Calendar No. 171

97TH CONGRESS } SENATE { REPORT
1st Session } { No. 97-139

OMNIBUS RECONCILIATION ACT OF 1981

REPORT

OF THE

COMMITTEE ON THE BUDGET

UNITED STATES SENATE

TO ACCOMPANY

S. 1377

A BILL TO PROVIDE FOR RECONCILIATION PURSUANT TO TITLE III OF THE FIRST CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 1982 (H. CON. RES. 115, NINETY-SEVENTH CONGRESS)

JUNE 17 (legislative day, JUNE 1), 1981.—Ordered to be printed

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CONTENTS

ernment. Savings of $122 million are expected in 1981 from recovery of outstanding disputed claims. Sections 24–29 would allow states more flexibility with which to operate their programs, including provisions such as cost sharing for services, limitation on freedom of choice, and competitive biding. States might be able to utilize these provisions to meet the cap and the reduced minimum match. However, it is not possible to estimate what effect these provisions might have beyond the cap and minimum match on an individual state basis.

Estimate comparison: The Administration has estimated an outlay savings of $1,069 million in 1982 from these proposals. The Administration's estimate is based upon state estimates calculated prior to January 1981, while CBO has utilized the February state estimates. CBO's savings estimates from this provision are lower than those of the Administration mostly because CBO's estimates of total current law Medicaid outlays are lower than those of the Administration.

V. CHANGES IN EXISTING LAW

In compliance with paragraph 12 of rule XXVI of the Standing Rules of the Senate, the changes in existing law made by the bill as reported are shown below (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT, AS AMENDED

TITLE I—GRANTS TO STATES FOR OLD-AGE ASSISTANCE AND MEDICAL ASSISTANCE FOR THE AGED

Appropriation

Section 1. For the purpose (a) of enabling each State, as far as practicable under the conditions in such State, to furnish financial assistance to aged needy individuals, and (b) of enabling each State, as far as practicable under the conditions in such State, to furnish medical assistance on behalf of aged individuals who are not recipients of old-age assistance but whose income and resources are insufficient to meet the costs of necessary medical services, [and (c) of encouraging each State, as far as practicable under the conditions in such State, to furnish rehabilitation and other services to help individuals referred to in clause (a) or (b) to attain or retain capability for self-care,] there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare (hereinafter referred to as the "Secretary"), State plans for old-age assistance, or for medical assistance for the aged, or for old-age assistance and medical assistance for the aged.

* * * * * * *

(3) for payment to Guam shall not exceed $90,000.

[(c) The total amount certified by the Secretary under title XIX with respect to any fiscal year—

[(1) for payment to Puerto Rico shall not exceed $30,000,000,

[(2) for payment to the Virgin Islands shall not exceed $1,000,000, and

[(3) for payment to Guam shall not exceed $900,000.]

* * * * * * *

Demonstration Projects

Sec. 1115. (a) In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of title I, VI, X, XIV, XVI, *or* XIX [, or XX], or part A of title IV, in a State or States—

(1) the Secretary may waive compliance with any of the requirements of section 2, 402, 602, 1002, 1402, 1602, [1902, 2002, 2003, or 2004] *or 1902*, as the case may be, to the extent and for the period he finds necessary to enable such State or States to carry out such project, and

(2) costs of such project which would not otherwise be included as expenditures under section 3, 403, 603, 1003, 1403, 1603, [1903, 2002] *or 1903*, as the case may be, and which are not included as part of the costs of projects under section 1110, shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under such title, or for administration of such State plan or plans, [or expenditures with respect to which payment shall be made under section 2002,] as may be appropriate.

* * * * * * *

Administrative and Judicial Review of Certain Administrative Determinations

Sec. 1116. (a)(1) Whenever a State plan is submitted to the Secretary by a State for approval under title I, VI, X, XIV, XVI, [XIX, or XX] *or XIX*, or part A of title IV, he shall not later than 90 days after the date the plan is submitted to him, make a determination as to whether it conforms to the requirements for approval under such title. The 90-day period provided herein may be extended by written agreement of the Secretary and the affected State.

