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COMPILATION

OF THE

SOCIAL SECURITY LAWS

INCLUDING THE SOCIAL SECURITY ACT,
AS AMENDED, AND RELATED ENACTMENTS
THROUGH JANUARY 1, 2005

VOLUME I

PRINTED FOR THE USE OF THE

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PREFACE

The Social Security Act

The original Social Security Act (the Act) is P.L. 74–271 (49 Stat. 620), approved August 14, 1935. The Act has been amended in part, a number of times. A list of laws which have amended the Act may be found in Volume II.

Administration of the Social Security Act

The Social Security Board was responsible for administration of the original Social Security Act except for parts 1, 2, 3, and 5 of Title V (which were administered by the Children's Bureau, then in the Department of Labor); part 4 of Title V which increased the appropriations authorized for carrying out the Act of June 2, 1920 and Title VI which authorized grants to the States for public health work.

The Social Security Board was transferred to the Federal Security Agency by Reorganization Plan No. 1 of 1939 and the Board's functions were to be carried on under the direction and supervision of the Federal Security Administrator. Reorganization Plan No. 2 of 1946 transferred the functions of the Children's Bureau and the functions of the Secretary of Labor under Title V of the Act to the Federal Security Administrator and the Board was abolished.

The Bureau of Employment Security, with its unemployment compensation and employment service function, was transferred from the Federal Security Agency to the Department of Labor by Reorganization Plan No. 2 of 1949.

The Department of Health, Education, and Welfare was established by Reorganization Plan No. 1 of 1953 with a Secretary of Health, Education, and Welfare as the head of the Department. All functions of the Federal Security Agency, which was abolished, were transferred to the Department of Health, Education, and Welfare. The functions of the Federal Security Administrator were transferred to the Secretary of Health, Education and Welfare.

The Department of Health, Education, and Welfare was redesignated the Department of Health and Human Services, and the Secretary of Health, Education, and Welfare was redesignated the Secretary of Health and Human Services by P.L. 96–88, §509, approved October 17, 1979. The Department of Health and Human Services redesignation was effective May 4, 1980 (45 Federal Register 29642; May 5, 1980). The Department of Education which was established by P.L. 96–88 was activated May 4, 1980 (Executive Order 12212 of May 2, 1980; 45 Federal Register 29557; May 5, 1980).

The Social Security Administration was established as an independent agency, effective March 31, 1995, by P.L. 103–296, §101, approved August 15, 1994 with a Commissioner of Social Security responsible for the exercise of all powers and the discharge of all duties of the Administration.

Compilation of the Social Security Laws

This compilation is current through January 1, 2005. This compilation contains:

Volume I

Table of Contents;
The Social Security Act, as in effect January 1, 2005;
Internal Revenue Code—Selected Provisions; and
Index to the Social Security Act.

Volume II

Table of Contents;
Other provisions of the Internal Revenue Code, provisions of public laws and statutes which are cited in the Social Security Act, and provisions of public laws which affect administration of the Act but do not amend it;

Appendixes containing other helpful information; and
Provisions of the Social Security Act which have been superseded.

Effect of Compilation

This Compilation of the Social Security Laws is not prima facie evidence of the provisions of the Social Security Act or other laws or statutes which are included, but has been prepared solely for convenient reference purposes.

Cautions

Although they are not a part of the text of the law, citations have been included which will enable the reader to locate the same material in the United States Code (U.S.C.). These matching citations to the United States Code are shown within brackets after the public law section, for example:

Social Security Act	Sec. 201.	[42 U.S.C. 401]
Public Law 99–509	Sec. 9342	[42 U.S.C. 1395b-1note]

Both sections may be found in Title 42 of the United States Code, the first at section 401 and the second in the notes following section 1395b-1. "**[**None Assigned**]**" means the provisions are not in the United States Code, but can be found in the public law.

COMPILED BY

THE SOCIAL SECURITY ADMINISTRATION

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OFFICE OF INCOME SECURITY PROGRAMS,

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This volume is available online at http://www.socialsecurity.gov under “Our Program Rules”.

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[1] This table of contents does not appear in the law.

