustment under such section or sec-
13 tion 1923A(a), as added by section 3004(a) of this Act,
14 and the amount of such adjustment; and

15 (2) an explanation of the relationship of the payment
16 adjustments made to access to services, and quality and
17 safety of services, under the State plan under title XIX of
18 the Social Security Act.

19 (e) EFFECTIVE DATE.—Except as provided in subsection
20 (c)(2), the amendments made by this section shall apply to pay-
21 ments to States under section 1903(a) of the Social Security
22 Act for payments to hospitals made under State plans after Oc-
23 tober 1, 1997.

24 Subtitle F—Fraud Reduction

25 SEC. 7501. MONITORING PAYMENTS FOR DUAL ELIGI- 26 BLES.

27 The Administrator of the Health Care Financing Adminis-
28 tration shall develop mechanisms to better monitor and prevent
29 inappropriate payments under the medicaid program in the
30 case of individuals who are dually eligible for benefits under
31 such program and under the medicare program.

32 SEC. 7502. IMPROVED IDENTIFICATION SYSTEMS.

33 The Administrator of the Health Care Financing Adminis-
34 tration shall develop improved mechanisms, such as picture
35 identification documents and smart documents, to provide
36 methods of improved identification and tracking of beneficiaries

1 and providers that perpetrate fraud against the medicaid pro-
2 gram.

3 Subtitle G—State Plan 4 Administration

5 SEC. 7601. MMIS REQUIREMENTS.

6 (a) IN GENERAL.—Subsection (r) of section 1903 (42
7 U.S.C. 1396b) is amended to read as follows:

8 “(r)(1) In order to receive payments under subsection (a)
9 for use of automated data systems in administration of the
10 State plan under this title, a State must have in operation
11 mechanized claims processing and information retrieval systems
12 that meet the requirements of this subsection and that the Sec-
13 retary has found to be—

14 “(A) adequate to provide efficient, economical, and ef-
15 fective administration of such State plan;

16 “(B) compatible with the claims processing and infor-
17 mation retrieval systems used in the administration of title
18 XVIII, and for this purpose—

19 “(i) having a uniform identification coding system
20 for providers, other payees, and beneficiaries under this
21 title or title XVIII;

22 “(ii) providing liaison between States and carriers
23 and intermediaries with agreements under title XVIII
24 to facilitate timely exchange of appropriate data; and

25 “(iii) providing for exchange of data between the
26 States and the Secretary with respect to persons sanc-
27 tioned under this title or title XVIII;

28 “(C) capable of providing accurate and timely data;

29 “(D) able to accommodate receipt of provider claims
30 in standard formats to the extent specified by the Sec-
31 retary; and

32 “(E) able to transmit electronically such data as is
33 specified by the Secretary.

34 “(2)(A) In order to meet the requirements of this para-
35 graph, mechanized claims processing and information retrieval
36 systems must meet the following requirements:

1 “(i) The systems must be capable of developing pro-
2 vider, physician, and patient profiles which are sufficient to
3 provide specific information as to the use of covered types
4 of services and items, including prescribed drugs.

5 “(ii) The State must provide that information on prob-
6 able fraud or abuse which is obtained from, or developed
7 by, the systems, is made available to the State’s medicaid
8 fraud control unit (if any) certified under subsection (q) of
9 this section.

10 “(iii) The systems must meet all performance stand-
11 ards and other requirements for initial approval developed
12 by the Secretary.

13 “(B) In order to be reapproved by the Secretary, mecha-
14 nized claims processing and information retrieval systems must
15 meet the requirements of subparagraphs (A)(i) and (A)(ii) and
16 performance standards and other requirements for reapproval
17 developed by the Secretary.”

18 (b) CONFORMING AMENDMENTS.—Section 1902
19 (a)(25)(A)(ii) (42 U.S.C. 1396a) is amended—

20 (1) by striking “shall—” and all that follows through
21 “(I) be integrated” and inserting “shall be integrated”, and
22 (2) by striking “, and” and all that follows up to the
23 semicolon at the end.

24 **SEC. 7602. ELIMINATION OF PERSONNEL REQUIRE-**
25 **MENTS.**

26 Section 1902(a)(4) (42 U.S.C. 1396a(a)(4)) is amended
27 by striking “(A) such methods” and all that follows through
28 “(C)” and inserting the following: “(A) provide such methods
29 of administration as found by the Secretary to be necessary for
30 the proper and efficient operation of the plan, and (B)”.

