

## STATE PLANS FOR MEDICAL ASSISTANCE<sup>[5]</sup>

SEC. 1902. [42 U.S.C. 1396a] (a) A State plan for medical assistance must—

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

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

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

(4) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, and including provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan,<sup>[6]</sup> (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency, (C) that each State or local officer, employee, or independent contractor who is responsible for the expenditure of substantial amounts of funds under the State plan, each individual who formerly was such an officer, employee, or contractor and each partner of such an officer or employee shall be prohibited from committing any act, in relation to any activity under the plan, the commission of which, in connection with any activity concerning the United States Government, by an officer or employee of the United States Government, an individual who was such an officer, employee, or contractor or a partner of such an officer or employee is prohibited by section 207 or 208 of title 18, United States Code<sup>[7]</sup>, and (D) that each State or local officer, employee, or independent contractor who is responsible for selecting, awarding, or otherwise obtaining items and services under the State plan shall be subject to safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423) to persons described in subsection (a)(2) of such section of that Act;

(5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under title I or XVI (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under title XVI, or by the agency or agencies administering

the supplemental security income program established under title XVI or the State plan approved under part A of title IV if the State is not eligible to participate in the State plan program established under title XVI;

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

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

(A) the administration of the plan; and

(B) at State option, the exchange of information necessary to verify the certification of eligibility of children for free or reduced price breakfasts under the Child Nutrition Act of 1966<sup>[8]</sup> and free or reduced price lunches under the Richard B. Russell National School Lunch Act<sup>[9]</sup>, in accordance with section 9(b) of that Act, using data standards and formats established by the State agency;

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

(9) provide—

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

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

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

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

(10) provide—

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

(i) all individuals—

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

(II)(aa) with respect to whom supplemental security income benefits are being paid under title XVI (or were being paid as of the date of the enactment of section 211(a) of the Personal Responsibility and Work Opportunity

Reconciliation Act of 1996 (P.L. 104-193<sup>[10]</sup>) and would continue to be paid but for the enactment of that section), (bb) who are qualified severely impaired individuals (as defined in section 1905(q)), or (cc) who are under 21 years of age and with respect to whom supplemental security income benefits would be paid under title XVI if subparagraphs (A) and (B) of section 1611(c)(7) were applied without regard to the phrase “the first day of the first month of the following”,

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

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

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

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

(VII) who are described in subparagraph (D) of subsection (l)(1) and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(C) for such a family; or<sup>[11]</sup>

(VIII) beginning January 1, 2014, who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and are not described in a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved, subject to subsection (k);<sup>[12]</sup>

(IX)<sup>[13]</sup> who—

(aa) are under 26 years of age;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(XIII) who are in families whose income is less than 250 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981<sup>[14]</sup>) applicable to a family of the size involved, and who but for earnings in excess of the limit established under section 1905(q)(2)(B), would be considered to be receiving supplemental security income (subject, notwithstanding section 1916, to payment of premiums or other cost-sharing charges (set on a sliding scale based on income) that the State may determine);

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

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

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

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

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

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

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

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

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

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

- (i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and
  - (ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A);
- (C) that if medical assistance is included for any group of individuals described in section 1905(a) who are not described in subparagraph (A) or (E), then—
  - (i) the plan must include a description of (I) the criteria for determining eligibility of individuals in the group for such medical assistance, (II) the amount, duration, and scope of medical assistance made available to individuals in the group, and (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be no more restrictive than the methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be no more restrictive than the methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups;
  - (ii) the plan must make available medical assistance—
    - (I) to individuals under the age of 18 who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A)(i), and
    - (II) to pregnant women, during the course of their pregnancy, who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A);
  - (iii) such medical assistance must include (I) with respect to children under 18 and individuals entitled to institutional services, ambulatory services, and (II) with respect to pregnant women, prenatal care and delivery services; and
  - (iv) if such medical assistance includes services in institutions for mental diseases or in an intermediate care facility for the mentally retarded (or both) for any such group, it also must include for all groups covered at least the care and services listed in paragraphs (1) through (5) and (17) of section 1905(a) or the care and services listed in any 7 of the paragraphs numbered (1) through (24) of such section;
- (D) for the inclusion of home health services for any individual who, under the State plan, is entitled to nursing facility services;
- (E)(i) for making medical assistance available for medicare cost-sharing (as defined in section 1905(p)(3)) for qualified medicare beneficiaries described in section 1905(p)(1);
  - (ii) for making medical assistance available for payment of medicare cost-sharing described in section 1905(p)(3)(A)(i) for qualified disabled and working individuals described in section 1905(s);
  - (iii) for making medical assistance available for medicare cost sharing described in section 1905(p)(3)(A)(ii) subject to section 1905(p)(4), for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) but is less than 110 percent in 1993 and 1994, and 120 percent in 1995 and years thereafter of the official poverty line (referred to in such section) for a family of the size involved;
  - (iv) subject to sections 1933 and 1905(p)(4), for making medical assistance available <sup>[15]</sup>for medicare cost-sharing described in section 1905(p)(3)(A)(ii) for

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

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

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

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1905(a) to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of title XVIII to individuals eligible therefor (either pursuant to an agreement entered into under section 1843 or by reason of the payment of premiums under such title by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of title XVIII for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A), (IV) the imposition of a deductible, cost sharing, or similar charge for any item or service furnished to an individual not eligible for the exemption under section 1916 (a)(2) or (b)(2) shall not require the imposition of a deductible, cost sharing, or similar charge for the same item or service furnished to an individual who is eligible for such exemption, (V) the making available to pregnant women covered under the plan of services relating to pregnancy (including prenatal, delivery, and postpartum services) or to any other condition which may complicate pregnancy shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any other individuals, provided such services are made available (in the same amount, duration, and scope) to all pregnant women covered under the State plan, (VI) with respect to the making available of medical assistance for hospice care to terminally ill individuals who have made a voluntary election described in section 1905(o) to receive hospice care instead of medical assistance for certain other services, such assistance may not be made available in an amount, duration, or scope less than that provided under title XVIII, and the making available of such assistance shall not, by reason of this paragraph (10), require the making available of medical assistance for hospice care to other individuals or the making available of medical assistance for services waived by such terminally ill individuals, (VII) the medical assistance made available to an individual described in subsection (l)(1)(A) who is eligible for medical assistance only because of subparagraph (A)(i)(IV) or (A)(ii)(IX) shall be limited to medical assistance for services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions which may

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

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



of information and education on pediatric vaccinations and the delivery of immunization services, with the State's operations under the special supplemental nutrition program for women, infants, and children under section 17 of the Child Nutrition Act of 1966<sup>[16]</sup>;

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

(13) provide—

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

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

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

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

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

(B) for payment for hospice care in amounts no lower than the amounts, using the same methodology, used under part A of title XVIII and for payment of amounts under section 1905(o)(3); except that in the case of hospice care which is furnished to an individual who is a resident of a nursing facility or intermediate care facility for the mentally retarded, and who would be eligible under the plan for nursing facility services or services in an intermediate care facility for the mentally retarded if he had not elected to receive hospice care, there shall be paid an additional amount, to take into account the room and board furnished by the facility, equal to at least 95 percent of the rate that would have been paid by the State under the plan for facility services in that facility for that individual; and

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

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

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

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

(17) except as provided in subsections (e)(14), (e)(14), (l)(3), (m)(3), and (m)(4), include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being

paid under title XVI, based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this title, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or to have paid with respect to him supplemental security income benefits under title XVI) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under title XVI), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1614 (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums, payments made to the State under section 1903(f)(2)(B), or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof) incurred for medical care or for any other type of remedial care recognized under State law;

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

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

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

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

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

(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services referred to in section 3(a)(4)(A)(i) and (ii)<sup>[17]</sup> or section 1603(a)(4)(A)(i) and (ii)<sup>[18]</sup> which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the

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

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

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

(23) provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services, and (B) an enrollment of an individual eligible for medical assistance in a primary care case-management system (described in section 1915(b)(1)), a medicaid managed care organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive services under section 1905(a)(4)(C), except as provided in subsection (g), in section 1915, and in section 1932(a), except that this paragraph shall not apply in the case of Puerto Rico, the Virgin Islands, and Guam, and except that nothing in this paragraph shall be construed as requiring a State to provide medical assistance for such services furnished by a person or entity convicted of a felony under Federal or State law for an offense which the State agency determines is inconsistent with the best interests of beneficiaries under the State plan or by a provider or supplier to which a moratorium under subsection (kk)(4) is applied during the period of the moratorium;

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

(25) provide—

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

- (i) the collection of sufficient information as specified by the Secretary in regulations) to enable the State to pursue claims against such third parties, with such information being collected at the time of any determination or redetermination of eligibility for medical assistance, and
  - (ii) the submission to the Secretary of a plan (subject to approval by the Secretary) for pursuing claims against such third parties, which plan shall be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval systems required under section 1903(r);
- (B) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance;<sup>[19]</sup>
- (C) that in the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service (i) if the total of the amount of the liabilities of third parties for that service is at least equal to the amount payable for that service under the plan (disregarding section 1916), or (ii) in an amount which exceeds the lesser of (I) the amount which may be collected under section 1916, or (II) the amount by which the amount payable for that service under the plan (disregarding section 1916) exceeds the total of the amount of the liabilities of third parties for that service;
- (D) that a person who furnishes services and is participating under the plan may not refuse to furnish services to an individual (who is entitled to have payment made under the plan for the services the person furnishes) because of a third party's potential liability for payment for the service;
- (E) that in the case of prenatal or preventive pediatric care (including early and periodic screening and diagnosis services under section 1905(a)(4)(B)) covered under the State plan, the State shall—
- (i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to the liability of a third party for payment for such services, except that the State may, if the State determines doing so is cost-effective and will not adversely affect access to care, only make such payment if a third party so liable has not made payment within 90 days after the date the provider of such services has initially submitted a claim to such third party for payment for such services; and<sup>[20]</sup>
  - (ii) seek reimbursement from such third party in accordance with subparagraph (B);
- (F) that in the case of any services covered under such plan which are provided to an individual on whose behalf child support enforcement is being carried out by the State agency under part D of title IV of this Act, the State shall—
- (i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to any third-party liability for payment for such services, if such third-party liability is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by such agency, if payment has not been made by such third party within 90 days after the date the provider of such services has initially submitted a claim to such third party for payment for such services, except that

the State may make such payment within 30 days after such date if the State determines doing so is cost-effective and necessary to ensure access to care;<sup>[21]</sup>

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

(G) that the State prohibits any health insurer (including a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974<sup>[22]</sup>, a self-insured plan, a service benefit plan, and a health maintenance organization), in enrolling an individual or in making any payments for benefits to the individual or on the individual's behalf, from taking into account that the individual is eligible for or is provided medical assistance under a plan under this title for such State, or any other State;

(H) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to any payments by such third party; and<sup>[23]</sup>

(I) that the State shall provide assurances satisfactory to the Secretary that the State has in effect laws requiring health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974<sup>[24]</sup>), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, as a condition of doing business in the State, to—

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

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

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

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

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

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

(26) if the State plan includes medical assistance for inpatient mental hospital services, provide, with respect to each patient receiving such services, for a regular program of

medical review (including medical evaluation) of his need for such services, and for a written plan of care;

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

(28) provide—

(A) that any nursing facility receiving payments under such plan must satisfy all the requirements of subsections (b) through (d) of section 1919 as they apply to such facilities;

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

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

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

(i) section 1919(e);

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

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

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

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

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

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

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

ascertained, and (II) subjecting admissions to early or more extensive review where information indicates that such consideration is warranted to a hospital, intermediate care facility for the mentally retarded, or hospital for mental diseases;

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

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

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

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

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

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

(33) provide—

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

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

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

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

(36) provide that within 90 days following the completion of each survey of any health care facility, laboratory, agency, clinic, or organization, by the appropriate State agency described in paragraph (9), such agency shall (in accordance with regulations of the Secretary) make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, laboratory, clinic, agency, or organization with (A) the statutory conditions of participation imposed under this title, and (B) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such facility, laboratory, clinic, agency, or organization;

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

(38) require that an entity (other than an individual practitioner or a group of practitioners) that furnishes, or arranges for the furnishing of, items or services under the plan, shall supply (within such period as may be specified in regulations by the Secretary



or by the single State agency which administers or supervises the administration of the plan) upon request specifically addressed to such entity by the Secretary or such State agency, the information described in section 1128(b)(9);<sup>[25]</sup>

(39) provide that the State agency shall exclude any specified individual or entity from participation in the program under the State plan for the period specified by the Secretary, when required by him to do so pursuant to section 1128 or section 1128A, terminate the participation of any individual or entity in such program if (subject to such exceptions as are permitted with respect to exclusion under sections 1128(c)(3)(B) and 1128(d)(3)(B)) participation of such individual or entity is terminated under title XVIII or any other State plan under this title (or waiver of the plan), or any State child health plan under title XXI (or waiver of the plan) and such termination is included by the Secretary in any database or similar system developed pursuant to section 6401(b)(2) of the Patient Protection and Affordable Care Act,<sup>[26]</sup> and provide that no payment may be made under the plan with respect to any item or service furnished by such individual or entity during such period;

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

(41) provide, in accordance with subsection (kk)(8) (as applicable), that whenever a provider of services or any other person is terminated, suspended, or otherwise sanctioned or prohibited from participating under the State plan, the State agency shall promptly notify the Secretary and, in the case of a physician and notwithstanding paragraph (7), the State medical licensing board of such action;<sup>[27]</sup>