SOCIAL SECURITY ACT [1]

(As Amended through January 1, 2005)

AN ACT

To provide for the general welfare by establishing a system of Federal old-age benefits, and by enabling the several States to make more adequate provision for aged persons, blind persons, dependent and crippled children, maternal and child welfare, public health, and the administration of their unemployment compensation laws; to establish a Social Security Board; to raise revenue; and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

[TITLE I—GRANTS TO STATES FOR OLD-AGE ASSISTANCE FOR THE AGED [2]]

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APPROPRIATION

SEC. 1. [42 U.S.C. 301] For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish

[1] P.L. 74-271, approved August 14, 1935, 49 Stat. 620.

[2] Title I of the Social Security Act is administered by the Department of Health and Human Services. The Office of Family Assistance administers benefit payments under Title I. The Administration for Public Services, Office of Human Development Services, administers social services under Title I.

Title I appears in the United States Code as §§301–306, subchapter I, chapter 7, Title 42.

Regulations relating to Title I are contained in subtitle A and chapter XIII, Title 45, Code of Federal Regulations.

P.L. 92–603, §303, *repealed* Title I effective January 1, 1974, *except* with respect to Puerto Rico, Guam, and the Virgin Islands. The Commonwealth of the Northern Marianas may elect to initiate a Title I social services program if it chooses; see Vol. II, P.L. 94–241, approved March 24, 1976, 90 Stat. 263, [Covenant to Establish Northern Mariana Islands].

See Vol. II, 31 U.S.C. 6504–6505, with respect to intergovernmental cooperation and 31 U.S.C. 7501–7507, with respect to uniform audit requirements for State and local governments receiving Federal financial assistance.

See Vol. II, P.L. 82–183, §618, for the "Jenner Amendment", which prohibits denial of grants-in-aid under certain conditions.

See Vol. II, P.L. 88–352, §601, for prohibition against discrimination in Federally assisted programs.

See Vol. II, P.L. 89–97, §121(b), with respect to restrictions on payment to a State receiving payments under Title XIX.

See Vol. II, P.L. 90–248, §234(c), with respect to nursing homes which do not meet all requirements of a State for licensure.

See Vol. II, P.L. 95–521, §102(i), with respect to reporting of benefits received under the Social Security Act.

[3] This table of contents does not appear in the law.

financial assistance to aged needy individuals, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare[4] (hereinafter referred to as the "Secretary"), State plans for old-age assistance.

STATE OLD-AGE PLANS

SEC. 2. [42 U.S.C. 302] (a) A State plan for old-age assistance must—

(1) except to the extent permitted by the Secretary with respect to services, 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;

(3) either provide for the establishment or designation of a single State agency to administer the plan, or provide for the establishment or designation of a single State agency to supervise the administration of the plan;

(4) provide (A) for granting an opportunity for a fair hearing before the State agency to any individual whose claim for assistance under the plan is denied or is not acted upon with reasonable promptness, and (B) that if the State plan is administered in each of the political subdivisions of the State by a local agency and such local agency provides a hearing at which evidence may be presented prior to a hearing before the State agency, such local agency may put into effect immediately upon issuance its decision upon the matter considered at such hearing;

(5) 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) as are found by the Secretary[5] to be necessary for the proper and efficient operation of the plan, and (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;

(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 provi-

[4] This was deemed to refer to the Secretary of Health and Human Services under section 509 of the "Department of Education Organization Act" (P.L. 96–88, 93 Stat. 695), effective May 4, 1980.

[5] 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, effective January 1, 1979, to the Director of the Office of Personnel Management by section 102 of Reorganization Plan No. 2 of 1978.

sions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) provide safeguards which permit the use or disclosure of information concerning applicants or recipients only (A) to public officials who require such information in connection with their official duties, or (B) to other persons for purposes directly connected with the administration of the State plan;

(8) provide that all individuals wishing to make application for 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, if the plan includes assistance for or on behalf of individuals in private or public institutions, for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for such institutions;

(10) if the State plan includes old-age assistance—

(A) provide that the State agency shall, in determining need for such assistance, take into consideration any other income and resources of an individual claiming old-age assistance, as well as any expenses reasonably attributable to the earning of any such income; except that, in making such determination, (i) the State agency may disregard not more than $7.50 per month of any income and (ii) of the first $80 per month of additional income which is earned the State agency may disregard not more than the first $20 thereof plus one-half of the remainder;[6]

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[6] See Vol. II, 10 U.S.C. 2546, with respect to shelter for the homeless at military installations.

See Vol. II, P.L. 81–171, §521(a)(1)(E), with respect to exclusion from income and resources of certain assistance rendered to provide occupant-owned, rental and cooperative housing.