31 **SEC. 7603. ELIMINATION OF REQUIREMENTS FOR COOP-**
32 **ERATIVE AGREEMENTS WITH HEALTH AGEN-**
33 **CIES.**

34 Section 1902(a) (42 U.S.C. 1396a(a)) is amended by
35 striking paragraph (11).

1 SEC. 7604. ELIMINATION OF REQUIREMENT FOR AN-
2 NUAL INDEPENDENT REVIEW OF HMO CARE.

3 Section 1902(a)(30) (42 U.S.C. 1396a(a)(30)) is amend-
4 ed—

5 (1) by adding “and” at the end of subparagraph (A),

6 (2) by striking “and” at the end of subparagraph (B),

7 and

8 (3) by striking subparagraph (C).

9 SEC. 7605. STATE REVIEW OF MENTALLY ILL OR RE-
10 TARDLED NURSING FACILITY RESIDENTS
11 UPON CHANGE IN PHYSICAL OR MENTAL
12 CONDITION.

13 (a) STATE REVIEW ON CHANGE IN RESIDENT'S CONDI-
14 TION.—Section 1919(e)(7)(B)(iii) (42 U.S.C.
15 1396r(e)(7)(B)(iii)) is amended to read as follows:

16 “(iii) REVIEW REQUIRED UPON CHANGE IN
17 RESIDENT'S CONDITION.—A review and determina-
18 tion under clause (i) or (ii) must be conducted
19 promptly after a nursing facility has notified the
20 State mental health authority or State mental re-
21 tardation or developmental disability authority, as
22 applicable, with respect to a mentally ill or men-
23 tally retarded resident, that there has been a sig-
24 nificant change in the resident's physical or mental
25 condition.”

26 (b) CONFORMING AMENDMENTS.—

27 (1) Section 1919(b)(3)(E) (42 U.S.C. 1396r(b)(3)(E))
28 is amended by adding at the end the following: “In addi-
29 tion, a nursing facility shall notify the State mental health
30 authority or State mental retardation or developmental dis-
31 ability authority, as applicable, promptly after a significant
32 change in the physical or mental condition of a resident
33 who is mentally ill or mentally retarded.”

34 (2) The headings to subparagraphs (B) and (D)(i) of
35 section 1919(e)(7) (42 U.S.C. 1396r(e)(7)(B)) are each
36 amended by striking “annual”.

1 **SEC. 7606. NURSE AIDE TRAINING IN MEDICARE AND**
2 **MEDICAID NURSING FACILITIES SUBJECT**
3 **TO EXTENDED SURVEY AND UNDER CERTAIN**
4 **OTHER CONDITIONS.**

5 Sections 1819(f)(2) and section 1919(f)(2) (42 U.S.C.
6 1395i-3(f)(2), 1396r(f)(2)) are each amended—

7 (1) in subparagraph (B)(iii)(I), in the matter preced-
8 ing subdivision (a), by inserting “, subject to subparagraph
9 (C),” after “offered by or”, and

10 (2) by adding at the end the following new subpara-
11 graph:

12 “(C) EXCEPTION.—The prohibition of subpara-
13 graph (B)(iii) shall not apply to a program that is of-
14 fered in, but not by, a skilled nursing facility if the
15 State—

16 “(i) determines that there is no other such
17 program offered within a reasonable distance,

18 “(ii) provides notice of the approval to the
19 State long-term care ombudsman, and

20 “(iii) assures, through an oversight effort, that
21 an adequate environment exists for such a pro-
22 gram.”.

23 **SEC. 7607. PUBLIC PROCESS FOR DEVELOPING STATE**
24 **PLAN AMENDMENTS.**

25 (a) **IN GENERAL.**—Section 1902(a) (42 U.S.C. 1396a(a))
26 is amended—

27 (1) by striking “and” at the end of paragraph (61);

28 (2) by striking the period at the end of paragraph (62)
29 and inserting “; and”; and

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

32 “(63) a process for development of amendments to the
33 State plan that affords an opportunity for review and com-
34 ment to interested persons and groups, including bene-
35 ficiaries, providers, Indian tribes, tribal organizations, In-
36 dian Health Service facilities, and urban Indian health or-
37 ganizations.”.

1 (b) EFFECTIVE DATE.—(1) Except as provided in para-
2 graph (2), the amendments made by subsections (a) shall apply
3 to calendar quarters beginning after the date of the enactment
4 of this Act.