(42) provide that—

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

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

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

(ii) provide assurances satisfactory to the Secretary that—

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

(II) from such amounts recovered, payment—

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

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

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

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

(aa) for purposes of section 1903(a)(7), that amounts expended by the State to carry out the program shall be considered amounts

expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan;

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

(cc) that the State and any such contractors under contract with the State shall coordinate such recovery audit efforts with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, including efforts with Federal and State law enforcement with respect to the Department of Justice, including the Federal Bureau of Investigations, the Inspector General of the Department of Health and Human Services, and the State medicaid fraud control unit; and

(43) provide for—

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

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

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

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

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

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

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

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

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

(A) a physician (or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician) certifies at the time of admission, or, if later, the time the individual applies for medical assistance under the State plan (and a physician, a physician assistant under the supervision of a physician, or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician, recertifies, where such services are furnished over a period of time, in such cases, at least as often as required under section 1903(g)(6) (or, in the case of services that are services provided in an intermediate care facility for the mentally retarded, every year), and accompanied by such supporting material, appropriate to

the case involved, as may be provided in regulations of the Secretary), that such services are or were required to be given on an inpatient basis because the individual needs or needed such services, and

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

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

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

(B)[28] provide, with respect to an individual declaring to be a citizen or national of the United States for purposes of establishing eligibility under this title, that the State shall satisfy the requirements of—

(i) section 1903(x); or

(ii) subsection (ee);

(47) provide—

(A) at the option of the State,<sup>[29]</sup> for making ambulatory prenatal care available to pregnant women during a presumptive eligibility period in accordance with section 1920 and provide for making medical assistance for items and services described in subsection (a) of section 1920A available to children during a presumptive eligibility period in accordance with such section and provide for making medical assistance available to individuals described in subsection (a) of section 1920B during a presumptive eligible period in accordance with such section and provide for making medical assistance available to individuals described in subsection (a) of section 1920B during a presumptive eligibility period in accordance with such section and provide for making medical assistance available to individuals described in subsection (a) of section 1920C during a presumptive eligibility period in accordance with such section;

(B)[30] that any hospital that is a participating provider under the State plan may elect to be a qualified entity for purposes of determining, on the basis of preliminary information, whether any individual is eligible for medical assistance under the State plan or under a waiver of the plan for purposes of providing the individual with medical assistance during a presumptive eligibility period, in the same manner, and subject to the same requirements, as apply to the State options with respect to populations described in section 1920, 1920A, 1920B, or 1920C (but without regard to whether the State has elected to provide for a presumptive eligibility period under any such sections), subject to such guidance as the Secretary shall establish;

(48) provide a method of making cards evidencing eligibility for medical assistance available to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address;

(49) provide that the State will provide information and access to certain information respecting sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921;

(50) provide, in accordance with subsection (q), for a monthly personal needs allowance for certain institutionalized individuals and couples;

(51) meet the requirements of section 1924 (relating to protection of community spouses);

(52) meet the requirements of section 1925 (relating to extension of eligibility for medical assistance);

(53) provide—

(A) for notifying in a timely manner all individuals in the State who are determined to be eligible for medical assistance and who are pregnant women, breastfeeding or postpartum women (as defined in section 17 of the Child Nutrition Act of 1966<sup>[31]</sup>), or children below the age of 5, of the availability of benefits furnished by the special supplemental nutrition program under such section, and

(B) for referring any such individual to the State agency responsible for administering such program;

(54) in the case of a State plan that provides medical assistance for covered outpatient drugs (as defined in section 1927(k)), comply with the applicable requirements of section 1927;

(55) provide for receipt and initial processing of applications of individuals for medical assistance under subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), or (a)(10)(A)(ii)(IX)—

(A) at locations which are other than those used for the receipt and processing of applications for aid under part A of title IV and which include facilities defined as disproportionate share hospitals under section 1923(a)(1)(A) and Federally-qualified health centers described in section 1905(1)(2)(B)<sup>[32]</sup>, and

(B) using applications which are other than those used for applications for aid under such part;

(56) provide, in accordance with subsection (s), for adjusted payments for certain inpatient hospital services;

(57) provide that each hospital, nursing facility, provider of home health care or personal care services, hospice program, or medicaid managed care organization (as defined in section 1903(m)(1)(A)) receiving funds under the plan shall comply with the requirements of subsection (w);

(58) provide that the State, acting through a State agency, association, or other private nonprofit entity, develop a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives that would be distributed by providers or organizations under the requirements of subsection (w);

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code<sup>[33]</sup>, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs(as defined in section 1128B(f));

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

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

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

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

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

(B) may be conducted under contract with a broker who—

(i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs;

(ii) has oversight procedures to monitor beneficiary access and complaints and ensure that transport personnel are licensed, qualified, competent, and courteous;

(iii) is subject to regular auditing and oversight by the State in order to ensure the quality of the transportation services provided and the adequacy of beneficiary access to medical care and services; and

(iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on the prohibitions on physician referrals under section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate);

(71) provide that the State will implement an asset verification program as required under section "1940";

(72) provide that the State will not prevent a Federally-qualified health center from entering into contractual relationships with private practice dental providers in the provision of Federally-qualified health center services;

(73) in the case of any State in which 1 or more Indian Health Programs or Urban Indian Organizations furnishes health care services, provide for a process under which the State seeks advice on a regular, ongoing basis from designees of such Indian Health Programs and Urban Indian Organizations on matters relating to the application of this subchapter that are likely to have a direct effect on such Indian Health Programs and Urban Indian Organizations and that—

(A) shall include solicitation of advice prior to submission of any plan amendments, waiver requests, and proposals for demonstration projects likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations; and

(B) may include appointment of an advisory committee and of a designee of such Indian Health Programs and Urban Indian Organizations to the medical care advisory committee advising the State on its State plan under this subchapter;

(74) provide for maintenance of effort under the State plan or under any waiver of the plan in accordance with subsection (gg); and

(75) provide that, beginning January 2015, and annually thereafter, the State shall submit a report to the Secretary that contains—

(A) the total number of enrolled and newly enrolled individuals in the State plan or under a waiver of the plan for the fiscal year ending on September 30 of the preceding calendar year, disaggregated by population, including children, parents, nonpregnant childless adults, disabled individuals, elderly individuals, and such other categories or sub-categories of individuals eligible for medical assistance under the State plan or under a waiver of the plan as the Secretary may require;

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

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

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

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

(78) [Repealed.<sup>[34]</sup>]

(78) provide that, not later than January 1, 2017, in the case of a State that pursuant to its State plan or waiver of the plan for medical assistance pays for medical assistance on a fee- for-service basis, the State shall require each provider furnishing items and services to, or ordering, prescribing, referring, or certifying eligibility for, services for individuals eligible to receive medical assistance under such plan to enroll with the State agency and provide to the State agency the provider's identifying information, including the name, specialty, date of birth, Social Security number, national provider identifier (if applicable), Federal taxpayer identification number, and the State license or certification number of the provider (if applicable);<sup>[35]</sup>

(79)[36] provide that any agent, clearinghouse, or other alternate payee (as defined by the Secretary) that submits claims on behalf of a health care provider must register with the State and the Secretary in a form and manner specified by the Secretary;

(80) provide that the State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States;<sup>[37]</sup>

(81) [Stricken.<sup>[38]</sup>]

(82) [Stricken.<sup>[39]</sup>]

(82) provide that the State agency responsible for administering the State plan under this title provides assurances to the Secretary that the State agency is in compliance with subparagraphs (A), (B), and (C) of section 1128K(b)(2); and<sup>[40]</sup>

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

(A) includes—

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

(I) the name of the physician or provider;

(II) the name of the physician or provider;

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

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

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

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

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

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

- (i) the Internet website of such physician or provider; or
- (ii) whether the physician or provider is accepting as new patients individuals who receive medical assistance under this title.<sup>[41]</sup>

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

Notwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State submits its plan for approval under this title, the State agency which administered or supervised the administration of the plan of such State approved under title X (or title XVI, insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under title I (or title XVI, insofar as it relates to the aged), the State agency which administered or supervised the administration of such plan approved under title X (or title XVI, insofar as it relates to the blind) may be designated to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and a different State agency may be established or designated to administer or supervise the administration of the rest of the State plan for medical assistance; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this title (except for purposes of paragraph (10)). The provisions of paragraphs (9)(A), (31), and (33) and of section 1903(i)(4) shall not apply to a religious nonmedical health care institution (as defined in section 1861(ss)(1)).

For purposes of paragraph (10) any individual who, for the month of August 1972, was eligible for or receiving aid or assistance under a State plan approved under title I, X, XIV, or XVI, or part A of title IV and who for such month was entitled to monthly insurance benefits under title II shall for purposes of this title only be deemed to be eligible for financial aid or assistance for any month thereafter if such individual would have been eligible for financial aid or assistance for such month had the increase in monthly insurance benefits under title II resulting from enactment of Public Law 92-336<sup>[42]</sup> not been applicable to such individual.

The requirement of clause<sup>[43]</sup> (A) of paragraph (37) with respect to a State plan may be waived by the Secretary if he finds that the State has exercised good faith in trying to meet such requirement. For purposes of this title, any child who meets the requirements of paragraph (1) or (2) of section 473(b) shall be deemed to be a dependent child as defined in section 406 and shall be deemed to be a recipient of aid to families with dependent children under part A of title IV in the State where such child resides. Notwithstanding paragraph (10)(B) or any other provision of this subsection, a State plan shall provide medical assistance with respect to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law only in accordance with section 1903(v).

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

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

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



(d) If a State contracts with an entity which meets the requirements of section 1152, as determined by the Secretary, or a utilization and quality control peer review organization having a contract with the Secretary under part B of title XI for the performance of medical or utilization review functions required under this title of a State plan with respect to specific services or providers (or services or providers in a geographic area of the State), such requirements shall be deemed to be met for those services or providers (or services or providers in that area) by delegation to such an entity or organization under the contract of the State's authority to conduct such review activities if the contract provides for the performance of activities not inconsistent with part B of title XI and provides for such assurances of satisfactory performance by such an entity or organization as the Secretary may prescribe.

(e)(1) Beginning April 1, 1990, for provisions relating to the extension of eligibility for medical assistance for certain families who have received aid pursuant to a State plan approved under part A of title IV and have earned income, see section 1925.<sup>[44]</sup>

(2)(A) In the case of an individual who is enrolled with a medicaid managed care organization (as defined in section 1903(m)(1)(A)), with a primary care case manager (as defined in section 1905(t)), or with an eligible organization with a contract under section 1876 and who would (but for this paragraph) lose eligibility for benefits under this title before the end of the minimum enrollment period (defined in subparagraph (B)), the State plan may provide, notwithstanding any other provision of this title, that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum period, but, except for benefits furnished under section 1905(a)(4)(C), only with respect to such benefits provided to the individual as an enrollee of such organization or entity or by or through the case manager.<sup>[45]</sup>

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

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

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

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

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

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

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

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

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

(4) A child born to a woman eligible for and receiving medical assistance under a State plan on the date of the child's birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance under such plan on the date of such birth and to remain eligible for such assistance for a period of one year. During the period in which a child is deemed under the preceding sentence to be eligible for medical assistance, the medical assistance eligibility identification number of the

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

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

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

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

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

(B) who, but for attaining such age, would remain eligible for medical assistance under such subsection,

the infant or child shall continue to be treated as an individual described in such respective provision until the end of the stay for which the inpatient services are furnished.

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

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

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

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

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

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

(v) wishes to be cared for at home.

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

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

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

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

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

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

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

- (A) the end of a period (not to exceed 12 months) following the determination; or
- (B) the time that the individual exceeds that age.

(13)[46](A) IN GENERAL.—

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

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

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

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

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

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

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

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

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

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

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

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

(ii) ESTABLISHING A SCREENING THRESHOLD.—

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

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

(III) CHILDREN WITH INCOME ABOVE THRESHOLD.—If the income of a child exceeds the screening threshold, the child shall be considered to have an income above the Medicaid applicable income level described in section 2110(b)(4) and to satisfy the requirement under section 2110(b)(1)(C) (relating to the requirement that CHIP matching funds be used only for

children not eligible for Medicaid). If such a child is enrolled in child health assistance under title XXI, the State shall provide the parent, guardian, or custodial relative with the following:

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

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

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

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

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

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

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

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

(D) OPTION FOR AUTOMATIC ENROLLMENT.—

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

(ii) INFORMATION REQUIREMENT.—The requirement of this clause is that the State informs the parent, guardian, or custodial relative of the child of the services that will be covered, appropriate methods for using such services, premium or other cost sharing charges (if any) that apply, medical support obligations (under

section 1912(a)) created by enrollment (if applicable), and the actions the parent, guardian, or relative must take to maintain enrollment and renew coverage.

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

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

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

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

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

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

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

(ii) NO PUNITIVE ACTION BASED ON ERROR RATE.—The Secretary shall not apply the error rate derived from the sample under clause (i) to the entire population of children enrolled in the State Medicaid plan or the State CHIP plan through reliance on a finding made by an Express Lane agency, or to the population of children enrolled in such plans on the basis of the State's regular procedures for determining eligibility, or penalize the State on the basis of such error rate in any manner other than the reduction of payments provided for under clause (i)(V).