See Vol. II, P.L. 87–543, §141(b), with respect to ineligibility to receive payments under Title XIV where payments have been made under Title XVI.

See Vol. II, P.L. 88–525, §8(b), with respect to exclusion from income and resources of the value of food stamps.

See Vol. II, P.L. 89–73, §210(b), with respect to exclusion from income of the costs of any project under that act.

See Vol. II, P.L. 89–329, §479B, with respect to exclusion from income or resources of certain student financial assistance.

See Vol. II, P.L. 91–646, §216, with respect to exclusion from income of payments made under that act.

See Vol. II, P.L. 93–112, §613(c), for the conditional exclusion from income of wages, allowances, transportation reimbursement, and attendant care provided to handicapped individuals under community service employment pilot programs.

See Vol. II, P.L. 93–113, §404(f), with respect to exclusion from income and resources of payments to volunteers under that act.

See Vol. II, P.L. 93–134, §§7 and 8, with respect to exclusion from income and resources of certain judgment funds to any Indian tribe.

See Vol. II, P.L. 93–288, §312(d), with respect to exclusion from income and resources of certain Federal major disaster and emergency assistance.

See Vol. II, P.L. 94–114, §6, with respect to exclusion from income and resources of property and receipts from submarginal land to certain Indians.

See Vol. II, P.L. 95–433, §2, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 95–498, §6, with respect to an income and resources exclusion applicable to the Pueblo of Santa Ana Indians, New Mexico.

See Vol. II, P.L. 95–499, §6, with respect to an income and resources exclusion applicable to the Pueblo of Zia Indians, New Mexico.

See Vol. II, P.L. 95–557, §410(b), with respect to exclusion from income of services (but not of wages) provided to a public housing resident or to a resident of a housing project assisted under the "Housing Act of 1959" (see Vol. II, P.L. 86–372, §202).

See Vol. II, P.L. 97–35, §2605(f), with respect to exclusion from income and resources of home energy assistance payments or allowances.

See Vol. II, P.L. 98–64, §2(a), with respect to exclusion from income and resources of per capita payments to Indians.

See Vol. II, P.L. 98–432, §5(e), with respect to exclusion from income and resources of certain judgment funds.

Continued

(B) include reasonable standards, consistent with the objectives of this title, for determining eligibility for and the extent of such assistance; and

(C) provide a description of the services (if any) which the State agency makes available (using whatever internal organizational arrangement it finds appropriate for this purpose) to applicants for and recipients of such assistance to help them attain self-care, including a description of the steps taken to assure, in the provision of such services, maximum utilization of other agencies providing similar or related services; and

(11) 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.

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

(1) an age requirement of more than sixty-five years; or

(2) any residence requirement which (A) in the case of applicants for old-age assistance, excludes any resident of the State who has resided therein five years during the nine years immediately preceding the application for old-age assistance and has resided therein continuously for one year immediately preceding the application, and (B) in the case of applicants for medical assistance for the aged, excludes any individual who resides in the State; or

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

At the option of the State, the plan may provide that manuals and other policy issuances will be furnished to persons without charge for the reasonable cost of such materials, but such provision shall

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See Vol. II, P.L. 98–500, §8, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 98–602, §106(d), with respect to exclusion from income and resources of certain funds distributed per capita.

See Vol. II, P.L. 99–130, §8, with respect to exclusion from income and resources of certain funds.

See Vol. II, P.L. 99–146, §6(b), with respect to exclusion from income and resources of certain funds.

See Vol. II, P.L. 99–264, §16, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 99–346, §6(b), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 99–377, §4(b), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 100–139, §4(h)(6), with respect to exclusion of benefits as basis for denial of eligibility.

See Vol. II, P.L. 100–407, §105(g), with respect to the effect of financial assistance under that Act.

See Vol. II, P.L. 100–409, §5, with respect to the effect of this Act on P.L. 92–203 or P.L. 96–487.

See Vol. II, P.L. 100–411, §2(d)(3)(B), with respect to the effect of per capita payments.

See Vol. II, P.L. 100–581, §§501, 502(b)(1), and 503, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 101–41, §10(b)-(d), with respect to eligibility for Federal programs and treatment of funds, assets, and income.

See Vol. II, P.L. 101–42, §3, with respect to the restoration of Federal recognition, rights, and privileges.

See Vol. II, P.L. 101–201, with respect to Agent Orange settlement payments.