(2) Any State dissatisfied with a determination of the Secretary under paragraph (1) with respect to any plan may, within 60 days after it has been notified of such determination, file a petition with the Secretary for reconsideration of the issue of whether such plan conforms to the requirements for approval under such title. Within 30 days after receipt of such a petition, the Secretary shall notify the State of the time and place at which a hearing will be held for the purpose of reconsidering such issue. Such hearing shall be held not less than 20 days nor more than 60 days after the date notice of such hearing is furnished to such State, unless the Secretary and such State agree in writing to holding the hearing at another time. The

Secretary shall affirm, modify, or reverse his original determination within 60 days of the conclusion of the hearing.

(3) Any State which is dissatisfied with a final determination made by the Secretary on such a reconsideration or a final determination of the Secretary under section 4, 404, 604, 1004, 1404, 1604, [1904, or 2003] *or 1904* may, within 60 days after it has been notified of such determination, file with the United States court of appeals for the circuit in which such State is located a petition for review of such determination. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary. The Secretary thereupon shall file in the court the record of the proceedings on which he based his determination as provided in section 2112 of title 28, United States Code.

(4) The findings of fact by the Secretary, if supported by substantial evidence, shall be conclusive; but the court, for good cause shown, may remand the case to the Secretary to take further evidence, and the Secretary may thereupon make new or modified findings of fact and may modify his previous action, and shall certify to the court the transcript and record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence.

(5) The court shall have jurisdiction to affirm the action of the Secretary or to set it aside, in whole or in part, the judgment of the court shall be subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code.

(b) For the purposes of subsection (a), any amendment of a State plan approved under title I, VI, X, XIV, XVI, [XIX, or XX] *or XIX*, or part A of title IV, may, at the option of the State, be treated as the submission of a new State plan.

(c) Action pursuant to an initial determination of the Secretary described in subsection (a) shall not be stayed pending reconsideration, but in the event that the Secretary subsequently determines that his initial determination was incorrect he shall certify restitution forthwith in a lump sum of any funds incorrectly withheld or otherwise denied.

(d) Whenever the Secretary determines that any item or class of items on account of which Federal financial participation is claimed under title I, VI, X, XIV, XVI, [XIX, XX] *or XIX* or part A of title IV, shall be disallowed for such participation, the State shall be entitled to and upon request shall receive a reconsideration of the disallowance.

Sec. 1117. [Repealed.]

Alternative Federal Payment With Respect to Public Assistance Expenditures

Sec. 1118. In the case of any State which has in effect a plan approved under title XIX for any calendar quarter, the total of the payments to which such State is entitled for such quarter, and for each succeeding quarter in the same fiscal year (which for purposes of this section means the 4 calendar quarters ending with September 30),

under paragraphs (1) and (2) of sections 3(a), 403(a), 1003(a), 1403 (a), and 1603(a) shall, at the option of the State, be determined by application of the Federal medical assistance percentage (as defined by section 1905, instead of the percentages provided under each such section, to the expenditures under its State plans approved under titles I, X, XIV, and XVI, and part A of title IV, which would be included in determining the amounts of the Federal payments to which such State is entitled under such sections, but without regard to any maximum on the dollar amounts per recipient which may be counted under such sections. For purposes of the preceding sentence, the term "Federal medical assistance percentage" shall, in the case of Puerto Rico, the Virgin Islands, and Guam, mean 75 per centum, *and, in the case of all States, such percentage shall not be less than 50 per centum.*

* * * * * * *

Disclosure of Ownership and Related Information

Sec. 1124. (a)(1) The Secretary shall be regulation or by contract provision provide that each disclosing entity (as defined in paragraph (2)) shall—

(A) as a condition of the disclosing entity's participation in, or certification or recertification under, any of the programs established by titles [V,] XVIII, [XIX, and XX] *and XIX*, or

(B) as a condition for the approval or renewal of a contract or agreement between the disclosing entity and the Secretary or the appropriate State agency under any of the programs established under title [V,] XVIII, [XIX, and XX] *and XIX*,

supply the Secretary or the appropriate State agency with full and complete information as to the identity of each person with an ownership or control interest (as defined in paragraph (3)) in the entity or in any subcontractor (as defined by the Secretary in regulations) in which the entity directly or indirectly has a 5 per centum or more ownership interest.