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

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

(F) EXPRESS LANE AGENCY.—

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

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

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

(III) notifies the child's family—

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

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

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

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

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

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

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

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

(cc) The State Medicaid plan.

(dd) The State CHIP plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(v) ADDITIONAL DEFINITIONS.—In this paragraph:

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

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

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

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

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

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

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

(I) APPLICATION.—This paragraph shall not apply with respect to eligibility determinations made after September 30, 2017<sup>[47]</sup>.

(14)[48] EXCLUSION OF COMPENSATION FOR PARTICIPATION IN A CLINICAL TRIAL FOR TESTING OF TREATMENTS FOR A RARE DISEASE OR CONDITION.—The first \$2,000 received by an individual (who has attained 19 years of age) as compensation for participation in a clinical trial meeting the requirements of section 1612(b)(26) shall be disregarded for purposes of determining the income eligibility of such individual for medical assistance under the State plan or any waiver of such plan.

(14)[49] INCOME DETERMINED USING MODIFIED ADJUSTED GROSS INCOME.—

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



do not lose coverage under the State plan or under a waiver of the plan. The Secretary may waive such provisions of this title and title XXI as are necessary to ensure that States establish income and eligibility determination systems that protect beneficiaries.

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

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

(D) EXCEPTIONS.—

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

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

(II) Individuals who have attained age 65.

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

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

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

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

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

(iv) LONG-TERM CARE.—Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility of individuals for purposes of medical assistance for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, home or community-based services furnished under a

waiver or State plan amendment under section 1915 or a waiver under section 1115, and services described in section 1917(c)(1)(C)(ii).

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

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

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

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

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

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

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

(I) TREATMENT OF PORTION OF MODIFIED ADJUSTED GROSS INCOME.—For purposes of determining the income eligibility of an individual for medical assistance whose

eligibility is determined based on the application of modified adjusted gross income under subparagraph (A), the State shall—

- (i) determine the dollar equivalent of the difference between the upper income limit on eligibility for such an individual (expressed as a percentage of the poverty line) and such upper income limit increased by 5 percentage points; and
- (ii) notwithstanding the requirement in subparagraph (A) with respect to use of modified adjusted gross income, utilize as the applicable income of such individual, in determining such income eligibility, an amount equal to the modified adjusted gross income applicable to such individual reduced by such dollar equivalent amount.

(f) Notwithstanding any other provision of this title, except as provided in subsection (e) and section 1619(b)(3) and section 1924, except with respect to qualified disabled and working individuals (described in section 1905(s)), and except with respect to qualified medicare beneficiaries, qualified severely impaired individuals, and individuals described in subsection (m)(1), no State not eligible to participate in the State plan program established under title XVI shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of title XVI) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this title and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such individual as determined in accordance with section 1903(f) (after deducting any supplemental security income payment and State supplementary payment made with respect to such individual, and incurred expenses for medical care as recognized under State law regardless of whether such expenses are reimbursed under another public program of the State or political subdivision thereof) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972. In States which provide medical assistance to individuals pursuant to paragraph (10)(C) of subsection (a) of this section, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection if that individual is, or is eligible to be (1) an individual with respect to whom there is payable a State supplementary payment on the basis of which similarly situated individuals are eligible to receive medical assistance equal in amount, duration, and scope to that provided to individuals eligible under paragraph (10)(A), or (2) an eligible individual or eligible spouse, as defined in title XVI, with respect to whom supplemental security income benefits are payable; otherwise that individual shall be considered to be an individual eligible for medical assistance under paragraph (10)(C) of that subsection. In States which do not provide medical assistance to individuals pursuant to paragraph (10)(C) of that subsection, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection.

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

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

(i)(1) In addition to any other authority under State law, where a State determines that a intermediate care facility for the mentally retarded which is certified for participation under its

plan no longer substantially meets the requirements for such a facility under this title and further determines that the facility's deficiencies—

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

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

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

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

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

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

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

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

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

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

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

(B) infants under one year of age,

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

(D) children born after September 30, 1983 (or, at the option of a State, after any earlier date), who have attained 6 years of age but have not attained 19 years of age, who are not described in any of subclauses (I) through (III) of subsection (a)(10)(A)(i) and whose family income does not exceed the income level established by the State under paragraph (2) for a family size equal to the size of the family, including the woman, infant, or child.

(2)(A)(i) For purposes of paragraph (1) with respect to individuals described in subparagraph (A) or (B) of that paragraph, the State shall establish an income level which is a percentage (not less than the percentage provided under clause (ii) and not more than 185 percent) of the income official poverty line (as defined by the Office of Management and Budget and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981<sup>[50]</sup>) applicable to a family of the size involved.

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

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

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

(iii) In the case of a State which, as of the date of the enactment of this clause<sup>[51]</sup>, has elected to provide, and provides, medical assistance to individuals described in this subsection or has enacted legislation authorizing, or appropriating funds, to provide such assistance to such individuals before July 1, 1989, the percentage provided under clause (ii)(I) shall not be less than—

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

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

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

(iv) In the case of a State which, as of the date of the enactment of this clause<sup>[52]</sup>, has established under clause (i), or has enacted legislation authorizing, or appropriating funds, to provide for, a percentage (of the income official poverty line) that is greater than 133 percent, the percentage provided under clause (ii) for medical assistance on or after April 1, 1990, shall not be less than—

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

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

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

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

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

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

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

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

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

(E) family income shall be determined in accordance with the methodology employed under the State plan under part A or E of title IV (except to the extent such methodology is inconsistent with clause (D) of subsection (a)(17)), and costs incurred for medical care or for any other type of remedial care shall not be taken into account.

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

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

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

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

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

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

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

(2)(A) The income level established under paragraph (1)(B) may not exceed a percentage (not more than 100 percent) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673 (2) of the Omnibus Budget Reconciliation Act of 1981<sup>[53]</sup>) applicable to a family of the size involved.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) is eligible for medical assistance under the plan, and

(2) is in a hospital, skilled nursing facility, or intermediate care facility at the time such benefits are paid,

will be disregarded for purposes of determining the amount of any post-eligibility contribution by the individual to the cost of the care and services provided by the hospital, skilled nursing facility, or intermediate care facility.

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

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

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

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

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

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

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

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

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



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

- (i) who is an inpatient (or who are inpatients) in a medical institution or nursing facility for which payments are made under this title throughout a month, and
- (ii) who is or are determined to be eligible for medical assistance under the State plan.

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

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

- (i) medicare and other health insurance premiums, deductibles, or coinsurance, and
- (ii) necessary medical or remedial care recognized under State law but not covered under the State plan under this title, subject to reasonable limits the State may establish on the amount of these expenses.

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

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

(II) resides in a State veterans home with respect to which the Secretary of Veterans Affairs makes per diem payments for nursing home care pursuant to section 1741(a) of title 38, United States Code<sup>[54]</sup>,

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

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

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

- (i) in the case of groups consisting of aged, blind, or disabled individuals, under the supplemental security income program under title XVI, or
- (ii) in the case of other groups, under the State plan most closely categorically related.

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

(s) In order to meet the requirements of subsection (a)(55), the State plan must provide that payments to hospitals under the plan for inpatient hospital services furnished to infants who

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

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

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

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

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

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

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

(B) whose income (as determined under section 1612 for purposes of the supplemental security income program) does not exceed 100 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981<sup>[55]</sup>) applicable to a family of the size involved,

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

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

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

(3) In this subsection, the term “COBRA continuation coverage” means coverage under a group health plan provided by an employer with 75 or more employees provided pursuant to title XXII of the Public Health Service Act, section 4980B of the Internal Revenue Code of 1986, or title VI of the Employee Retirement Income Security Act of 1974<sup>[56]</sup>.

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

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

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

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

(v) A State plan may provide for the making of determinations of disability or blindness for the purpose of determining eligibility for medical assistance under the State plan by the single State agency or its designee, and make medical assistance available to individuals whom it

finds to be blind or disabled and who are determined otherwise eligible for such assistance during the period of time prior to which a final determination of disability or blindness is made by the Social Security Administration with respect to such an individual. In making such determinations, the State must apply the definitions of disability and blindness found in section 1614(a) of the Social Security Act.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) For construction relating to this subsection, see section 7 of the Assisted Suicide Funding Restriction Act of 1997 (relating to clarification respecting assisted suicide, euthanasia, and mercy killing)<sup>[57]</sup>.

(x) The Secretary shall establish a system, for implementation by not later than July 1, 1991, which provides for a unique identifier for each physician who furnishes services for which payment may be made under a State plan approved under this title.<sup>[58]</sup>

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

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

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

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

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

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

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

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

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

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

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

(A) who are infected with tuberculosis;

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

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

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

(A) Prescribed drugs.

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

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

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

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

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

(aa) INDIVIDUALS DESCRIBED IN THIS SUBSECTION ARE INDIVIDUALS WHO—

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

(2) have not attained age 65;

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

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

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

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

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

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

(A) increased by the percentage increase in the MEI (as defined in section 1842(i)

(3)) applicable to primary care services (as defined in section 1842(i)(4)) for that fiscal year; and

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

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

same or adjacent area with a similar case load or, in the absence of such a center or clinic, in accordance with the regulations and methodology referred to in paragraph (2) or based on such other tests of reasonableness as the Secretary may specify. For each fiscal year following the fiscal year in which the entity first qualifies as a Federally-qualified health center or rural health clinic, the State plan shall provide for the payment amount to be calculated in accordance with paragraph (3).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2)(A) If an employer of a parent of an individual described in paragraph (1) offers family coverage under a group health plan (as defined in section 2791(a) of the Public Health Service Act<sup>[59]</sup>), the State shall—

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

(ii) if such coverage is obtained—

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

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

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

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

(ee)(1)[60] For purposes of subsection (a)(46)(B)(ii), the requirements of this subsection with respect to an individual declaring to be a citizen or national of the United States for purposes of establishing eligibility under this title, are, in lieu of requiring the individual to present satisfactory documentary evidence of citizenship or nationality under section 1903(x) (if the individual is not described in paragraph (2) of that section), as follows:

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

(B) If the State receives notice from the Commissioner of Social Security that the name or social security number, or the declaration of citizenship or nationality, of the individual is inconsistent with information in the records maintained by the Commissioner—

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

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

(I) notifies the individual of such fact

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

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

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

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

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

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

(C) The program established under this paragraph shall provide that, in the case of any individual who is required to submit a social security number to the State under subparagraph (A) and who is unable to provide the State with such number, shall be provided with at least the reasonable opportunity to present satisfactory documentary evidence of citizenship or nationality (as defined in section 1903(x)(3)) as is provided under clauses (i) and (ii) of section 1137(d)(4)(A) to an individual for the submittal to the State of evidence indicating a satisfactory immigration status.

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

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

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

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

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

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



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

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

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

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

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

(ff) Notwithstanding any other requirement of this title or any other provision of Federal or State law, a State shall disregard the following property from resources for purposes of determining the eligibility of an individual who is an Indian for medical assistance under this title:

(1) Property, including real property and improvements, that is held in trust, subject to Federal restrictions, or otherwise under the supervision of the Secretary of the Interior, located on a reservation, including any federally recognized Indian Tribe's reservation, pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act<sup>[61]</sup>, and Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs of the Department of the Interior.

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

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

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

(gg) MAINTENANCE OF EFFORT. —

(1) GENERAL REQUIREMENT TO MAINTAIN ELIGIBILITY STANDARDS UNTIL STATE EXCHANGE IS FULLY OPERATIONAL. — Subject to the succeeding paragraphs of this subsection, during the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on the date on which the Secretary determines that an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act<sup>[62]</sup> is fully operational, as a condition for receiving any Federal payments under section 1903(a) for calendar quarters occurring during such period, a State shall not have in effect eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of such plan that is in effect during that period, that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under the plan or

waiver that are in effect on the date of enactment of the Patient Protection and Affordable Care Act<sup>[63]</sup>.

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

(3) NONAPPLICATION.—During the period that begins on January 1, 2011, and ends on December 31, 2013, the requirement under paragraph (1) shall not apply to a State with respect to nonpregnant, nondisabled adults who are eligible for medical assistance under the State plan or under a waiver of the plan at the option of the State and whose income exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved if, on or after December 31, 2010, the State certifies to the Secretary that, with respect to the State fiscal year during which the certification is made, the State has a budget deficit, or with respect to the succeeding State fiscal year, the State is projected to have a budget deficit. Upon submission of such a certification to the Secretary, the requirement under paragraph (1) shall not apply to the State with respect to any remaining portion of the period described in the preceding sentence.

(4) DETERMINATION OF COMPLIANCE.—

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

(B) STATES MAY EXPAND ELIGIBILITY OR MOVE WAIVERED POPULATIONS INTO COVERAGE UNDER THE STATE PLAN.—With respect to any period applicable under paragraph (1), (2), or (3), a State that applies eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, applied under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act<sup>[64]</sup>, or that makes individuals who, on such date of enactment, are eligible for medical assistance under a waiver of the State plan, after such date of enactment eligible for medical assistance through a State plan amendment with an income eligibility level that is not less than the income eligibility level that applied under the waiver, or as a result of the application of subclause (VIII) of section 1902 (a)(10)(A)(i), shall not be considered to have in effect eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

(hh)(1) STATE OPTION FOR COVERAGE FOR INDIVIDUALS WITH INCOME THAT EXCEEDS 133 PERCENT OF THE POVERTY LINE A State may elect to phase-in the extension of eligibility for medical assistance to individuals described in subclause (XX) of subsection (a)(10)(A)(ii) based on the categorical group (including nonpregnant childless adults) or income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

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

(ii)(1) Individuals described in this subsection are individuals—

(A) whose income does not exceed an income eligibility level established by the State that does not exceed the highest income eligibility level established under the State plan under this title (or under its State child health plan under title XXI) for pregnant women; and

(B) who are not pregnant.