See Vol. II, P.L. 101–239, §10405, with respect to Agent Orange settlement payments excluded from countable income and resources under Federal means-tested programs.

See Vol. II, P.L. 101–277, §8(b), with respect to exclusion, from income or resources, of funds held in trust or distributed to Seminole Indians.

not be required by the Secretary as a condition for the approval of such plan under this title.

(c) Nothing in this title shall be construed to permit a State to have in effect with respect to any period more than one State plan approved under this title.

PAYMENT TO STATES

SEC. 3. [42 U.S.C. 303] (a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing October 1, 1960—

(1) [Stricken.[7]]

(2) in the case of Puerto Rico, the Virgin Islands, and Guam, an amount equal to one-half of the total of the sums expended during such quarter as old-age assistance under the State plan, not counting so much of any expenditure with respect to any month as exceeds $37.50 multiplied by the total number of recipients of old-age assistance for such month; plus

(3) [Stricken.[8]]

(4) in the case of any State, an amount equal to 50 percent of the total amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

(b) The method of computing and paying such amounts shall be as follows:

(1) The Secretary of Health, Education, and Welfare shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection(a), such estimate to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, (B) records showing the number of aged individuals in the State, and (C) such other investigation as the Secretary may find necessary.

(2) The Secretary of Health, Education, and Welfare shall then certify to the Secretary of the Treasury the amount so estimated by the Secretary of Health, Education, and Welfare, (A) reduced or increased, as the case may be, by any sum by which he finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State under subsection (a) for such quarter, and (B) reduced by a sum equivalent to the pro rata share to which the United States is equitably entitled, as determined by the Secretary of Health, Education, and Welfare, of the net amount recovered during any prior quarter by the State or any political subdivision thereof with respect to assistance furnished under the State plan; except that such increases or reductions shall not be made to the extent that such sums have been applied

[7] P.L. 97–35, §2184(a)(4)(A); 95 Stat. 816.
[8] P.L. 97–35, §2184(a)(4)(A); 95 Stat. 816.

to make the amount certified for any prior quarter greater or less than the amount estimated by the Secretary for such prior quarter: *Provided,* That any part of the amount recovered from the estate of a deceased recipient which is not in excess of the amount expended by the State or any political subdivision thereof for the funeral expenses of the deceased shall not be considered as a basis for reduction under clause (B) of this paragraph.

(3) The Secretary of the Treasury shall thereupon, through the Division of Disbursement[9] of the Treasury Department and prior to audit or settlement by the General Accounting Office[10], pay to the State, at the time or times fixed by the Secretary of Health, Education, and Welfare, the amount so certified.

OPERATION OF STATE PLANS

SEC. 4. [42 U.S.C. 304] In the case of any State plan which has been approved under this title by the Secretary of Health, Education, and Welfare, if the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, finds—

(1) that the plan has been so changed as to impose any age, residence, or citizenship requirement prohibited by section 2(b), or that in the administration of the plan any such prohibited requirement is imposed, with the knowledge of such State agency, in a substantial number of cases; or

(2) that in the administration of the plan there is a failure to comply substantially with any provision required by section 2(a) to be included in the plan;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure) until the Secretary is satisfied that such prohibited requirement is no longer so imposed, and that there is no longer any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

SEC. 5. [Repealed.[11]]

DEFINITION[12]

SEC. 6. [42 U.S.C. 306] (a)[13] For the purposes of this title, the term "old-age assistance" means money payments to, or (if provided in or after the third month before the month in which the recipient

[9] As in original. The Division of Disbursement was consolidated in the Fiscal Service of the Treasury Department by Reorganization Plan No. III, §1(a), effective June 30, 1940 (54 State. 1231).

[10] P.L. 108-271, §8(b), provided that "Any reference to the General Accounting Office in any law, rule, regulation, certificate, directive, instruction, or other official paper in force on the date of enactment of this Act (July 7, 2004) shall be considered to refer and apply to the Government Accountability Office."

[11] P.L. 92–603, §303(a); 86 Stat. 1484.

The P.L. 92–603, §303(b), repeal exception is deemed not applicable to §5 because it was executed with expenditure of the appropriation for the fiscal year ending June 30, 1936, and never became applicable to Puerto Rico, Guam, or the Virgin Islands.

[12] As in original. P.L. 86–778, §601(f)(2), [74 Stat. 991], did not amend the catchline.