(2) As used in this section, the term "disclosing entity" means an entity which is—

(A) a provider of services (as defined in section 1861(u), other than a fund), an independent clinical laboratory, a renal disease facility, or a health maintenance organization (as defined in section 1301(a) of the Public Health Service Act);

(B) an entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, items or services with respect to which payment may be claimed by the entity under any plan or program established [pursuant to title V or] under a State plan approved under title XIX; *or*

(C) a carrier or other agency or organization that is acting as a fiscal intermediary or agent with respect to one or more providers of services (for purposes of part A or part B of title XVIII, or both, or for purposes of a State plan approved under title XIX) pursuant to (i) an agreement under section 1816, (ii) a contract under section 1842, or (iii) an agreement with a single State agency administering or supervising the administration of a State plan approved under title XIX[; or].

Agreements With Providers of Services

Sec. 1866. (a)(1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) not to charge, except as provided in paragraph (2), any individual or any other person for items or services for which such individual is entitled to have payment made under this title (or for which he would be so entitled if such provider of services had complied with the procedural and other requirements under or pursuant to this title or for which such provider is paid pursuant to the provisions of section 1814(e)), and

* * * * * * *

[An agreement under this paragraph with a skilled nursing facility shall be for a term of not exceeding 12 months, except that the Secretary may extend such term for a period not exceeding 2 months, where the health and safety of patients will not be jeopardized thereby, if he finds that such extension is necessary to prevent irreparable harm to such facility or hardship to the individuals being furnished items or services by such facility or if he finds it impracticable within such 12-month period to determine whether such facility is complying with the provisions of this title and regulations thereunder.]

(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1813(a)(1) or (a)(3), section 1833(b), or section 1861(y)(3) with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under part B (but in the case of items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary). In the case of items and services described in section 1833(c), clause (ii) of the preceding sentence shall be applied by substituting for 20 per centum the proportion which is appropriate under such section. [A provider of services may not impose a charge under clause (ii) of the first sentence of this subparagraph with respect to items and services described in section 1861(s)(10) for which payment is made under part B.]

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TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * * * *

State Plans for Medical Assistance

Sec. 1902. (a) * * *

(10) provide—

(A) for making medical assistance available to all individuals receiving aid or assistance under any plan of the

State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI *or who is an individual specified in subsection (1)*; *and*

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

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

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

[(C) if medical assistance is included for any group of individuals who are not described in clause (A) and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under title XVI, as the case may be, as determined in accordance with standards prescribed by the Secretary—

(i) for making medical assistance available to all individuals who would, except for income and resources, be eligible for aid or assistance under any such State plan or to have paid with respect to them supplemental security income benefits under title XVI, and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services, and

(ii) that the medical assistance made available to all individuals not described in clause (A) shall be equal in amount, duration, and scope;]

(C) that if medical assistance is included for any group of individuals described in section 1905(a), other than individuals described in subparagraph (A), then the plan shall include a description with respect to each such group of the criteria for determining eligibility for, and the extent of, such medical assistance;

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1905(a) to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, *and* (II) the making available of supplementary medical insurance benefits under part B of title XVIII to individuals eligible therefor (either pursuant to an agreement entered into under section 1843 or by reason of the payment of premiums under such title by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of title XVIII for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, [and (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals

approved by the Secretary, with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A);]*;*

* * * * * * *

(13) provide—

(A)[(i) for the inclusion of some institutional and some noninstitutional care and services, and]

[(ii)] for the inclusion of home health services for any individual who, under the State plan, is entitled to skilled nursing facility services, [and]

(B) in the case of individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, for the inclusion of at least the care and services listed in paragraphs (1) through (5) and (17) of section 1905(a), and

[(C) in the case of individuals not included under subparagraph (B) for the inclusion of at least—

(i) the care and services listed in paragraphs (1) through (5) and (17) of section 1905(a) or

(ii)(I) the care and services listed in any 7 of the paragraphs numbered (1) through (17) of such section and (II) in the event the care and services provided under the State plan include hospital or skilled nursing facility services, physicians' services to an individual in a hospital or skilled nursing facility during any period he is receiving hospital services from such hospital or skilled nursing facility services from such home, and]

[(D)(i) for payment (except where the State agency is subject to an order under section 1914) of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards, consistent with section 1122, which shall be developed by the State and reviewed and approved by the Secretary and (after notice of approval by the Secretary) included in the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1861(v) as the reasonable cost of such services for purposes of title XVIII, except that in the case of hospitals reimbursed for services under part A of title XVIII in accordance with section 1814(b)(3), the plan must provide for payment of inpatient hospital services provided in such hospitals under the plan in accordance with the reimbursement system used under such section, and (ii) for payment of the reasonable cost of

inappropriate inpatient services (described in subsection (h)(1)) for which payment is provided only because of subsection (h) at the rate of payment for such services provided for under such subsection.]