5 (2) In the case of a State plan for medical assistance
6 under title XIX of the Social Security Act which the Secretary
7 of Health and Human Services determines requires State legis-
8 lation (other than legislation appropriating funds) in order for
9 the plan to meet the additional requirement imposed by the
10 amendment made by subsections (a)(3), the State plan shall
11 not be regarded as failing to comply with the requirements of
12 such title solely on the basis of its failure to meet this addi-
13 tional requirement before the first day of the first calendar
14 quarter beginning after the close of the first regular session of
15 the State legislature that begins after the date of the enact-
16 ment of this Act. For purposes of the previous sentence, in the
17 case of a State that has a 2-year legislative session, each year
18 of such session shall be deemed to be a separate regular session
19 of the State legislature.

20 **Subtitle H—Provider Eligibility for** 21 **PACE Projects**

22 **SEC. 7701. PROVIDER ELIGIBILITY FOR PACE PROJECTS.**

23 (a) PROVIDER ELIGIBILITY FOR PACE PROJECTS.—

24 (1) IN GENERAL.—The Secretary of Health and
25 Human Services (in this section referred to as the “Sec-
26 retary”) shall establish a program under which PACE pro-
27 vider status is available for public or nonprofit community-
28 based organizations to enable such organizations to provide
29 comprehensive health care services of proper quality on a
30 cost-effective capitated basis to frail elderly patients at risk
31 of institutionalization under titles XVIII and XIX of the
32 Social Security Act (42 U.S.C. 1395 et seq. and 1396 et
33 seq.), or under any other applicable title of such Act. Each
34 of the initial 3 years of such provider status shall be condi-
35 tioned upon annual reapplication for such status and timely
36 review and approval by the Secretary as to compliance with

1 such program requirements as the Secretary may establish.
2 During such 3-year period of conditional PACE provider
3 status, an organization may, at its option, or as determined
4 necessary by the Secretary, be allowed to progressively as-
5 sume the financial risk inherent in implementing the pro-
6 gram (commonly referred to as "risk-sharing"). Upon suc-
7 cessful conclusion of the initial 3-year period, an organiza-
8 tion shall undertake full financial risk for the cost of serv-
9 ices provided to enrollees and shall continue as a PACE
10 provider, not conditioned upon annual reapplication for
11 such status, but must thereafter continue to meet any pro-
12 gram requirements the Secretary may establish.

13 (2) APPROVAL OF APPLICATIONS.—An appropriately
14 completed application for PACE provider status under this
15 section is deemed approved unless the Secretary specifically
16 disapproves it in writing—

17 (A) not later than 90 days after the date the com-
18 pleted application is filed in proper form; or

19 (B) not later than 90 days after the date addi-
20 tional information is provided to the Secretary if the
21 Secretary requests reasonable and substantial addi-
22 tional information during the 90-day period described
23 in subparagraph (A).

24 (3) SOLE AUTHORITY.—The Secretary shall have sole
25 and exclusive authority to approve or disapprove the initial
26 or continuing eligibility of an organization to participate
27 under this section and shall make such determinations in
28 a timely manner.

29 (4) CONSIDERATION OF EXISTING SITES.—In review-
30 ing an application for PACE provider status under this sec-
31 tion, the Secretary shall—

32 (A) consider whether any existing organization al-
33 ready operates as a provider under this section in the
34 proposed service area identified in the application; and

35 (B) if the Secretary determines that such an orga-
36 nization exists, assure that the potential population of
37 eligible individuals to be served by the prospective

1 PACE provider is reasonably sufficient to sustain an
2 additional organization without jeopardizing the eco-
3 nomic or service viability of any other organization op-
4 erating in that service area.

5 (b) TERMS AND CONDITIONS FOR PACE PROVIDER STA-
6 TUS.—

7 (1) IN GENERAL.—Except as otherwise provided by
8 law or regulation, the terms and conditions of PACE pro-
9 vider status granted pursuant to this section, other than
10 terms and conditions specific to research and demonstra-
11 tion programs, shall be substantially equivalent to—

12 (A) the terms and conditions of the On Lok waiver
13 (referred to in section 603(c) of the Social Security
14 Amendments of 1983 and extended by section 9220 of
15 the Consolidated Omnibus Budget Reconciliation Act of
16 1985), including such terms and conditions that permit
17 the organization to assume the full financial risk of
18 providing comprehensive health care services progres-
19 sively; and

20 (B) the terms and conditions provided under the
21 Protocol for the Program of All-Inclusive care for the
22 Elderly (PACE), as published by On Lok, Inc. as of
23 April 14, 1995, and made generally available.