[13] As in original; "(a)" should be stricken.

makes application for assistance) medical care in behalf of or any type of remedial care recognized under State law in behalf of, needy individuals who are 65 years of age or older, but does not include any such payments to or care in behalf of any individual who is an inmate of a public institution (except as a patient in a medical institution). Such term also includes payments which are not included within the meaning of such term under the preceding sentence, but which would be so included except that they are made on behalf of such a needy individual to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such needy individual, but only with respect to a State whose State plan approved under section 2 includes provision for—

(1) determination by the State agency that such needy individual has, by reason of his physical or mental condition, such inability to manage funds that making payments to him would be contrary to his welfare and, therefore, it is necessary to provide such assistance through payments described in this sentence;

(2) making such payments only in cases in which such payments will, under the rules otherwise applicable under the State plan for determining need and the amount of old-age assistance to be paid (and in conjunction with other income and resources), meet all the need[14] of the individuals with respect to whom such payments are made;

(3) undertaking and continuing special efforts to protect the welfare of such individual and to improve, to the extent possible, his capacity for self-care and to manage funds;

(4) periodic review by such State agency of the determination under paragraph (1) to ascertain whether conditions justifying such determination still exist, with provision for termination of such payments if they do not and for seeking judicial appointment of a guardian or other legal representative, as described in section 1111, if and when it appears that such action will best serve the interests of such needy individual; and

(5) opportunity for a fair hearing before the State agency on the determination referred to in paragraph (1) for any individual with respect to whom it is made.

At the option of a State (if its plan approved under this title so provides), such term (i) need not include money payments to an individual who has been absent from such State for a period in excess of 90 consecutive days (regardless of whether he has maintained his residence in such State during such period) until he has been present in such State for 30 consecutive days in the case of such an individual who has maintained his residence in such State during such period or 90 consecutive days in the case of any other such individual, and (ii) may include rent payments made directly to a public housing agency on behalf of a recipient or a group or groups of recipients of assistance under such plan.

[14] As in original. Should be "needs".

TITLE II—FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS [1]

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[1] Title II of the Social Security Act is administered by the Social Security Administration. Title II appears in the United States Code as §§401–433, subchapter II, chapter 7, Title 42.

Regulations relating to Title II are contained in chapter III, Title 20, Code of Federal Regulations.

See Vol. II, 31 U.S.C. 3720 and 3720A with respect to collection of payments due to Federal agencies; and §3803(c)(2)(C) with respect to benefits not affected by P.L. 100–383.

See Vol. II, P.L. 94–566, §503, with respect to preservation of medicaid eligibility for individuals who cease to be eligible for supplemental security income benefits on account of cost-of-living increases in social security benefits.

See Vol. II, P.L. 95–521, §102(i), with respect to reporting of benefits received under the Social Security Act.

See Vol. II, P.L. 95–608, §§201–204, with respect to Indian child and family programs.

See Vol. II, P.L. 96–265, §505, with respect to authority for demonstration projects.

See Vol. II, P.L. 98–21, §101(e), with respect to the effect of amendments made by that law on benefits under the Federal Retirement System.

See Vol. II, P.L. 99–177, §255, with respect to exemption of certain benefits from budget reductions.

See Vol. II, P.L. 100–204, §724(d), with respect to furnishing information to the United States Commission on Improving the Effectiveness of the United Nations; and §725(b), with respect to the detailing of Government personnel.

See Vol. II, P.L. 100–235, §§5–8, with respect to responsibilities of each Federal agency for computer systems security and privacy.

See Vol. II, P.L. 100–383, §§105(f)(2) and 206(d)(2), with respect to exclusion from income and resources of certain payments to certain individuals.

See Vol. II, P.L. 100–690, §5301(a)(1)(C) and (d)(1)(B), with respect to benefits of drug traffickers and possessors.

See Vol. II, P.L. 101–508, §§13301 and 13302, with respect to OASDI Trust Funds.

See Vol II, P.L. 106–170, §302, with respect to demonstration projects providing for reductions in disability insurance benefits based on earnings.

[2] This table of contents does not appear in the law.