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

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

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

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

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

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

(1) SCREENING —The State complies with the process for screening providers and suppliers under this title, as established by the Secretary under section 1866(j)(2).

(2) PROVISIONAL PERIOD OF ENHANCED OVERSIGHT FOR NEW PROVIDERS AND SUPPLIERS—The State complies with procedures to provide for a provisional period of enhanced oversight for new providers and suppliers under this title, as established by the Secretary under section 1866(j)(3).

(3) DISCLOSURE REQUIREMENTS.—The State requires providers and suppliers under the State plan or under a waiver of the plan to comply with the disclosure requirements established by the Secretary under section 1866(j)(5).

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

(A) TEMPORARY MORATORIUM IMPOSED BY THE SECRETARY.—

(i) IN GENERAL.—Subject to clause (ii), the State complies with any temporary moratorium on the enrollment of new providers or suppliers imposed by the Secretary under section 1866(j)(7).<sup>[65]</sup>

(ii) EXCEPTIONS.—

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

(II) FFP AVAILABLE Notwithstanding section 1903(i)(2)(E), payment may be made to a State under this title with respect to amounts expended for items and services described in such section if the Secretary, in consultation with the State agency administering the State plan under this title (or a waiver of the plan), determines that denying payment to the State pursuant to such section would adversely impact beneficiaries' access to medical assistance.

[66]

(iii) LIMITATION ON CHARGES TO BENEFICIARIES With respect to any amount expended for items or services furnished during calendar quarters beginning on or after October 1, 2017, the State prohibits, during the period of a temporary moratorium described in clause (i), a provider meeting the requirements specified in subparagraph (C)(iii) of section 1866(j)(7) from charging an individual or other person eligible to receive medical assistance under the State plan under this title (or a waiver of the plan) for an item or service described in section 1903(i)(2)(E) furnished to such an individual.<sup>[67]</sup>

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

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

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

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

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

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

(8) PROVIDER TERMINATIONS

(A) IN GENERAL Beginning on July 1, 2018, in the case of a notification under subsection (a)(41) with respect to a termination for a reason specified in section 455.101 of title 42, Code of Federal Regulations (as in effect on November 1, 2015) or for any other reason specified by the Secretary, of the participation of a provider of services or any other person under the State plan (or under a waiver of the plan), the State, not later than 30 days after the effective date of such termination, submits to the Secretary with respect to any such provider or person, as appropriate—

(i) the name of such provider or person;

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

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

- (iv) the date of birth, Social Security number, national provider identifier (if applicable), Federal taxpayer identification number, and the State license or certification number of such provider or person (if applicable);
- (v) the reason for the termination;
- (vi) a copy of the notice of termination sent to the provider or person;
- (vii) the date on which such termination is effective, as specified in the notice; and
- (viii) any other information required by the Secretary.

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

- (i) the date on which such termination is effective, as specified in the notice of such termination; or
- (ii) the date on which all appeal rights applicable to such termination have been exhausted or the timeline for any such appeal has expired.<sup>[68]</sup>

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

(II) **TERMINATION NOTIFICATION DATABASE** In the case of a provider of services or any other person whose participation under this title or title XXI is terminated (as described in subsection (kk)(8)), the Secretary shall, not later than 30 days after the date on which the Secretary is notified of such termination under subsection (a)(41) (as applicable), review such termination and, if the Secretary determines appropriate, include such termination in any database or similar system developed pursuant to section 6401(b)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 1395cc note; Public Law 111-148).<sup>[69]</sup>

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

(1) in the case of a physician or provider of a provider type for which the State agency, as a condition on receiving payment for items and services furnished by the physician or provider to individuals eligible to receive medical assistance under the State plan, requires the enrollment of the physician or provider with the State agency, a physician or a provider that—

- (A) is enrolled with the agency as of the date on which the directory is published or updated (as applicable) under subsection (a)(83); and
- (B) received payment under the State plan in the 12-month period preceding such date; and

(2) in the case of a physician or provider of a provider type for which the State agency does not require such enrollment, a physician or provider that received payment under the State plan (or a waiver of the plan) in the 12-month period preceding the date on which the directory is published or updated (as applicable) under subsection (a)(83).<sup>[70]</sup>

<sup>[5]</sup> See Vol. II, P.L. 93-233, §13(c), with respect to medicaid eligibility for individuals receiving mandatory State supplementary payments.

See Vol. II, P.L. 94-437, §402(c) and (d) with respect to a special fund for Indian Health Service facilities and §403 with respect to reports.

See Vol. II, P.L. 109-171, §6063, with respect to demonstration projects regarding home and community-based alternatives to psychiatric residential treatment facilities for children; §6071, with respect to “money follows the person rebalancing” demonstration project.

<sup>[6]</sup> P.L. 91-648, §208(a)(3)(D), transferred to the U.S. Civil Service Commission, effective March 6, 1971, all powers, functions, and duties of the Secretary under subparagraph (A). Functions of the Commission were transferred to the Director of the Office of Personnel Management under §102 of Reorganization Plan No. 2 of 1978 (5 U.S.C. 1101 note), effective January 1, 1979.

[7] See Vol. II, 18 U.S.C. 207 and 208.

[8] P.L. 89-642; 80 Stat. 885.

[9] P.L. 79-396; 60 Stat. 239.

[10] August 22, 1996 [P.L. 104-193; 110 Stat. 2105].

[11] **P.L. 111-148, §2004(a)(1), strikes out “or”, effective January 1, 2014.**

[12] P.L. 111-148, §2004(a)(2), adds “or”, effective January 1, 2014.

[13] P.L. 111-148, §2004(a)(3), added this new subclause (IX), to take effect on January 1, 2014. P.L. 111-148, §10201(a)(1), amended this new subclause (IX) in its entirety, to take effect on January 1, 2014.

[14] See Vol. II, P.L. 97-35, §673(2).

[15] P.L. 112-78, §310(a), struck out “December 2011” and inserted “February 2012”, effective December 23, 2011.

\*P.L. 112-96, §3101(a), struck out “February” and inserted “December”, effective February 22, 2012.

\*\*P.L. 112-240, §621(a), struck out “2012” and inserted “2013”, effective January 2, 2013.

\*\*\*P.L. 113-67, §1201(a), Struck “December 2013”, and inserted “March 2014”. Effective December 26, 2013.

\*\*\*\*P.L. 113-93, §201(a), Struck “March 2014”, and inserted “March 2015”. Effective April 1, 2014.

\*\*\*\*\*P.L. 114-10, §211(a) Struck “(but only for premiums payable with respect to months during the period beginning with January 1998, and ending with March 2015)”. Effective April 16, 2015.

[16] See Vol. II, P.L. 89-642, §17.

[17] Section 3(a)(4) was amended by P.L. 97-35, §235(a)(1)(A); 95 Stat. 871 and by P.L. 103-66, §13741(b); 107 Stat. 663 and no longer contains subparagraphs.

[18] Section 1603(a)(4)(A)(i) and (ii) is a reference to §1603(a)(4)(A)(i) and (ii) existing prior to amendment by P.L. 92-603, title III, §301; 86 Stat. 1465. The prior section continues in effect for Puerto Rico, Guam, and the Virgin Islands.

[19] P.L. 113-67, §202(b)(1)(A), struck “to the extent of such legal liability”. Effective October 1, 2014.

[20] P.L. 113-67, §202(a)(1), adds text following “payment for such services” Effective October 1, 2014.

[21] P.L. 113-67, §202(a)(2), adds text following “such third party within” October 1, 2014.

[22] See Vol. II, P.L. 93-406, §607(1).

[23] P.L. 113-67, §202(b)(1)(B), struck “payment by any other party for such health care items or services” and inserted “any payments by such third party”. Effective October 1, 2014.

[24] See Vol. II, P.L. 93-406, §607(1).

[25] See Vol. II, P.L. 78-410, §1318, with respect to disclosure of financial information required to be supplied under this paragraph.

[26] P.L. 111-148, §6501, inserted “terminate the participation of any individual or entity in such program if (subject to such exceptions as are permitted with respect to exclusion under sections 1128(c)(3)(B) and 1128(d)(3)(B)) participation of such individual or entity is terminated under title XVIII or any other State plan under this title,”. For the general effective date [January 1, 2011] and the delay if State legislation is required, see Vol. II, P.L. 111-148, §6508.

\* P.L. 114-255, §5005(c)(2); struck “title XVIII or any other State plan under this title” and inserted “title XVIII, any other State plan under this title (or waiver of the plan), or any State child health plan under title XXI (or waiver of the plan) and such termination is included by the Secretary in any database or similar system developed pursuant to section 6401(b)(2) of the Patient Protection and Affordable Care Act”. Effective December 10, 2016.

[27] \* P.L. 114-255, §5005(a)(5); struck “provide that whenever” and inserted “provide, in accordance with subsection (kk)(8) (as applicable), that whenever”. Effective December 10, 2016.

[28] See Vol. II, P.L. 111-3, §211(a)(2), with respect to limitation on waiver authority.

[29] P.L. 111-148, §2202(a)(1), struck “at the option of the State, provide” and inserted “provide—”(A) at the option of the State,” to take effect on January 1, 2014, and to be applicable to services furnished on and after January 1, 2014.

[30] P.L. 111-148, §2202(a)(3), inserted new subparagraph (B), to take effect on January 1, 2014, and to be applicable to services furnished on and after January 1, 2014.

[31] See Vol. II, P.L. 89-642, §17.

[32] Probably should be “1905(l)(2)(B)”.

[33] See Vol. II, 31 U.S.C. 3729, 3733 and 3803.

[34] P.L. 111-148, §6502, added a new paragraph (78), to take effect on January 1, 2011. P.L. 111-309, §205(a), repealed paragraph (78), effective December 15, 2010.

[35] P.L. 114-255, §5005(b)(1); inserted new paragraph 1902(a)(78). Effective December 10, 2016.

[36] P.L. 111-148, §6503(a), added this new paragraph (79). For the general effective date [January 1, 2011] and the delay if State legislation is required, see Vol. II, P.L. 111-148, §6508.

[37] P.L. 111-148, §6505, added this new paragraph (80). For the general effective date [January 1, 2011] and the delay if State legislation is required, see Vol. II, P.L. 111-148, §6508.

\* P.L. 114-255, §706(b)(1)(A) struck “and” at the end of the paragraph. Effective December 10, 2016.

[38] P.L. 112-240, §642(b)(2), struck out paragraph (81), effective January 2, 2013. [P.L. 112-240, §642(b)(1), repealed Title VIII of the Patient Protection and Affordable Care Act (Public Law 111-148; 124 Stat. 119, 846–847). For paragraph (81) as it formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L. 112–240.

[39] P.L. 112-240, §642(b)(2), struck out paragraph (82), effective January 2, 2013. [P.L. 112-240, §642(b)(1), repealed Title VIII of the Patient Protection and Affordable Care Act (Public Law 111-148; 124 Stat. 119, 846–847). For paragraph (82) as it formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L. 112–240.

[40] P.L. 114-255, §706(b)(1)(C) added paragraph (82). Effective December 10, 2016.

\* P.L. 114-255, §5006(a)(2); struck period at end and inserted “; and”. Effective December 10, 2016.

[41] \* P.L. 114-255, §5006(a)(3); inserted new paragraph (83). Effective December 10, 2016.

[42] See Vol. II, P.L. 92-336, §201(h)(2).

[43] As in original. Should be “subparagraph”.

[44] P.L. 114-10, §212(b) amended paragraph (e)(1) to read “Beginning April 1, 1990, for provisions relating to the extension of eligibility for medical assistance for certain families who have received aid pursuant to a State plan approved under part A of title IV and have earned income, see section 1925.”. Effective April 16, 2015.

[45] See Vol. II, P.L. 100-203, §4113(d), with respect to continued eligibility and restriction on disenrollment without cause for metropolitan health plan HMO’s.

[46] See Vol. II, P.L. 111-3, §203(b), with respect to an evaluation and report on the express lane option.

[47] P.L. 112-240, §623), struck out “2013” and inserted “2014”, effective January 2, 2013.

P.L. 113-93, §203, struck out “September 30, 2014” and inserted “September 30, 2015”, effective April 1, 2014.

P.L. 114-10, §302 struck “2015”; inserted “2017”. Effective April 16, 2015.

[48] P.L. 111-255, §3(a)(3), added this new paragraph (14); §3(d), provided that the effective date shall be “on the date that is the earlier of—(1) the effective date of final regulations promulgated by the Commissioner of Social Security to carry out this section [3] and such amendments; or (2) 180 days after the date of enactment” — (October 5, 2010) — April 5, 2011.

P.L. 111-255, §3(e), provides **“SUNSET PROVISION.—This Act and the amendments made by this Act are repealed on the date that is 5 years after the date of the enactment of this Act.”**

P.L. 111–255 was enacted on October 5, 2010.