24 (2) NOT CONDITIONED ON INFORMATION.—

25 (A) IN GENERAL.—The Secretary's approval of
26 PACE provider status shall not be conditioned upon an
27 organization collecting information for purposes other
28 than operational purposes, including monitoring of cost
29 and quality of care provided, except to the extent, if
30 any, that such information previously was required of
31 an organization participating under a waiver as of De-
32 cember 31, 1995 (but such requirement may not con-
33 tinue beyond October 1, 1997). Issuance of interim
34 final regulations and implementation of this section
35 shall not be conditioned upon receipt of any such infor-
36 mation pursuant to such a requirement. Nothing in the
37 preceding sentence shall be construed as prohibiting the

1 Secretary, subsequent to collection and review of any
2 information pursuant to such a requirement, from mak-
3 ing necessary modifications, if any, to implement regu-
4 lations for this section.

5 (B) RESEARCH.—The Secretary may require in-
6 formation from an organization operating under this
7 section for purposes of general research or general eval-
8 uation, but only if an organization agrees to participate
9 in such research or evaluation and is appropriately
10 compensated for any expenses incurred, or where such
11 research is undertaken entirely at the expense of the
12 Secretary.

13 (c) ELIGIBILITY FOR PACE PROVIDER STATUS.—

14 (1) IN GENERAL.—Upon successful completion of the
15 first 3 years as a PACE provider under subsection (a), an
16 organization which continues to meet the requirements of
17 this section, including such program requirements as the
18 Secretary may establish, shall continue as a PACE provider
19 under any applicable title of the Social Security Act and
20 shall be recognized as such in accordance with regulations
21 promulgated by the Secretary. Such regulations shall not
22 condition such recognition upon formal annual review and
23 approval of the organization.

24 (2) REQUIREMENTS.—No organization may be eligible
25 to be a PACE provider under any applicable title of the So-
26 cial Security Act if—

27 (A) the Secretary specifically and formally finds
28 that projected reimbursement for such organization
29 would not, without any reimbursement modifications
30 specified in the Secretary's finding, result in payments
31 below the projected costs for a comparable population
32 under the medicare program under title XVIII of the
33 Social Security Act (42 U.S.C. 1395 et seq.) and the
34 medicaid program under title XIX of such Act (42
35 U.S.C. 1396 et seq.), or under any other applicable
36 title of such Act, or that the care provided by such or-
37 ganization is significantly deficient; and

1 (B) such projected reimbursement costs or signifi-
2 cant deficiencies in quality of care are not appropriately
3 adjusted or corrected on a timely basis (as determined
4 by the Secretary) in accordance with the specific rec-
5 ommendations for reimbursement adjustments or cor-
6 rections in the quality of service included in the Sec-
7 retary's formal finding under subparagraph (A).

8 (d) REIMBURSEMENT.—Notwithstanding any other provi-
9 sion of law, an organization that is eligible to be a PACE pro-
10 vider under any applicable title of the Social Security Act as
11 a result of this section, shall ordinarily be reimbursed on a
12 capitation basis. Any such organization may provide additional
13 services as deemed appropriate by the organization for qualified
14 participants without regard to whether such services are spe-
15 cifically reimbursable through capitation payments. To the ex-
16 tent such services, in terms of type or frequency, are not reim-
17 burstable, no payments for such services may be required of
18 participants.

19 (e) APPLICATION TO ON LOK WAIVERS.—The provisions
20 of this section also shall apply to an organization operating
21 under the On Lok waiver described in subsection (b)(1)(A).

22 (f) APPLICATION OF INCOME AND RESOURCES STAND-
23 ARDS FOR CERTAIN INSTITUTIONALIZED SPOUSES.—Section
24 1924 of the Social Security Act (42 U.S.C. 1396r-5) (relating
25 to the treatment of income and resources for certain institu-
26 tionalized spouses) shall apply to any individual receiving serv-
27 ices from an organization operating as a PACE provider under
28 this section.

29 (g) PROVISION OF SERVICES TO ADDITIONAL POPU-
30 LATIONS.—Nothing in this section shall prevent any participat-
31 ing organization from independently developing distinct pro-
32 grams to provide appropriate services to frail populations other
33 than the elderly under any provision of law other than this sec-
34 tion, except where the Secretary finds that the provision of
35 such services impairs the ability of the organization to provide
36 services required under this section.