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FEDERAL OLD-AGE AND SURVIVORS INSURANCE TRUST FUND AND FEDERAL DISABILITY INSURANCE TRUST FUND[3]

SEC. 201. [42 U.S.C. 401] (a) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Old-Age and Survivors Insurance Trust Fund". The Federal Old-Age and Survivors Insurance Trust Fund shall consist of the securities held by the Secretary of the Treasury for the Old-Age Reserve Account and the amount standing to the credit of the Old-Age Reserve Account on the books of the Treasury on January 1, 1940, which securities and amount the Secretary of the Treasury is authorized and directed to transfer to the Federal Old-Age and Survivors Insurance Trust Fund, and, in addition, such gifts and bequests as may be made as provided in subsection (i)(1), and such amounts as may be appropriated to, or deposited in, the Federal Old-Age and Survivors Insurance Trust Fund as hereinafter provided. There is hereby appropriated to the Federal Old-Age and Survivors Insurance Trust Fund for the fiscal year ending June 30, 1941, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

(1) the taxes (including interest, penalties, and additions to the taxes) received under subchapter A of chapter 9 of the Internal Revenue Code of 1939[4] (and covered into the Treasury) which are deposited into the Treasury by collectors of internal revenue before January 1, 1951; and

(2) the taxes certified each month by the Commissioner of Internal Revenue as taxes received under subchapter A of chapter 9 of such Code which are deposited into the Treasury by collectors of internal revenue after December 31, 1950, and be-

[3] See Vol. II, 14 U.S.C. 707(e)(3) with respect to the requirement for certification to the Secretary of Labor of an individual's insured status.

See Vol. II, P.L. 95–250, §201(19), with respect to trust fund contributions and §204(b)(4), with respect to Title XVIII ineligibility.

See Vol. II, P.L. 98–21, §121(e), with respect to transfers of funds from the Secretary of the Treasury to the Trust Fund.

See Vol. II, P.L. 98–168, §§201–208, with respect to certain Federal employees covered under both the Social Security Act and a Federal retirement system.

[4] P.L. 76–1.

fore January 1, 1953, with respect to assessments of such taxes made before January 1, 1951; and

(3) the taxes imposed by subchapter A of chapter 9 of such Code with respect to wages (as defined in section 1426 of such Code), and by chapter 21 (other than sections 3101(b) and 3111(b)) of the Internal Revenue Code of 1954[5] with respect to wages (as defined in section 3121 of such Code[6]) reported to the Commissioner of Internal Revenue pursuant to section 1420(c) of the Internal Revenue Code of 1939 after December 31, 1950, or to the Secretary of the Treasury or his delegates pursuant to subtitle F of the Internal Revenue Code of 1954 after December 31, 1954, as determined by the Secretary of the Treasury by applying the applicable rates of tax under such subchapter or chapter 21 (other than sections 3101(b) and 3111(b)) to such wages, which wages shall be certified by the Commissioner of Social Security on the basis of the records of wages established and maintained by such Commissioner in accordance with such reports, less the amounts specified in clause (1) of subsection (b) of this section; and

(4) the taxes imposed by subchapter E of chapter 1 of the Internal Revenue Code of 1939, with respect to self-employment income (as defined in section 481 of such Code), and by chapter 2 (other than section 1401(b)) of the Internal Revenue Code of 1954[7] with respect to self-employment income (as defined in section 1402 of such Code[8]) reported to the Commissioner of Internal Revenue on tax returns under such subchapter or to the Secretary of the Treasury or his delegate on tax returns under subtitle F of such Code, as determined by the Secretary of the Treasury by applying the applicable rate of tax under such subchapter or chapter (other than section 1401(b)) to such self-employment income, which self-employment income shall be certified by the Commissioner of Social Security on the basis of the records of self-employment income established and maintained by the Commissioner of Social Security in accordance with such returns, less the amounts specified in clause (2) of subsection (b) of this section.

The amounts appropriated by clauses (3) and (4) shall be transferred from time to time from the general fund in the Treasury to the Federal Old-Age and Survivors Insurance Trust Fund, and the amounts appropriated by clauses (1) and (2) of subsection (b) shall be transferred from time to time from the general fund in the Treasury to the Federal Disability Insurance Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes, specified in clauses (3) and (4) of this subsection, paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the taxes specified in such clauses (3) and (4) of this subsection. All amounts transferred to either Trust Fund under the preceding sentence shall be invested by the Managing Trustee in the same manner and to the same extent as the other assets of such Trust Fund.

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[5] See P.L. 83–591 chapter 21 (this volume).

[6] See P.L. 83–591, §3121 (this volume).

P.L. 99–514, §2, provides, except when inappropriate, any reference to the Internal Revenue Code of 1954 shall include a reference to the Internal Revenue Code of 1986.

[7] See P.L. 83–591, chapter 2 (this volume).