[49] As in original. **P.L. 111-148, §2002(a), adds this new paragraph (14), to be effective January 1, 2014.**

See Vol. II, P.L. 111-148, §2101(f), with respect to CHIP eligibility for children ineligible for Medicaid as a result of elimination of disregards.

[50] See Vol. II, P.L. 97-35, §673(2).

[51] July 1, 1988 [P.L. 100-360; 102 Stat. 753].

[52] December 19, 1989 [P.L. 101-239; 103 Stat. 2106].

[53] See Vol. II, P.L. 97-35, §673(2).

[54] See Vol. II, 38 U.S.C. 1741.

[55] See Vol. II, P.L. 97-35, §673(2).

[56] P.L. 78-410, title XXII, P.L. 83-591, §4980B, and P.L. 93-406, title VI.

[57] See Vol. II, P.L. 105-12, §7, with respect to construction relating to subsection 1902 (w) .

[58] See Vol. II, P.L. 101-508, §4752(d), with respect to foreign medical graduate certification.

[59] See Vol. II, P.L. 78-410, §2791(a).

[60] See Vol. II, P.L. 111-3, §211(a)(4), with respect to appropriation.

[61] See Vol. II, P.L. 92-203.

[62] See Vol. II, P.L. 111-148, §1311.

[63] P.L. 111-148 was enacted on March 23, 2010.

[64] P.L. 111-148, was enacted March 23, 2010.

[65] P.L.114-255, §17004(b)(2)(B); In paragraph (1) struck "section 1886(j)(2)" and inserted "section 1866(j)(2)"; in paragraph (2) struck "section 1886(j)(3) and inserted "section 1866(j)(3)"; in paragraph (3) struck "section 1886(j)(4)" and Inserted "section 1866(j)(5); in paragraph (4)(A) struck "section 1886(j)(6)" and inserted "section 1866(J)(j)(7). Effective December 10, 2016.

[66] P.L.114-255, §17004(b)(1)(B); Changed header to "Exceptions"; restructured text into subclause (I); inserted new subclause 1902(kk)(4)(A)(ii)(II). Effective December 10, 2016.

[67] P.L.114-255, §17004(b)(1)(C); Inserted new clause 1902(kk)(4)(A)(iii). Effective December 10, 2016.

[68] \* P.L.114-255, §5005(a)(1)(A&B); renumbered paragraph (8) to paragraph (9); inserted new paragraph (8), Effective December 10, 2016.

[69] \* P.L.114-255, §5005(a)(3);inserted new subsection 1902(II). Effective December 10, 2016.

[70] \* P.L.114-255, §5006(b);inserted new subsection 1902(mm). Effective December 10, 2016.



## PROVISIONS RESPECTING INAPPLICABILITY AND WAIVER OF CERTAIN REQUIREMENTS OF THIS TITLE

SEC. 1915. [42 U.S.C. 1396n] (a) A State shall not be deemed to be out of compliance with the requirements of paragraphs (1), (10), or (23) of section 1902(a) solely by reason of the fact that the State (or any political subdivision thereof)—

(1) has entered into—

(A) a contract with an organization which has agreed to provide care and services in addition to those 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; or

(B) arrangements through a competitive bidding process or otherwise for the purchase of laboratory services referred to in section 1905(a)(3) or medical devices if the Secretary has found that—

(i) adequate services or devices will be available under such arrangements, and

(ii) any such laboratory services will be provided only through laboratories—

(I) which meet the applicable requirements of section 1861(e)(9) or paragraphs (16) and (17) of section 1861(s), and such additional requirements as the Secretary may require, and

(II) no more than 75 percent of whose charges for such services are for services provided to individuals who are entitled to benefits under this title or under part A or part B of title XVIII; or

(2) restricts for a reasonable period of time the provider or providers from which an individual (eligible for medical assistance for items or services under the State plan) can receive such items or services, if—

(A) the State has found, after notice and opportunity for a hearing (in accordance with procedures established by the State), that the individual has utilized such items or services at a frequency or amount not medically necessary (as determined in accordance with utilization guidelines established by the State), and

(B) under such restriction, individuals eligible for medical assistance for such services have reasonable access (taking into account geographic location and reasonable travel time) to such services of adequate quality.

(b) The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this title, may waive such requirements of section 1902 (other than subsection (s)) (other than sections 1902(a)(15), 1902(bb), and 1902(a)(10)(A) insofar as it requires provision of the care and services described in section 1905(a)(2)(C)) as may be necessary for a State—

(1) to implement a primary care case-management system or a specialty physician services arrangement which restricts the provider from (or through) whom an individual (eligible for medical assistance under this title) can obtain medical care services (other than in emergency circumstances), if such restriction does not substantially impair access to such services of adequate quality where medically necessary,

(2) to allow a locality to act as a central broker in assisting individuals (eligible for medical assistance under this title) in selecting among competing health care plans, if

such restriction does not substantially impair access to services of adequate quality where medically necessary,

(3) to share (through provision of additional services) with recipients of medical assistance under the State plan cost savings resulting from use by the recipient of more cost-effective medical care, and

(4) to restrict the provider from (or through) whom an individual (eligible for medical assistance under this title) can obtain services (other than in emergency circumstances) to providers or practitioners who undertake to provide such services and who meet, accept, and comply with the reimbursement, quality, and utilization standards under the State plan, which standards shall be consistent with the requirements of section 1923 and are consistent with access, quality, and efficient and economic provision of covered care and services, if such restriction does not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing those services and if providers under such restriction are paid on a timely basis in the same manner as health care practitioners must be paid under section 1902(a)(37)(A).

No waiver under this subsection may restrict the choice of the individual in receiving services under section 1905(a)(4)(C).<sup>[162]</sup>

Subsection (h)(2) shall apply to a waiver under this subsection.

(c)(1) The Secretary may by waiver provide that a State plan approved under this title may include as “medical assistance” under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan. For purposes of this subsection, the term “room and board” shall not include an amount established under a method determined by the State to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded.

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

(B) the State will provide, with respect to individuals who—

(i) are entitled to medical assistance for inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded under the State plan,

(ii) may require such services, and

(iii) may be eligible for such home or community-based care under such waiver,

for an evaluation of the need for inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded;

(C) such individuals who are determined to be likely to require the level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded are informed of the feasible alternatives, if available under the waiver, at the choice of such individuals, to the provision of inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded;

(D) under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted; and

(E) the State will provide to the Secretary annually, consistent with a data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

(3) A waiver granted under this subsection may include a waiver of the requirements of section 1902(a)(1) (relating to statewideness), section 1902(a)(10)(B) (relating to comparability), and section 1902(a)(10)(C)(i)(III) (relating to income and resource rules applicable in the community). A waiver under this subsection (other than a waiver described in subsection (h)(2)) shall be for an initial term of three years and, upon the request of a State, shall be extended for additional five-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met. A waiver may provide, with respect to post-eligibility treatment of income of all individuals receiving services under that waiver, that the maximum amount of the individual's income which may be disregarded for any month for the maintenance needs of the individual may be an amount greater than the maximum allowed for that purpose under regulations in effect on July 1, 1985.

(4) A waiver granted under this subsection may, consistent with paragraph (2)—

(A) limit the individuals provided benefits under such waiver to individuals with respect to whom the State has determined that there is a reasonable expectation that the amount of medical assistance provided with respect to the individual under such waiver will not exceed the amount of such medical assistance provided for such individual if the waiver did not apply, and

(B) provide medical assistance to individuals (to the extent consistent with written plans of care, which are subject to the approval of the State) for case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care, and such other services requested by the State as the Secretary may approve and for day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness.

Except as provided under paragraph (2)(D), the Secretary may not restrict the number of hours or days of respite care in any period which a State may provide under a waiver under this subsection.

(5) For purposes of paragraph (4)(B), the term "habilitation services"—

(A) means services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings; and

(B) includes (except as provided in subparagraph (C)) prevocational, educational, and supported employment services; but

(C) does not include—

(i) special education and related services (as such terms are defined in section 602 of the Individuals with Disabilities Education Act<sup>[163]</sup> (20 U.S.C. 1401)) which otherwise are available to the individual through a local educational agency; and

(ii) vocational rehabilitation services which otherwise are available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973<sup>[164]</sup> (29 U.S.C. 730).

(6) The Secretary may not require, as a condition of approval of a waiver under this section under paragraph (2)(D), that the actual total expenditures for home and community-based services under the waiver (and a claim for Federal financial participation in expenditures for the services) cannot exceed the approved estimates for these services. The Secretary may not deny Federal financial payment with respect to services under such a waiver on the ground that, in order to comply with paragraph (2)(D), a State has failed to comply with such a requirement.

(7)(A) In making estimates under paragraph (2)(D) in the case of a waiver that applies only to individuals with a particular illness or condition who are inpatients in, or who would require the level of care provided in, hospitals, nursing facilities, or intermediate care facilities for the mentally retarded, the State may determine the average per capita expenditure that would have been made in a fiscal year for those individuals under the State plan separately from the expenditures for other individuals who are inpatients in, or who would require the level of care provided in, those respective facilities.

(B) In making estimates under paragraph (2)(D) in the case of a waiver that applies only to individuals with developmental disabilities who are inpatients in a nursing facility and whom the State has determined, on the basis of an evaluation under paragraph (2)(B), to need the level of services provided by an intermediate care facility for the mentally retarded, the State may determine the average per capita expenditures that would have been made in a fiscal year for those individuals under the State plan on the basis of the average per capita expenditures under the State plan for services to individuals who are inpatients in an intermediate care facility for the mentally retarded, without regard to the availability of beds for such inpatients.

(C) In making estimates under paragraph (2)(D) in the case of a waiver to the extent that it applies to individuals with mental retardation or a related condition who are resident in an intermediate care facility for the mentally retarded the participation of which under the State plan is terminated, the State may determine the average per capita expenditures that would have been made in a fiscal year for those individuals without regard to any such termination.

(8) The State agency administering the plan under this title may, whenever appropriate, enter into cooperative arrangements with the State agency responsible for administering the program for children with special health care needs under title V in order to assure improved access to coordinated services to meet the needs of such children.

(9) In the case of any waiver under this subsection which contains a limit on the number of individuals who shall receive home or community-based services, the State may substitute additional individuals to receive such services to replace any individuals who die or become ineligible for services under the State plan.

(10) The Secretary shall not limit to fewer than 200 the number of individuals in the State who may receive home and community-based services under a waiver under this subsection.

(d)(1) Subject to paragraph (2), the Secretary shall grant a waiver to provide that a State plan approved under this title shall include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) which are provided pursuant to a written plan of care to individuals 65 years of age or older with respect to whom there has been a determination that but for the provision of such services the individuals would be likely to require the level of care provided in a skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan. For purposes of this subsection, the term "room and board" shall not include an amount established under a method determined by the State to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household

with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded.

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

(B) with respect to individuals 65 years of age or older who—

(i) are entitled to medical assistance for skilled nursing or intermediate care facility services under the State plan,

(ii) may require such services, and

(iii) may be eligible for such home or community-based services under such waiver,

the State will provide for an evaluation of the need for such skilled nursing facility or intermediate care facility services; and

(C) such individuals who are determined to be likely to require the level of care provided in a skilled nursing facility or intermediate care facility are informed of the feasible alternatives to the provision of skilled nursing facility or intermediate care facility services, which such individuals may choose if available under the waiver.

Each State with a waiver under this subsection shall provide to the Secretary annually, consistent with a reasonable data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

(3) A waiver granted under this subsection may include a waiver of the requirements of section 1902(a)(1) (relating to statewideness), section 1902(a)(10)(B) (relating to comparability), and section 1902(a)(10)(C)(i)(III) (relating to income and resource rules applicable in the community). Subject to a termination by the State (with notice to the Secretary) at any time, a waiver under this subsection (other than a waiver described in subsection (h)(2)) shall be for an initial term of 3 years and, upon the request of a State, shall be extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met. A waiver may provide, with respect to post-eligibility treatment of income of all individuals receiving services under the waiver, that the maximum amount of the individual's income which may be disregarded for any month is equal to the amount that may be allowed for that purpose under a waiver under subsection (c).

(4) A waiver under this subsection may, consistent with paragraph (2), provide medical assistance to individuals for case management services, homemaker/home health aide services and personal care services, adult day health services, respite care, and other medical and social services that can contribute to the health and well-being of individuals and their ability to reside in a community-based care setting.

(5)(A) In the case of a State having a waiver approved under this subsection, notwithstanding any other provision of section 1903 to the contrary, the total amount expended by the State for medical assistance with respect to skilled nursing facility services, intermediate care facility services, and home and community-based services under the State plan for individuals 65 years of age or older during a waiver year under this subsection may not exceed the projected amount determined under subparagraph (B).

(B) For purposes of subparagraph (A), the projected amount under this subparagraph is the sum of the following:

(i) The aggregate amount of the State's medical assistance under this title for skilled nursing facility services and intermediate care facility services furnished to individuals who have attained the age of 65 for the base year increased by a percentage which is equal to the lesser of 7 percent times the number of years (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year involved or the sum of—

(I) the percentage increase (based on an appropriate market-basket index representing the costs of elements of such services) between the beginning of the base year and the beginning of the waiver year involved, plus

(II) the percentage increase between the beginning of the base year and the beginning of the waiver year involved in the number of residents in the State who have attained the age of 65, plus

(III) 2 percent for each year (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year.