[(E)] (*C*) for payment (except where the State agency is subject to an order under section 1914) of the *hospital* skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by [each skilled nursing or intermediate care facility] *each hospital, skilled nursing facility, and intermediate care facility* and periodic audits by the State of such reports; *except that the rate established by the State for payment for services provided by hospitals under the plan must be established at a level such that the aggregate of the payments made under such plan for each fiscal year to hospitals shall not exceed the aggregate amount of such payments for such fiscal year which would be made for provision of the same services if reimbursement were on a reasonable cost basis as determined under section 1861(v) for purposes of title XVIII*

[(F)] (*D*) for payment for services described in section 1905(a)(2)(B) provided by a rural health clinic under the plan of 100 percent of costs which are reasonable and related to the cost of furnishing such services or based on such other tests of reasonableness, as the Secretary may prescribe in regulations under section 1833(a)(3), or, in the case of services to which those regulations do not apply, on such tests of reasonableness as the Secretary may prescribe in regulations under this subparagraph;

* * * * * * *

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

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

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

(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services referred to in section 3(a)(4)(A) (i) and (ii), section 603(a)(1)(A) (i) and (ii), or section 1603(a)(4)(A) (i) and (ii) which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out; [and]

[(D) provide methods of determining the reasonable cost of institutional care for such patients;]

* * * * * * *

[(23) except in the case of Puerto Rico, the Virgin Islands, and Guam, provide that any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services; and a State plan shall not be deemed to be out of compliance with the requirements of this paragraph or paragraph (1) or (10) solely by reason of the fact that the State (or any political subdivision thereof) has entered into a contract with an organization which has agreed to provide care and services in addition to these offered under the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization, or by reason of the fact that the plan provides for payment for rural health clinic services only if those services are provided by a rural health clinic;]

(23) provide that limitations or restrictions elected by a State with respect to choice by recipients of medical assistance provided for by the State—

(A) must be cost-effective arrangements which provide for reasonable payment based upon comparison of costs at which services of proper quality may be obtained and are actually available (and for this purpose the plan may provide that such arrangements need not be in effect in all political subdivisions of the State notwithstanding the provisions of paragraph (1); and

(B) must assure that such recipients shall have reasonable access to services (taking into account geographic location and reasonable traveltime) for which they are eligible (including emergency services and provision for timely referral and transfer to other providers when medically appropriate) through providers which meet all applicable standards under the State plan and whose services are available to such recipients;

* * * * * * *

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

(1) an age requirement of more than 65 years; or

[(2) effective July 1, 1967, any age requirement which excludes any individual who has not attained the age of 21 and is or would except for the provisions of section 406(a)(2), be a dependent child under part A of subchapter IV of this chapter; or]

(2) any age requirements which excludes any individual who has not attained the age of 19 and is a dependent child under part A of title IV;

(3) any residence requirement which excludes any individual who resides in the State; or

(4) any citizenship requirement which excludes any citizen of the United States.

* * * * * * *

(h)(1) In any case in which a hospital provides inpatient services to an individual that would constitute skilled nursing facility services if provided by a skilled nursing facility or that would constitute intermediate care facility services if provided by an intermediate care facility and a Professional Standards Review Organization (or, in the absence of such a qualified organization, an organization or agency with review responsibility as is otherwise provided for under part A of title XI) determines that inpatient hospital services for the individual are not medically necessary but skilled nursing facility services or intermediate care facility services, respectively, for the individual are medically necessary and such type of facility services are not otherwise available to the individual (as determined in accordance with criteria established by the Secretary) at the time of such determination, payment for inpatient hospital services (shall continue to be made under the State plan approved under this title at the payment rate described in paragraph (2)] *may continue to be made under the State plan but at a rate of payment not to exceed the rate described in paragraph (2)* for such type of services during the period in which—

(A) such skilled nursing facility services or intermediate care facility services (as the case may be) for the individual are medically necessary and not otherwise available to the individual (as so determined)

(B) inpatient hospital services for the individual are not medically neecssary, and

(C) the individual is entitled to receive medical assistance with respect to such facility services under the State plan.

except that if the Secretary determines that [the hospital had (during the immediately preceding calendar year) an average daily occupancy rate of 80 percent or more], *there is not an excess of hospital beds in such hospital or in the area of such hospital which could be converted for use in providing the required skilled nursing facility services or intermediate care facility services (as the case may be)*, such payment [shall] *may* be made (during such period) on the same basis as otherwise used under the State's plan for payments for providing inpatient hospital services.