1 (h) DEFINITION OF PROVIDER.—The term “provider”
2 means a provider of services which—

3 (1) has filed an agreement with the Secretary under
4 section 1866 of the Social Security Act (42 U.S.C. 1395cc);

5 (2) is eligible to participate in a State plan under title
6 XIX of the Social Security Act (42 U.S.C. 1396 et seq.);

7 or

8 (3) is eligible to receive payment for such services
9 under any other applicable title of the Social Security Act.

10 (i) APPLICATION OF SPOUSAL IMPOVERISHMENT
11 RULES.—Section 1924(a)(5) (42 U.S.C. 1396r-5(a)(5)) is
12 amended to read as follows:

13 “(5) APPLICATION TO INDIVIDUALS RECEIVING SERV-
14 ICES FROM CERTAIN ORGANIZATIONS.—This section applies
15 to individuals receiving institutional or noninstitutional
16 services from any organization—

17 “(A) operating under a waiver under—

18 “(i) section 603(c) of the Social Security
19 Amendments of 1983 (as in effect on the day be-
20 fore the date of the enactment of the Medicaid Ac-
21 cess Protection Act of 1996); or

22 “(ii) section 9412(b) of the Omnibus Budget
23 Reconciliation Act of 1986 (as so in effect); or

24 “(B) which has become a PACE provider under
25 section 901 of the Medicaid Access Protection Act of
26 1996.”

27 (j) REPEALS; EFFECTIVE DATE; APPLICATION TO EXIST-
28 ING WAIVERS.—

29 (1) REPEALS.—Except as provided in paragraph (2),
30 section 603(c) of the Social Security Amendments of 1983,
31 section 9220 of the Consolidated Omnibus Budget Rec-
32 onciliation Act of 1985, and section 9412(b) of the Omni-
33 bus Budget Reconciliation Act of 1986 are repealed.

34 (2) EFFECTIVE DATE.—

35 (A) CONDITIONED UPON ISSUANCE OF REGULA-
36 TIONS.—Not later than the first day of the month that
37 begins 9 months after the date of the enactment of this

1 Act. the Secretary shall issue and implement interim
2 final regulations applicable to the provisions of this sec-
3 tion. The authority for the On Lok waiver (referred to
4 in section 603(c) of the Social Security Amendments of
5 1983 and extended by section 9220 of the Consolidated
6 Omnibus Budget Reconciliation Act of 1985) and the
7 demonstration sites authorized under section 9412(b)
8 of the Omnibus Budget Reconciliation Act of 1986
9 shall remain in effect (as in effect on the day before
10 the date of the enactment of this Act) until the earlier
11 of the effective date for such regulations or the first
12 day of the month that begins 9 months after the date
13 of the enactment of this Act.

14 (B) APPLICATION TO EXISTING WAIVERS.—

15 (i) IN GENERAL.—Upon issuance and imple-
16 mentation of interim final regulations governing
17 PACE providers, any organization operating under
18 the On Lok waiver (referred to in section 603(c) of
19 the Social Security Amendments of 1983 and ex-
20 tended by section 9220 of the Consolidated Omni-
21 bus Budget Reconciliation Act of 1985) and any
22 demonstration sites authorized under section
23 9412(b) of the Omnibus Budget Reconciliation Act
24 of 1986 that have completed an initial 3-year dem-
25 onstration period, and which are otherwise qualified
26 under such regulations, shall be eligible for PACE
27 provider status without the requirement of annual
28 reapplication for such status so long as such orga-
29 nizations or sites comply with any program require-
30 ments established by the Secretary pursuant to
31 subsection (a)(1).

32 (ii) RULE FOR WAIVERS OPERATED FOR LESS
33 THAN 3 YEARS.—An organization operating under
34 an On Lok waiver (as so referred to) or a dem-
35 onstration site authorized under section 9412(b) of
36 the Omnibus Budget Reconciliation Act of 1986
37 that is otherwise qualified, but which has not com-

1 pleted an initial 3-year demonstration period, shall
2 be afforded PACE provider status under this sec-
3 tion with such status predicated upon annual re-
4 view and approval by the Secretary for a period of
5 3 years (which shall include any period during
6 which such organization or site previously operated
7 under such a waiver or authorization). Following
8 successful completion, as determined by the Sec-
9 retary, of the third year, such organization or site
10 may continue as a PACE provider and such status
11 may not be conditioned upon annual reapplication
12 for such status provided that the organization or
13 site continues to meet any program requirements
14 established by the Secretary pursuant to subsection
15 (a).