(ii) The aggregate amount of the State's medical assistance under this title for home and community-based services for individuals who have attained the age of 65 for the base year increased by a percentage which is equal to the lesser of 7 percent times the number of years (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year involved or the sum of—

(I) the percentage increase (based on an appropriate market-basket index representing the costs of elements of such services) between the beginning of the base year and the beginning of the waiver year involved, plus

(II) the percentage increase between the beginning of the base year and the beginning of the waiver year involved in the number of residents in the State who have attained the age of 65, plus

(III) 2 percent for each year (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year.

(iii) The Secretary shall develop and promulgate by regulation (by not later than October 1, 1989)—

(I) a method, based on an index of appropriately weighted indicators of changes in the wages and prices of the mix of goods and services which comprise both skilled nursing facility services and intermediate care facility services (regardless of the source of payment for such services), for projecting the percentage increase for purposes of clause (i)(I);

(II) a method, based on an index of appropriately weighted indicators of changes in the wages and prices of the mix of goods and services which comprise home and community-based services (regardless of the source of payment for such services), for projecting the percentage increase for purposes of clause (ii)(I); and

(III) a method for projecting, on a State specific basis, the percentage increase in the number of residents in each State who are over 65 years of age for any period.

The Secretary shall develop (by not later than October 1, 1989) a method for projecting, on a State-specific basis, the percentage increase in the number of residents in each State who are over 65 years of age for any period. Effective on and after the date the Secretary promulgates the regulation under clause (iii), any reference in this subparagraph to the "lesser of 7 percent" shall be deemed to be a reference to the "greater of 7 percent".

(iv) If there is enacted after December 22, 1987, an Act which amends this title whose provisions become effective on or after such date and which results in an

increase in the aggregate amount of medical assistance under this title for nursing facility services and home and community-based services for individuals who have attained the age of 65 years, the Secretary, at the request of a State with a waiver under this subsection for a waiver year or years and in close consultation with the State, shall adjust the projected amount computed under this subparagraph for the waiver year or years to take into account such increase.

(C) In this paragraph:

(i) The term “home and community-based services” includes services described in sections 1905(a)(7) and 1905(a)(8), services described in subsection (c)(4)(B), services described in paragraph (4), and personal care services.

(ii)(I) Subject to subclause (II), the term “base year” means the most recent year (ending before the date of the enactment of this subsection) for which actual final expenditures under this title have been reported to, and accepted by, the Secretary.

(II) For purposes of subparagraph (C), in the case of a State that does not report expenditures on the basis of the age categories described in such subparagraph for a year ending before the date of the enactment of this subsection, the term “base year” means fiscal year 1989.

(iii) The term “intermediate care facility services” does not include services furnished in an institution certified in accordance with section 1905(d).

(6)(A) A determination by the Secretary to deny a request for a waiver (or extension of waiver) under this subsection shall be subject to review to the extent provided under section 1116(b).

(B) Notwithstanding any other provision of this Act, if the Secretary denies a request of the State for an extension of a waiver under this subsection, any waiver under this subsection in effect on the date such request is made shall remain in effect for a period of not less than 90 days after the date on which the Secretary denies such request (or, if the State seeks review of such determination in accordance with subparagraph (A), the date on which a final determination is made with respect to such review).

(e)(1)(A) Subject to paragraph (2), the Secretary shall grant a waiver to provide that a State plan approved under this title shall include as “medical assistance” under such plan payment for part or all of the cost of nursing care, respite care, physicians’ services, prescribed drugs, medical devices and supplies, transportation services, and such other services requested by the State as the Secretary may approve which are provided pursuant to a written plan of care to a child described in subparagraph (B) with respect to whom there has been a determination that but for the provision of such services the infants would be likely to require the level of care provided in a hospital or nursing facility the cost of which could be reimbursed under the State plan.

(B) Children described in this subparagraph are individuals under 5 years of age who—

(i) at the time of birth were infected with (or tested positively for) the etiologic agent for acquired immune deficiency syndrome (AIDS),

(ii) have such syndrome, or

(iii) at the time of birth were dependent on heroin, cocaine, or phencyclidine, and with respect to whom adoption or foster care assistance is (or will be) made available under part E of title IV.

(C) PROJECTION OF NUMBER OF INDIVIDUALS TO BE PROVIDED HOME AND COMMUNITY-BASED SERVICES.—The State submits to the Secretary, in such form and manner, and

upon such frequency as the Secretary shall specify, the projected number of individuals to be provided home and community-based services. and

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

(B) under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted; and

(C) the State will provide to the Secretary annually, consistent with a data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

(3) A waiver granted under this subsection may include a waiver of the requirements of section 1902(a)(1) (relating to statewideness) and section 1902(a)(10)(B) (relating to comparability). A waiver under this subsection shall be for an initial term of 3 years and, upon the request of a State, shall be extended for additional five-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met.

(4) The provisions of paragraph (6) of subsection (d) shall apply to this subsection in the same manner as it applies to subsection (d).

(f)(1) The Secretary shall monitor the implementation of waivers granted under this section to assure that the requirements for such waiver are being met and shall, after notice and opportunity for a hearing, terminate any such waiver where he finds noncompliance has occurred.

(2) A request to the Secretary from a State for approval of a proposed State plan or plan amendment or a waiver of a requirement of this title submitted by the State pursuant to a provision of this title shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State agency in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. After the date the Secretary receives such additional information, the request shall be deemed granted unless the Secretary, within 90 days of such date, denies such request.

(g)(1) A State may provide, as medical assistance, case management services under the plan without regard to the requirements of section 1902(a)(1) and section 1902(a)(10)(B). The provision of case management services under this subsection shall not restrict the choice of the individual to receive medical assistance in violation of section 1902(a)(23). A State may limit the provision of case management services under this subsection to individuals with acquired immune deficiency syndrome (AIDS), or with AIDS-related conditions, or with either, or to individuals described in section 1902(z)(1)(A) and a State may limit the provision of case management services under this subsection to individuals with chronic mental illness. The State may limit the case managers available with respect to case management services for eligible individuals with developmental disabilities or with chronic mental illness in order to ensure that the case managers for such individuals are capable of ensuring that such individuals receive needed services.



(2) For purposes of this subsection, the term “case management services” means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.

(h)(1) No waiver under this section (other than a waiver under subsection (c), (d), or (e), or a waiver described in paragraph (2)) may extend over a period of longer than two years unless the State requests continuation of such waiver, and such request shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State agency in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. After the date the Secretary receives such additional information, the request shall be deemed granted unless the Secretary, within 90 days of such date, denies such request.

(2)(A) Notwithstanding subsections (c)(3) and (d) (3), any waiver under subsection (b), (c), or (d), or a waiver under section 1115, that provides medical assistance for dual eligible individuals (including any such waivers under which non dual eligible individuals may be enrolled in addition to dual eligible individuals) may be conducted for a period of 5 years and, upon the request of the State, may be extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the conditions for the waiver have not been met or it would no longer be cost-effective and efficient, or consistent with the purposes of this title, to extend the waiver.

(B) In this paragraph, the term “dual eligible individual” means an individual who is entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and is eligible for medical assistance under the State plan under this title or under a waiver of such plan.

(i) STATE PLAN AMENDMENT OPTION TO PROVIDE HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND DISABLED INDIVIDUALS.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, a State may provide through a State plan amendment for the provision of medical assistance for home and community-based services (within the scope of services described in paragraph (4) (B) of subsection (c) for which the Secretary has the authority to approve a waiver and not including room and board) for individuals eligible for medical assistance under the State plan whose income does not exceed 150 percent of the poverty line (as defined in section 2110(c)(5)), without determining that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded, but only if the State meets the following requirements:

(A) NEEDS-BASED CRITERIA FOR ELIGIBILITY FOR, AND RECEIPT OF, HOME AND COMMUNITY-BASED SERVICES.—The State establishes needs-based criteria for determining an individual’s eligibility under the State plan for medical assistance for such home and community-based services, and if the individual is eligible for such services, the specific home and community-based services that the individual will receive.

(B) ESTABLISHMENT OF MORE STRINGENT NEEDS-BASED ELIGIBILITY CRITERIA FOR INSTITUTIONALIZED CARE.—The State establishes needs-based criteria for determining whether an individual requires the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded under the State plan or under any waiver of such plan that are more stringent than the needs-based criteria established under subparagraph (A) for determining eligibility for home and community-based services.

(C) PROJECTION OF NUMBER OF INDIVIDUALS TO BE PROVIDED HOME AND COMMUNITY-BASED SERVICES.—The State submits to the Secretary, in such form and manner, and

upon such frequency as the Secretary shall specify, the projected number of individuals to be provided home and community-based services

(D) CRITERIA BASED ON INDIVIDUAL ASSESSMENT.—

(i) IN GENERAL.—The criteria established by the State for purposes of subparagraphs (A) and (B) requires an assessment of an individual's support needs and capabilities, and may take into account the inability of the individual to perform 2 or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986)<sup>[165]</sup> or the need for significant assistance to perform such activities, and such other risk factors as the State determines to be appropriate.

(ii) ADJUSTMENT AUTHORITY.—The State plan amendment provides the State with the option to modify the criteria established under subparagraph (A)(without having to obtain prior approval from the Secretary) in the event that the enrollment of individuals eligible for home and community-based services exceeds the projected enrollment submitted for purposes of subparagraph (C), but only if—

(I) the State provides at least 60 days notice to the Secretary and the public of the proposed modification;

(II) the State deems an individual receiving home and community-based services on the basis of the most recent version of the criteria in effect prior to the effective date of the modification to continue to be eligible for such services after the effective date of the modification and until such time as the individual no longer meets the standard for receipt of such services under such pre-modified criteria; and

(III) after the effective date of such modification, the State, at a minimum, applies the criteria for determining whether an individual requires the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded under the State plan or under any waiver of such plan which applied prior to the application of the more stringent criteria developed under subparagraph (B).

(E) INDEPENDENT EVALUATION AND ASSESSMENT.—

(i) ELIGIBILITY DETERMINATION.—The State uses an independent evaluation for making the determinations described in subparagraphs (A) and (B).

(ii) ASSESSMENT.—In the case of an individual who is determined to be eligible for home and community-based services, the State uses an independent assessment, based on the needs of the individual to—

(I) determine a necessary level of services and supports to be provided, consistent with an individual's physical and mental capacity;

(II) prevent the provision of unnecessary or inappropriate care; and

(III) establish an individualized care plan for the individual in accordance with subparagraph (G).

(F) ASSESSMENT.—The independent assessment required under subparagraph (E)(ii) shall include the following:

(i) An objective evaluation of an Individual's inability to perform 2 or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986)<sup>[166]</sup> or the need for significant assistance to perform such activities.

(ii) A face-to-face evaluation of the individual by an individual trained in the assessment and evaluation of individuals whose physical or mental conditions trigger a potential need for home and community-based services.

(iii) Where appropriate, consultation with the individual's family, spouse, guardian, or other responsible individual.

(iv) Consultation with appropriate treating and consulting health and support professionals caring for the individual.

(v) An examination of the individual's relevant history, medical records, and care and support needs, guided by best practices and research on effective strategies that result in improved health and quality of life outcomes.

(vi) If the State offers individuals the option to self-direct the purchase of, or control the receipt of, home and community-based service, an evaluation of the ability of the individual or the individual's representative to self-direct the purchase of, or control the receipt of, such services if the individual so elects.

(G) INDIVIDUALIZED CARE PLAN.—

(i) IN GENERAL.—In the case of an individual who is determined to be eligible for home and community-based services, the State uses the independent assessment required under subparagraph (E)(ii) to establish a written individualized care plan for the individual.

(ii) PLAN REQUIREMENTS.—The State ensures that the individualized care plan for an individual—

(I) IS DEVELOPED—

(aa) in consultation with the individual, the individual's treating physician, health care or support professional, or other appropriate individuals, as defined by the State, and, where appropriate the individual's family, caregiver, or representative; and

(bb) taking into account the extent of, and need for, any family or other supports for the individual;

(II) identifies the necessary home and community-based services to be furnished to the individual (or, if the individual elects to self-direct the purchase of, or control the receipt of, such services, funded for the individual); and

(III) is reviewed at least annually and as needed when there is a significant change in the individual's circumstances.

(iii) STATE OPTION TO OFFER ELECTION FOR SELF-DIRECTED SERVICES.—

(I) INDIVIDUAL CHOICE.—At the option of the State, the State may allow an individual or the individual's representative to elect to receive self-directed home and community-based services in a manner which gives them the most control over such services consistent with the individual's abilities and the requirements of subclauses (II) and (III).

(II) SELF-DIRECTED SERVICES.—The term "self-directed" means, with respect to the home and community-based services offered under the State plan amendment, such services for the individual which are planned and purchased under the direction and control of such individual or the individual's authorized representative, including the amount, duration, scope, provider, and location of such services, under the State plan consistent with the following requirements:

(aa) ASSESSMENT.—There is an assessment of the needs, capabilities, and preferences of the individual with respect to such services.

(bb) SERVICE PLAN.—Based on such assessment, there is developed jointly with such individual or the individual's authorized representative a plan for such services for such individual that is approved by the State and that satisfies the requirements of subclause (III).