* * * * * * *

[(4) For the purpose of determining the occupancy rate with respect to hospitals under paragraph (2)—

(A) public hospitals under common ownership may elect (with the approval of the Secretary) to be treated as a single hospital, and

(B) beginning two years after the date this subsection is first applied with respect to a hospital, the Secretary, to the extent feasible, shall not treat as an inpatient an individual with respect to whom payment is made to the hospital only because of this subsection or section 1861(v)(1)(G)]

(k)(1) The Secretary may waive any requirements of this title with respect to provision of or payment for medical care in order to permit the State agency to share, by means of providing additional services, with any recipient of medical assistance under the State plan, any cost savings which may result from use by such recipient of medical care which is more cost-effective than medical care generally provided or paid for under such plan. A waiver shall not be provided under this paragraph unless the State provides assurances satisfactory to the Secretary that the granting of such waiver would not be inconsistent with the purposes of this title.

(2) The Secretary may by waiver provide that a State plan approved under this part may include as 'medical assistance' under such plan personal care services and any other services (other than room and board) approved by the Secretary which are provided pursuant to a plan of care to an individual who, but for such services, may require institutionalization in a medical institution in which the cost of his care could be reimbursed under the State plan. A waiver shall not be granted under this paragraph unless the State provides assurances satisfactory to the Secretary that necessary safeguards have been taken to protect the health and welfare of any recipients of such services.

(l)(1) The Secretary may by waiver provide that a State plan approved under this part may include as "medical assistance" under such plan—

(A) case management;
(B) supervised living;
(C) home services;
(D) rehabilitation; and
(E) any other nonmedical services (other than room and board) approved by the Secretary,

which are provided pursuant to a plan of care to an individual who is mentally ill, mentally retarded, or otherwise at risk of being institu-

tionalized, if such services were not provided, in a medical institution in which the cost of his care could be reimbursed under the State plan.

(2) A waiver shall not be granted under paragraph (1) unless the State provides assurances satisfactory to the Secretary that necessary safeguards have been taken to protect the health and welfare of any recipients of such services.

(m) Individuals specified in section 1902(a)(10)(A) shall include—

(1) any child on whose behalf foster care maintenance payments are being made under any program administered by or administered under the supervision of the State—

(A) who would meet the requirements of section 406(a) or of section 407 but for his removal from the home of a relative specified in section 406(a);

(B) whose removal from the home was the result of a judicial determination to the effect that continuation therein would be contrary to the welfare of such child; and

(C)(i) who received aid under the State plan approved under section 402 in or for the month in which court proceedings leading to the removal of the child from the home were initiated,

(ii) who would have received such aid in or for such month if application had been made therefor, or

(iii) who had been living with a relative specified in section 406(a) within six months prior to the month in which such proceedings were initiated, and would have received such aid in or for such month if in such month he had been living with such a relative and application therefor had been made; and

(2) any child on whose behalf adoption assistance payments are being made under any program administered by or administered under the supervision of the State—

(A) who but for adoption would meet the requirements specified in paragraph (1), or

(B) who but for adoption would meet the requirements of title XVI with respect to eligibility for supplemental security income benefits.

Payment to States

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

(1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b), subject to subsections (g), (h), and (j) of this section) of the total amount expended during such quarter as medical assistance under the State plan (including expenditures for premiums under part B of title XVIII, for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or (B) with respect to whom there is being paid a State supplementary payment and are eligi-

ble for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A), and, except in the case of individuals sixty-five years of age or older and disabled individuals entitled to hospital insurance benefits under title XVIII or who are not enrolled under part B of title XVIII, other insurance premiums for medical or any other type of remedial care or the cost thereof); [plus]

(2) an amount equal to 75 per centum of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to compensation or training of skilled professional medical personnel, and staff directly supporting such personnel of the State agency or any other public agency; [plus]

(3) an amount equal to—

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

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

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

(4) an amount equal to 100 per centum of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration

of the State plan) which are attributable to compensation or training of personnel (of the State agency or any other public agency) responsible for inspecting public or private institutions (or portions thereof) providing long-term care to recipients of medical assistance to determine whether such institutions comply with health or safety standards applicable to such institutions under this Act; [plus]

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

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

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

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

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

[(7)] *(8)* an amount equal to 50 per centum of the remainder of the amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

* * * * * * *

(7) an amount equal to 100 percent of the reasonable costs incurred (not to exceed $10 per vaccination) in such quarter in administering pneumococcal vaccine (including the cost of the vaccine) to any individual aged 65 or older who is eligible under the plan or who is receiving supplemental security income benefits under title XVI, by any physician or other provider who participates in the State plan, or by a State or local health department in such State; and

(d) * * *

(5) In any case in which the Secretary estimates that there has been an overpayment under this section to a State on the basis of a claim by such State that has been disallowed by the Secretary under section 1116(d), and such State disputes such disallowance, the amount of the Federal payment in controversy [shall, at the option of the State, be retained by such State or recovered] *shall be recovered* by the Secretary pending a final determination with respect to such payment amount. [If such final determination is to the effect that any amount was properly disallowed, and the State chose to retain payment of the amount in controversy, the Secretary shall offset, from any subsequent payments made to such State under this title, an amount equal to the proper amount of the disallowance plus interest on such amount disallowed for the period beginning on the date such amount

79-757 O - 81 - 48

was disallowed and ending on the date of such final determination (but not to exceed a period of twelve months with respect to disallowances made prior to October 1, 1981, or six months with respect to disallowances made thereafter) at the rate (determined by the Secretary) based on the average of the bond equivalent of the weekly 90-day Treasury bill auction rates during such period.] *If such final determination is to the effect that such disallowance was not correct, the Secretary shall pay the proper amount of such Federal payment to the State, plus interest on such amount for the period beginning on the date such amount was recovered and ending on the date of such final determination at the rate (determined by the Secretary) based on the average of the bond equivalent of the weekly 90-day Treasury bill auction rates during such period.*".

(f) * * *

(3) For purposes of paragraph (1)(B), in the case of a family consisting of only one individual, the "highest amount which would ordinarily be paid" to such family under the State's plan approved under part A of title IV of this Act shall be the amount determined by the State agency (on the basis of reasonable relationship to the amounts payable under such plan to families consisting of two or more persons) to be the amount of the aid which would ordinarily be payable under such plan to a family (without any income or resources) consisting of one person if such plan [(without regard to section 408)] provided for aid to such a family.

* * * * * * *

(i) Payment under the preceding provisions of this section shall not be made—

[(1) with respect to any amount paid for items or services furnished under the plan after December 31, 1972, to the extent that such amount exceeds the charge which would be determined to be reasonable for such items or services under the fourth and fifth sentences of section 1842(b)(3); or]

(1) with respect to any amount paid for physician services, or for medical services, supplies, and equipment (including equipment servicing) which in the judgment of the Secretary do not vary significantly in quality among suppliers, to the extent that the aggregate of such amounts for any fiscal year exceeds the aggregate which would be paid for such fiscal years for such items and services on the basis of reasonable charges determined under section 1842;

* * * * * * *

[(m)(1)(A) The term "health maintenance organization" means a legal entity which provides health services to individuals enrolled in such organizations and which—

[(i) provides to its enrollees who are eligible for benefits under this title the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905, and, to the extent required by section 1902(a)(13)(A)(ii) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1905(a);

[(ii) provides such services and benefits in the manner prescribed in section 1301(b) of the Public Health Service Act

(except that, solely for purposes of this paragraph, the term "basic health services" and references thereto, when employed in such section, shall be deemed to refer to the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905(a), and, to the extent required by section 1902(a)(13)(A)(ii) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1905(a)); and

[(iii) is organized and operated in the manner prescribed by section 1301(c) of the Public Health Service Act (except that solely for purposes of this paragraph, the term "basic health services" and references thereto, when employed in such section shall be deemed to refer to the services and benefits described in section 1905(a)(1), (2), (3), (4)(C), and (5), and to the extent required by section 1902(a)(13)(A)(ii) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1905(a)).

[(B) The duties and functions of the Secretary, insofar as they involve making determinations as to whether an organization is a health maintenance organization within the meaning of subparagraph (A), shall be administered through the Assistant Secretary for Health and in the Office of the Assistant Secretary for Health, and the administration of such duties and functions shall be integrated with the administration of section 1312 (a) and (b) of the Public Health Service Act.