(III) PLAN REQUIREMENTS.—For purposes of subclause (II)(bb), the requirements of this subclause are that the plan—

(aa) specifies those services which the individual or the individual's authorized representative would be responsible for directing;

(bb) identifies the methods by which the individual or the individual's authorized representative will select, manage, and dismiss providers of such services;

(cc) specifies the role of family members and others whose participation is sought by the individual or the individual's authorized representative with respect to such services;

(dd) is developed through a person-centered process that is directed by the individual or the individual's authorized representative, builds upon the individual's capacity to engage in activities that promote community life and that respects the individual's preferences, choices, and abilities, and involves families, friends, and professionals as desired or required by the individual or the individual's authorized representative;

(ee) includes appropriate risk management techniques that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of such plan based upon the resources and capabilities of the individual or the individual's authorized representative; and

(ff) may include an individualized budget which identifies the dollar value of the services and supports under the control and direction of the individual or the individual's authorized representative.

(IV) BUDGET PROCESS.—With respect to individualized budgets described in subclause (III)(ff), the State plan amendment—

(aa) describes the method for calculating the dollar values in such budgets based on reliable costs and service utilization;

(bb) defines a process for making adjustments in such dollar values to reflect changes in individual assessments and service plans; and

(cc) provides a procedure to evaluate expenditures under such budgets.

(H) QUALITY ASSURANCE; CONFLICT OF INTEREST STANDARDS.—

(i) QUALITY ASSURANCE.—The State ensures that the provision of home and community-based services meets Federal and State guidelines for quality assurance.

(ii) CONFLICT OF INTEREST STANDARDS.—The State establishes standards for the conduct of the independent evaluation and the independent assessment to safeguard against conflicts of interest.

(I) REDETERMINATIONS AND APPEALS.—The State allows for at least annual redeterminations of eligibility, and appeals in accordance with the frequency of, and manner in which, redeterminations and appeals of eligibility are made under the State plan.

(J) PRESUMPTIVE ELIGIBILITY FOR ASSESSMENT.—The State, at its option, elects to provide for a period of presumptive eligibility (not to exceed a period of 60 days) only for those individuals that the State has reason to believe may be eligible for home and community-based services. Such presumptive eligibility shall be limited to medical assistance for carrying out the independent evaluation and assessment under subparagraph (E) to determine an individual's eligibility for such services and if the

individual is so eligible, the specific home and community-based services that the individual will receive.

(2) DEFINITION OF INDIVIDUAL'S REPRESENTATIVE.—In this section, the term “individual's representative” means, with respect to an individual, a parent, a family member, or a guardian of the individual, an advocate for the individual, or any other individual who is authorized to represent the individual.

(3) NONAPPLICATION.—A State may elect in the State plan amendment approved under this section to not comply with the requirements of section 1902(a)(10)(B) (relating to comparability) and section 1902(a)(10)(C)(i)(III) (relating to income and resource rules applicable in the community), but only for purposes of provided home and community-based services in accordance with such amendment. Any such election shall not be construed to apply to the provision of services to an individual receiving medical assistance in an institutionalized setting as a result of a determination that the individual requires the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded.

(4) NO EFFECT ON OTHER WAIVER AUTHORITY.—Nothing in this subsection shall be construed as affecting the option of a State to offer home and community-based services under a waiver under subsections (c) or (d) of this section or under section 1115.

(5) CONTINUATION OF FEDERAL FINANCIAL PARTICIPATION FOR MEDICAL ASSISTANCE PROVIDED TO INDIVIDUALS AS OF EFFECTIVE DATE OF STATE PLAN AMENDMENT.—Notwithstanding paragraph (1)(B), Federal financial participation shall continue to be available for an individual who is receiving medical assistance in an institutionalized setting, or home and community-based services provided under a waiver under this section or section 1115 that is in effect as of the effective date of the State plan amendment submitted under this subsection, as a result of a determination that the individual requires the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded, without regard to whether such individuals satisfy the more stringent eligibility criteria established under that paragraph, until such time as the individual is discharged from the institution or waiver program or no longer requires such level of care.

(6) STATE OPTION TO PROVIDE HOME AND COMMUNITY-BASED SERVICES TO INDIVIDUALS ELIGIBLE FOR SERVICES UNDER A WAIVER.—

(A) IN GENERAL.—A State that provides home and community-based services in accordance with this subsection to individuals who satisfy the needs-based criteria for the receipt of such services established under paragraph (1)(A) may, in addition to continuing to provide such services to such individuals, elect to provide home and community-based services in accordance with the requirements of this paragraph to individuals who are eligible for home and community-based services under a waiver approved for the State under subsection (c), (d), or (e) or under section 1115 to provide such services, but only for those individuals whose income does not exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1).

(B) APPLICATION OF SAME REQUIREMENTS FOR INDIVIDUALS SATISFYING NEEDS-BASED CRITERIA.—Subject to subparagraph (C), a State shall provide home and community-based services to individuals under this paragraph in the same manner and subject to the same requirements as apply under the other paragraphs of this subsection to the provision of home and community-based services to individuals who satisfy the needs-based criteria established under paragraph (1)(A).

(C) AUTHORITY TO OFFER DIFFERENT TYPE, AMOUNT, DURATION, OR SCOPE OF HOME AND COMMUNITY-BASED SERVICES.—A State may offer home and community-based services to individuals under this paragraph that differ in type, amount, duration, or scope from the home and community-based services offered for individuals who satisfy the

needs-based criteria established under paragraph (1)(A), so long as such services are within the scope of services described in paragraph (4)(B) of subsection (c) for which the Secretary has the authority to approve a waiver and do not include room or board.

(7) STATE OPTION TO OFFER HOME AND COMMUNITY-BASED SERVICES TO SPECIFIC, TARGETED POPULATIONS. —

(A) IN GENERAL. — A State may elect in a State plan amendment under this subsection to target the provision of home and community-based services under this subsection to specific populations and to differ the type, amount, duration, or scope of such services to such specific populations.

(B) 5-YEAR TERM. —

(i) IN GENERAL. — An election by a State under this paragraph shall be for a period of 5 years.

(ii) PHASE-IN OF SERVICES AND ELIGIBILITY PERMITTED DURING INITIAL 5-YEAR PERIOD. — A State making an election under this paragraph may, during the first 5-year period for which the election is made, phase-in the enrollment of eligible individuals, or the provision of services to such individuals, or both, so long as all eligible individuals in the State for such services are enrolled, and all such services are provided, before the end of the initial 5-year period.

(C) RENEWAL. — An election by a State under this paragraph may be renewed for additional 5-year terms if the Secretary determines, prior to beginning of each such renewal period, that the State has—

(i) adhered to the requirements of this subsection and paragraph in providing services under such an election; and

(ii) met the State's objectives with respect to quality improvement and beneficiary outcomes.

(j)(1) A State may provide, as "medical assistance", payment for part or all of the cost of self-directed personal assistance services (other than room and board) under the plan which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that, but for the provision of such services, the individuals would require and receive personal care services under the plan, or home and community-based services provided pursuant to a waiver under subsection (c). Self-directed personal assistance services may not be provided under this subsection to individuals who reside in a home or property that is owned, operated, or controlled by a provider of services, not related by blood or marriage.

(2) The Secretary shall not grant approval for a State self-directed personal assistance services program under this section unless the State provides assurances satisfactory to the Secretary of the following:

(A) Necessary safeguards have been taken to protect the health and welfare of individuals provided services under the program, and to assure financial accountability for funds expended with respect to such services.

(B) The State will provide, with respect to individuals who—

(i) are entitled to medical assistance for personal care services under the plan, or receive home and community-based services under a waiver granted under subsection (c);

(ii) may require self-directed personal assistance services; and

(iii) may be eligible for self-directed personal assistance services, an evaluation of the need for personal care under the plan, or personal services under a waiver granted under subsection (c).

(C) Such individuals who are determined to be likely to require personal care under the plan, or home and community-based services under a waiver granted under subsection (c) are informed of the feasible alternatives, if available under the State's self-directed personal assistance services program, at the choice of

such individuals, to the provision of personal care services under the plan, or personal assistance services under a waiver granted under subsection (c).

(D) The State will provide for a support system that ensures participants in the self-directed personal assistance services program are appropriately assessed and counseled prior to enrollment and are able to manage their budgets. Additional counseling and management support may be provided at the request of the participant.

(E) The State will provide to the Secretary an annual report on the number of individuals served and total expenditures on their behalf in the aggregate. The State shall also provide an evaluation of overall impact on the health and welfare of participating individuals compared to non-participants every three years.

(3) A State may provide self-directed personal assistance services under the State plan without regard to the requirements of section 1902(a)(1) and may limit the population eligible to receive these services and limit the number of persons served without regard to section 1902(a)(10)(B).

(4)(A) For purposes of this subsection, the term “self-directed personal assistance services” means personal care and related services, or home and community-based services otherwise available under the plan under this title or subsection (c), that are provided to an eligible participant under a self-directed personal assistance services program under this section, under which individuals, within an approved self-directed services plan and budget, purchase personal assistance and related services, and permits participants to hire, fire, supervise, and manage the individuals providing such services.

(B) AT THE ELECTION OF THE STATE—

(i) a participant may choose to use any individual capable of providing the assigned tasks including legally liable relatives as paid providers of the services; and

(ii) the individual may use the individual’s budget to acquire items that increase independence or substitute (such as a microwave oven or an accessibility ramp) for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

(5) For purpose of this section, the term “approved self-directed services plan and budget” means, with respect to a participant, the establishment of a plan and budget for the provision of self-directed personal assistance services, consistent with the following requirements:

(A) SELF-DIRECTION.—The participant (or in the case of a participant who is a minor child, the participant’s parent or guardian, or in the case of an incapacitated adult, another individual recognized by State law to act on behalf of the participant) exercises choice and control over the budget, planning, and purchase of self-directed personal assistance services, including the amount, duration, scope, provider, and location of service provision.

(B) ASSESSMENT OF NEEDS.—There is an assessment of the needs, strengths, and preferences of the participants for such services.

(C) SERVICE PLAN.—A plan for such services (and supports for such services) for the participant has been developed and approved by the State based on such assessment through a person-centered process that—

(i) builds upon the participant’s capacity to engage in activities that promote community life and that respects the participant’s preferences, choices, and abilities; and

(ii) involves families, friends, and professionals in the planning or delivery of services or supports as desired or required by the participant.

(D) SERVICE BUDGET.—A budget for such services and supports for the participant has been developed and approved by the State based on such assessment and plan and on a methodology that uses valid, reliable cost data, is open to public inspection, and includes a calculation of the expected cost of such services if those services were not self-directed. The budget may not restrict access to other medically necessary care and services furnished under the plan and approved by the State but not included in the budget.

(E) APPLICATION OF QUALITY ASSURANCE AND RISK MANAGEMENT.—There are appropriate quality assurance and risk management techniques used in establishing and implementing such plan and budget that recognize the roles and responsibilities in obtaining services in a self-directed manner and assure the appropriateness of such plan and budget based upon the participant's resources and capabilities.

(6) A State may employ a financial management entity to make payments to providers, track costs, and make reports under the program. Payment for the activities of the financial management entity shall be at the administrative rate established in section 1903(a).

(k) STATE PLAN OPTION TO PROVIDE HOME AND COMMUNITYBASED ATTENDANT SERVICES AND SUPPORTS.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, beginning October 1, 2011, a State may provide through a State plan amendment for the provision of medical assistance for home and community-based attendant services and supports for individuals who are eligible for medical assistance under the State plan whose income does not exceed 150 percent of the poverty line (as defined in section 2110(c)(5)) or, if greater, the income level applicable for an individual who has been determined to require an institutional level of care to be eligible for nursing facility services under the State plan and with respect to whom there has been a determination that, but for the provision of such services, the individuals would require the level of care provided in a hospital, a nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental diseases, the cost of which could be reimbursed under the State plan, but only if the individual chooses to receive such home and community-based attendant services and supports, and only if the State meets the following requirements:

(A) AVAILABILITY.—The State shall make available home and community-based attendant services and supports to eligible individuals, as needed, to assist in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through handson assistance, supervision, or cueing—

(i) under a person-centered plan of services and supports that is based on an assessment of functional need and that is agreed to in writing by the individual or, as appropriate, the individual's representative;

(ii) in a home or community setting, which does not include a nursing facility, institution for mental diseases, or an intermediate care facility for the mentally retarded;

(iii) under an agency-provider model or other model (as defined in paragraph (6)(C )); and

(iv) the furnishing of which—

(I) is selected, managed, and dismissed by the individual, or, as appropriate, with assistance from the individual's representative;

(II) is controlled, to the maximum extent possible, by the individual or where appropriate, the individual's representative, regardless of who may act as the employer of record; and



(III) provided by an individual who is qualified to provide such services, including family members (as defined by the Secretary).

(B) INCLUDED SERVICES AND SUPPORTS.—In addition to assistance in accomplishing activities of daily living, instrumental activities of daily living, and health related tasks, the home and community-based attendant services and supports made available include—

- (i) the acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living, and health related tasks;
- (ii) back-up systems or mechanisms (such as the use of beepers or other electronic devices) to ensure continuity of services and supports; and
- (iii) voluntary training on how to select, manage, and dismiss attendants.

(C) EXCLUDED SERVICES AND SUPPORTS.—Subject to subparagraph (D), the home and community-based attendant services and supports made available do not include—

- (i) room and board costs for the individual;
- (ii) special education and related services provided under the Individuals with Disabilities Education Act and vocational rehabilitation services provided under the Rehabilitation Act of 1973;
- (iii) assistive technology devices and assistive technology services other than those under (1)(B)(ii);
- (iv) medical supplies and equipment; or
- (v) home modifications.