[(2)(A) Except as provided in subparagraphs (B) and (C), no payment shall be made under this title to a State with respect to expenditures incurred by it for payment (determined under a prepaid capitation basis or under any other risk basis) for services provided by any entity which is responsible for the provision of inpatient hospital services and any other service described in paragraph (2), (3), (4), (5), or (7) of section 1905(a) or for the provision of any three or more of the services described in such paragraphs unless—

[(i) the Secretary (or the State as authorized by paragraph (3)) has determined that the entity is a health maintenance organization as defined in paragraph (1); and

[(ii) less than one-half of the membership of the entity consists of individuals who (I) are insured for benefits under part B of title XVIII or for benefits under both parts A and B of such title, or (II) are eligible to receive benefits under this title.

[(B) Subparagraph (A) does not apply with respect to payments under this title to a State with respect to expenditures incurred by it for payment for services provided by an entity which—

[(i)(I) received a grant of at least $100,000 in the fiscal year ending June 30, 1976, under section 319(d)(1)(A) or 330(d)(1) of the Public Health Service Act, and (II) for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this title has been the recipient of a grant under either such section; and

[(II) provides to its enrollees, on a prepaid capitation risk basis or on any other risk basis, all of the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905(a) and, to the extent required by section 1902(a)(13)(A)

(ii) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of such section; or

[(ii) is a nonprofit primary health care entity located in a rural area (as defined by the Appalachian Regional Commission)—

[(I) which received in the fiscal year ending June 30, 1976, at least $100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965, and

[(II) for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this title either has been the recipient of a grant, subgrant, or subcontract under such Act or has provided services under a contract (initially entered into during a year in which the entity was the recipient of such a grant, subgrant, or subcontract) with a State agency under this title on a prepaid capitation risk basis or on any other risk basis; or

[(iii) which has contracted with the single State agency for the provision of services (but not including inpatient hospital services) to persons eligible under this title on a prepaid risk basis prior to 1970.

[(C) Subparagraph (A)(ii) shall not apply with respect to payments under this title to a State with respect to expenditures incurred by it for payment for services by an entity during the three-year period beginning on the date of enactment of this subsection or beginning on the date the entity qualifies as a health maintenance organization (as determined by the Secretary), whichever occurs later, but only if the entity demonstrates to the satisfaction of the Secretary by the submission of plans for each year of such three-year period that it is making continuous efforts and progress toward achieving compliance with subparagraph (A)(ii).

[(3) A State may, in the case of an entity which has submitted an application to the Secretary for determination that it is a health maintenance organization within the meaning of paragraph (1) and for which no such determination has been made within 90 days of the submission of the application, make a provisional determination for the purposes of this title that such entity is such a health maintenance organization. Such provisional determination shall remain in force until such time as the Secretary makes a determination regarding the entity's qualification under paragraph (1).]

* * * * * * *

(r)(1)(A) In order to receive payments under paragraphs (2) and [(7)](8) of subsection (a) without being subject to per centum reductions set forth in subparagraph (C) of this paragraph, a State must provide that mechanized claims processing and information retrieval systems of the type described in subsection (a)(3)(B) and detailed in an advance planning document approved by the Secretary are operational on or before the deadline established under subparagraph (B).

(B) The deadline for operation of such systems for a State is the earlier of (i) September 3, 1982, or (ii) the last day of the sixth month following the date specified for operation of such systems in the State's most recently approved advance planning document submitted before the date of the enactment of this subsection.

(C) if a State fails to meet the deadline established under subparagraph (B), the per centums specified in paragraphs (2) and [(7)](8) of subsection (a) with respect to that State shall each be reduced by 5 percentage points for the first two quarters beginning on or after such deadline, and shall be further reduced by an additional 5 percentage points after each period consisting of two quarters during which the Secretary determines the State fails to meet the requirements of subparagraph (A); except that—

(i) neither such per centum may be reduced by more than 25 percentage points by reason of this paragraph; and

(ii) no reduction shall be made under this paragraph for any quarter following the quarter during which such State meets the requirements of subparagraph (A).

(2)(A) In order to receive payments under paragraphs (2) and [(7)](8) of subsection (a) without being subject to the per centum reductions set forth in subparagraph (C) of this paragraph, a State must have its mechanized claims processing and information retrieval systems, of the type required to be operational under paragraph (1), initially approved by the Secretary in accordance with paragraph (5)(A) on or before the deadline established under subparagraph (B).

(B) the deadline for approval of such systems for a State is the last day of the fourth quarter that begins after the date on which the Secretary determines that such systems became operational as required under paragraph (1).

(C) If a State fails to meet the deadline established under subparagraph (B), the per centums specified in paragraph (2) and [(7)](8) of subsection (a) with respect to that State shall each be reduced by 5 percentage points for the first two quarters beginning after such deadline, and shall be further reduced by an additional 5 percentage points at the end of each period consisting of two quarters during which the State fails to meet the requirements of subparagraph (A); except that—

(i) neither such per centum may be reduced by more than 25 percentage points by reason of this paragraph, and

(ii) no reduction shall be made under this paragraph for any quarter following the quarter during which such State's systems are approved by the Secretary as provided subparagraph (A).

* * * * * * *

(s) (1) Notwithstanding the preceding provisions of this section, no payment shall be made to a State (except as provided under this subsection) with respect to expenditures incurred by it for services provided by any person during any period that an order for denial of payment (as authorized by section 1107 (c) (7)) is effective with resepct to such person.

(2) Any order for denial of payment issued with respect to any person under section 1107 (c) (7) shall become effective, in the case of any State plan approved under this title, on the sixtieth day after the date on which the Secretary gives notice of such order to the State agency. Upon the determination of the Secretary that any such order shall cease to be effective, he shall notify each State agency to which he has submitted notice under section 1107 (c) (7) with respect to such person.

(3) Whenever any order which has been issued by the Secretary under section 1107 (c) (7) ceases to be effective, any payment to which any State would (except for the preceding provisions of this subsection) have been entitled under this section on account of services provided by such person shall be made to such State for the month in which such order ceases to be effective.

(t) (1) Notwithstanding any other provision of this section, payments under this title to any State for any fiscal year, other than—

(A) payments under subsection (a)(3), (a) (6), or (a) (7);

(B) interest paid under subsection (d) (5);

(C) payments to a facility of the Indian Health Service and

(D) payments for claims relating to expenditures made during fiscal year 1980 or 1981,

shall not exceed the amount of such State's cap for such fiscal year, as determined in accordance with this subsection.

(2) (A) Except as provided in paragraph (3), the amount of a State's cap for fiscal year 1982 shall be an amount equal to 109 percent of the estimate (based upon the last such estimate for such State received by the Secretary before April 1, 1981) of the Federal share of expenditures under this title (other than payments described in subparagraphs (A) through (C) of paragraph (1) and payments for claims relating to expenditures made prior to October 1, 1980) in fiscal year 1981 for such State.

(3) Except as provided in paragraph (3), the amount of a State's cap for fiscal year 1983 and for each fiscal year thereafter shall be an amount equal to the cap determined under this paragraph for such State for the preceding fiscal year, increased or decreased (as the case may be) by a percentage equal to the Gross National Product Implicit Price Deflator for such fiscal year (for which the cap is being determined) published by the Department of Commerce, as set forth in the President's proposed budget for such fiscal year.

(3) for fiscal year 1982 and each fiscal year thereafter—

(A) the amount of the cap for Puerto Rico shall be $45,000,000;

(B) the amount of the cap for the Virgin Islands shall be $1,000,000; and

(C) the amount of the cap for Guam shall be $900,000.

* * * * * * *

Definitions

Sec. 1905. For purposes of this title—

(a) The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A)) not receiving aid or assistance under any

plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, who are

[(i) under the age of 21,] *(i) under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose, or any reasonable category of such individuals,*

(ii) relatives specified in section 406(b)(1) with whom a child is living if such child [, except for section 406(a)(2),] is (or would, if needy, be) a dependent child under part A of title IV,

* * * * * * *

(b) The term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than [50] *40* per centum or more than 83 per centum, and (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, and Guam shall be 50 per centum. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of subparagraph (B) of section 1101(a)(8). Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act).

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TITLE XX—GRANTS TO STATES FOR SERVICES

Appropriation Authorized

[Sec. 2001. For the purpose of encouraging each State, as far as practicable under the conditions in that State, to furnish services directed at the goal of—

[(1) achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency,

[(2) achieving or maintaining self-sufficiency, including reduction or prevention of dependency,

[(3) preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating or reuniting families,

[(4) preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care, or

[(5) securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions,

there is authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available