(D) PERMISSIBLE SERVICES AND SUPPORTS.—The home and community-based attendant services and supports may include—

- (i) expenditures for transition costs such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from a nursing facility, institution for mental diseases, or intermediate care facility for the mentally retarded to a community-based home setting where the individual resides; and
- (ii) expenditures relating to a need identified in an individual's person-centered plan of services that increase independence or substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

(2) INCREASED FEDERAL FINANCIAL PARTICIPATION.—For purposes of payments to a State under section 1903(a)(1), with respect to amounts expended by the State to provide medical assistance under the State plan for home and community-based attendant services and supports to eligible individuals in accordance with this subsection during a fiscal year quarter occurring during the period described in paragraph (1), the Federal medical assistance percentage applicable to the State (as determined under section 1905(b)) shall be increased by 6 percentage points.

(3) STATE REQUIREMENTS.—In order for a State plan amendment to be approved under this subsection, the State shall—

(A) develop and implement such amendment in collaboration with a Development and Implementation Council established by the State that includes a majority of members with disabilities, elderly individuals, and their representatives and consults and collaborates with such individuals;

(B) provide consumer controlled home and community-based attendant services and supports to individuals on a statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity

of disability, or the form of home and community-based attendant services and supports that the individual requires in order to lead an independent life;

(C) with respect to expenditures during the first full fiscal year in which the State plan amendment is implemented, maintain or exceed the level of State expenditures for medical assistance that is provided under section 1905(a), section 1915, section 1115, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding fiscal year;

(D) establish and maintain a comprehensive, continuous quality assurance system with respect to community-based attendant services and supports that—

(i) includes standards for agency-based and other delivery models with respect to training, appeals for denials and reconsideration procedures of an individual plan, and other factors as determined by the Secretary;

(ii) incorporates feedback from consumers and their representatives, disability organizations, providers, families of disabled or elderly individuals, members of the community, and others and maximizes consumer independence and consumer control;

(iii) monitors the health and well-being of each individual who receives home and community-based attendant services and supports, including a process for the mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation in connection with the provision of such services and supports; and

(iv) provides information about the provisions of the quality assurance required under clauses (i) through (iii) to each individual receiving such services; and

(E) collect and report information, as determined necessary by the Secretary, for the purposes of approving the State plan amendment, providing Federal oversight, and conducting an evaluation under paragraph (5)(A), including data regarding how the State provides home and community-based attendant services and supports and other home and community-based services, the cost of such services and supports, and how the State provides individuals with disabilities who otherwise qualify for institutional care under the State plan or under a waiver the choice to instead receive home and community-based services in lieu of institutional care.

(4) COMPLIANCE WITH CERTAIN LAWS.—A State shall ensure that, regardless of whether the State uses an agency-provider model or other models to provide home and community-based attendant services and supports under a State plan amendment under this subsection, such services and supports are provided in accordance with the requirements of the Fair Labor Standards Act of 1938 and applicable Federal and State laws regarding—

(A) withholding and payment of Federal and State income and payroll taxes;

(B) the provision of unemployment and workers compensation insurance;

(C) maintenance of general liability insurance; and

(D) occupational health and safety.

(5) EVALUATION, DATA COLLECTION, AND REPORT TO CONGRESS.—

(A) EVALUATION.—The Secretary shall conduct an evaluation of the provision of home and community-based attendant services and supports under this subsection in order to determine the effectiveness of the provision of such services and supports in allowing the individuals receiving such services and supports to lead an independent life to the maximum extent possible; the impact on the physical and emotional health of the individuals who receive such services; and an comparative analysis of the costs of services provided under the State plan amendment under this subsection and those provided under institutional care in a nursing facility, institution for mental diseases, or an intermediate care facility for the mentally retarded.

(B) DATA COLLECTION.—The State shall provide the Secretary with the following information regarding the provision of home and community-based attendant services and supports under this subsection for each fiscal year for which such services and supports are provided:

- (i) The number of individuals who are estimated to receive home and community-based attendant services and supports under this subsection during the fiscal year.
- (ii) The number of individuals that received such services and supports during the preceding fiscal year.
- (iii) The specific number of individuals served by type of disability, age, gender, education level, and employment status.
- (iv) Whether the specific individuals have been previously served under any other home and community based services program under the State plan or under a waiver.

(C) REPORTS.—NOT LATER THAN—

- (i) December 31, 2013, the Secretary shall submit to Congress and make available to the public an interim report on the findings of the evaluation under subparagraph (A); and
- (ii) December 31, 2015, the Secretary shall submit to Congress and make available to the public a final report on the findings of the evaluation under subparagraph (A).

(6) DEFINITIONS.—In this subsection:

(A) ACTIVITIES OF DAILY LIVING.—The term “activities of daily living” includes tasks such as eating, toileting, grooming, dressing, bathing, and transferring.

(B) CONSUMER CONTROLLED.—The term “consumer controlled” means a method of selecting and providing services and supports that allow the individual, or where appropriate, the individual’s representative, maximum control of the home and community-based attendant services and supports, regardless of who acts as the employer of record.

(C) DELIVERY MODELS.—

(i) AGENCY-PROVIDER MODEL.—The term “agency-provider model” means, with respect to the provision of home and community-based attendant services and supports for an individual, subject to paragraph (4), a method of providing consumer controlled services and supports under which entities contract for the provision of such services and supports.

(ii) OTHER MODELS.—The term “other models” means, subject to paragraph (4), methods, other than an agency-provider model, for the provision of consumer controlled services and supports. Such models may include the provision of vouchers, direct cash payments, or use of a fiscal agent to assist in obtaining services.

(D) HEALTH-RELATED TASKS.—The term “health-related tasks” means specific tasks related to the needs of an individual, which can be delegated or assigned by licensed health-care professionals under State law to be performed by an attendant.

(E) INDIVIDUAL’S REPRESENTATIVE.—The term “individual’s representative” means a parent, family member, guardian, advocate, or other authorized representative of an individual

(F) INSTRUMENTAL ACTIVITIES OF DAILY LIVING.—The term “instrumental activities of daily living” includes (but is not limited to) meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community.

<sup>[162]</sup> See Vol. II, P.L. 99-272, §9524, with respect to the Wisconsin health maintenance organization waiver.

<sup>[163]</sup> See Vol. II, P.L. 91-230, §602(c)(5)(C).

<sup>[164]</sup> See Vol. II, P.L. 93-112, §110.

<sup>[165]</sup> See Vol. II, P.L. 83-591, §7702B(c)(2)(B).

<sup>[166]</sup> See Vol. II, P.L. 83-591, §7702B(c)(2)(B).

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## PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN

SEC. 1920. [42 U.S.C. 1396r-1] (a) A State plan approved under section 1902 may provide for making ambulatory prenatal care available to a pregnant woman during a presumptive eligibility period.

(b) For purposes of this section—

(1) the term “presumptive eligibility period” means, with respect to a pregnant woman, the period that—

(A) begins with the date on which a qualified provider determines, on the basis of preliminary information, that the family income of the woman does not exceed the applicable income level of eligibility under the State plan, and

(B) ends with (and includes) the earlier of—

(i) the day on which a determination is made with respect to the eligibility of the woman for medical assistance under the State plan, or

(ii) in the case of a woman who does not file an application by the last day of the month following the month during which the provider makes the determination referred to in subparagraph (A), such last day.

(2) the term “qualified provider” means any provider that—

(A) is eligible for payments under a State plan approved under this subchapter,

(B) provides services of the type described in subparagraph (A) or (B) of section 1905(a)(2) or in section 1905(a)(9),

(C) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A), and

(D)(i) receives funds under—

(I) section 330 or 330A of the Public Health Service Act<sup>[193]</sup>,

(II) title V of this Act, or

(III) title V of the Indian Health Care Improvement Act<sup>[194]</sup>;

(ii) participates in a program established under—

(I) section 17 of the Child Nutrition Act of 1966<sup>[195]</sup>, or

(II) section 4(a) of the Agriculture and Consumer Protection Act of 1973

<sup>[196]</sup>;

(iii) participates in a State perinatal program; or

(iv) is the Indian Health Service or is a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638).

The term “qualified provider” also includes a qualified entity, as defined in section 1920A

(b)(3).

(c)(1) The State agency shall provide qualified providers with—

(A) such forms as are necessary for a pregnant woman to make application for medical assistance under the State plan, and

(B) information on how to assist such women in completing and filing such forms.

(2) A qualified provider that determines under subsection (b)(1)(A) that a pregnant woman is presumptively eligible for medical assistance under a State plan shall—

(A) notify the State agency of the determination within 5 working days after the date on which determination is made, and

(B) inform the woman at the time the determination is made that she is required to make application for medical assistance under the State plan by not later than the last day of the month following the month during which the determination is made.

(3) A pregnant woman who is determined by a qualified provider to be presumptively eligible for medical assistance under a State plan shall make application for medical assistance under such plan by not later than the last day of the month following the month during which the determination is made, which application may be the application used for the receipt of medical assistance by individuals described in section 1902(l)(1)(A).

(d) Notwithstanding any other provision of this title, ambulatory prenatal care that—

(1) is furnished to a pregnant woman—

(A) during a presumptive eligibility period,

(B) by a provider that is eligible for payments under the State plan; and

(2) is included in the care and services covered by a State plan;

shall be treated as medical assistance provided by such plan for purposes of section 1903.

(e) If the State has elected the option to provide a presumptive eligibility period under this section or section 1920A, the State may elect to provide a presumptive eligibility period (as defined in subsection (b)(1)) for individuals who are eligible for medical assistance under clause (i)(VIII), clause (i)(IX),<sup>[197]</sup> or clause (ii)(XX) of subsection (a)(10)(A) or section 1931 in the same manner as the State provides for such a period under this section or section 1920A, subject to such guidance as the Secretary shall establish.

[193] See Vol. II, P.L. 78-410, §330.

[194] See Vol. II, P.L. 94-437, title V.

[195] See Vol. II, P.L. 89-642, §17.

[196] See Vol. II, P.L. 93-86, §4(a).

[197] **P.L. 111-148, §2004(b), inserts “or clause (i)(IX)”, to take effect on January 1, 2014.**

## PRESUMPTIVE ELIGIBILITY FOR CHILDREN

SEC. 1920A. [42 U.S.C. 1396r-1a] (a) A State plan approved under section 1902 may provide for making medical assistance with respect to health care items and services covered under the State plan available to a child during a presumptive eligibility period.

(b) For purposes of this section:

(1) The term “child” means an individual under 19 years of age.

(2) The term “presumptive eligibility period” means, with respect to a child, the period that—

(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the family income of the child does not exceed the applicable income level of eligibility under the State plan, and

(B) ends with (and includes) the earlier of—

(i) the day on which a determination is made with respect to the eligibility of the child for medical assistance under the State plan, or

(ii) in the case of a child on whose behalf an application is not filed by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

(3)(A) Subject to subparagraph (B), the term “qualified entity” means any entity that—

(i)(I) is eligible for payments under a State plan approved under this title and provides items and services described in subsection (a), (II) is authorized to determine eligibility of a child to participate in a Head Start program under the Head Start Act (42 U.S.C. 9831 et seq.), eligibility of a child to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990 (42 U.S.C. 9858 et seq.), eligibility of an infant or child to receive assistance under the special supplemental nutrition program for women, infants, and children (WIC) under section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786) eligibility of a child for medical assistance under the State plan under this title, or eligibility of a child for child health assistance under the program funded under title XXI, (III) is an elementary school or secondary school, as such terms are defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801), an elementary or secondary school operated or supported by the Bureau of Indian Affairs, a State or tribal child support enforcement agency, an organization that is providing emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act, or a State or tribal office or entity involved in enrollment in the program under this title, under part A of title IV, under title XXI, or that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437 et seq.) or under the Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4101 et seq.), or (IV) any other entity the State so deems, as approved by the Secretary; and

(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (2).

(B) The Secretary may issue regulations further limiting those entities that may become qualified entities in order to prevent fraud and abuse and for other reasons.

(C) Nothing in this section shall be construed as preventing a State from limiting the classes of entities that may become qualified entities, consistent with any limitations imposed under subparagraph (B).

(c)(1) The State agency shall provide qualified entities with—

(A) such forms as are necessary for an application to be made on behalf of a child for medical assistance under the State plan, and

(B) information on how to assist parents, guardians, and other persons in completing and filing such forms.

(2) A qualified entity that determines under subsection (b)(2) that a child is presumptively eligible for medical assistance under a State plan shall—

(A) notify the State agency of the determination within 5 working days after the date on which determination is made, and

(B) inform the parent or custodian of the child at the time the determination is made that an application for medical assistance under the State plan is required to be made by not later than the last day of the month following the month during which the determination is made.

(3) In the case of a child who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the parent, guardian, or other person shall make application on behalf of the child for medical assistance under such plan by not later than the last day of the month following the month during which the determination is made, which application may be the application used for the receipt of medical assistance by individuals described in section 1902(l)(1).

(d) Notwithstanding any other provision of this title, medical assistance for items and services described in subsection (a) that—

(1) are furnished to a child—

(A) during a presumptive eligibility period,

(B) by an entity that is eligible for payments under the State plan; and

(2) are included in the care and services covered by a State plan;

shall be treated as medical assistance provided by such plan for purposes of section 1903.