[8] See P.L. 83–591, §1402 (this volume).

Notwithstanding the preceding sentence, in any case in which the Secretary of the Treasury determines that the assets of either such Trust Fund would otherwise be inadequate to meet such Fund's obligations for any month, the Secretary of the Treasury shall transfer to such Trust Fund on the first day of such month the amount which would have been transferred to such Fund under this section as in effect on October 1, 1990; and such Trust Fund shall pay interest to the general fund on the amount so transferred on the first day of any month at a rate (calculated on a daily basis, and applied against the difference between the amount so transferred on such first day and the amount which would have been transferred to the Trust Fund up to that day under the procedures in effect on January 1, 1983) equal to the rate earned by the investments of such Fund in the same month under subsection (d).

(b) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Disability Insurance Trust Fund". The Federal Disability Insurance Trust Fund shall consist of such gifts and bequests as may be made as provided in subsection (i)(1), and such amounts as may be appropriated to, or deposited in, such fund as provided in this section. There is hereby appropriated to the Federal Disability Insurance Trust Fund for the fiscal year ending June 30, 1957, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

(1)(A) ½ of 1 per centum of the wages (as defined in section 3121 of the Internal Revenue Code of 1954[9]) paid after December 31, 1956, and before January 1, 1966, and reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1954, (B) 0.70 of 1 per centum of the wages (as so defined) paid after December 31, 1965, and before January 1, 1968, and so reported, (C) 0.95 of 1 per centum of the wages (as so defined) paid after December 31, 1967, and before January 1, 1970, and so reported, (D) 1.10 per centum of the wages (as so defined) paid after December 31, 1969, and before January 1, 1973, and so reported, (E) 1.1 per centum of the wages (as so defined) paid after December 31, 1972, and before January 1, 1974, and so reported, (F) 1.15 per centum of the wages (as so defined) paid after December 31, 1973, and before January 1, 1978, and so reported, (G) 1.55 per centum of the wages (as so defined) paid after December 31, 1977, and before January 1, 1979, and so reported, (H) 1.50 per centum of the wages (as so defined) paid after December 31, 1978, and before January 1, 1980, and so reported, (I) 1.12 per centum of the wages (as so defined) paid after December 31, 1979, and before January 1, 1981, and so reported, (J) 1.30 per centum of the wages (as so defined) paid after December 31, 1980, and before January 1, 1982, and so reported, (K) 1.65 per centum of the wages (as so defined) paid after December 31, 1981, and before January 1, 1983, and so reported, (L) 1.25 per centum of the wages (as so defined) paid after December 31, 1982, and before January 1, 1984, and so reported, (M) 1.00 per centum of the wages (as so defined) paid after December 31, 1983, and before January 1, 1988, and so reported, (N) 1.06 per centum of the wages (as so defined) paid after December

[9] See P.L. 83–591, §3121 (this volume).

31, 1987, and before January 1, 1990, and so reported, (O) 1.20 per centum of the wages (as so defined) paid after December 31, 1989, and before January 1, 1994, and so reported, (P) 1.88 per centum of the wages (as so defined) paid after December 31, 1993, and before January 1, 1997, and so reported, (Q) 1.70 per centum of the wages (as so defined) paid after December 31, 1996, and before January 1, 2000, and so reported, and (R) 1.80 per centum of the wages (as so defined) paid after December 31, 1999, and so reported, which wages shall be certified by the Commissioner of Social Security on the basis of the records of wages established and maintained by such Commissioner in accordance with such reports; and

(2)(A) ⅜ of 1 per centum of the amount of self-employment income (as defined in section 1402 of the Internal Revenue Code of 1954[10]) reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of the Internal Revenue Code of 1954 for any taxable year beginning after December 31, 1956, and before January 1, 1966, (B) 0.525 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1965, and before January 1, 1968, (C) 0.7125 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1967, and before January 1, 1970, (D) 0.825 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1969, and before January 1, 1973, (E) 0.795 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1972, and before January 1, 1974, (F) 0.815 of 1 per centum of the amount of self-employment income (as so defined) as reported for any taxable year beginning after December 31, 1973, and before January 1, 1978, (G) 1.090 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1977, and before January 1, 1979, (H) 1.0400 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1978, and before January 1, 1980, (I) 0.7775 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1979, and before January 1, 1981, (J) 0.9750 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1980, and before January 1, 1982, (K) 1.2375 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1981, and before January 1, 1983, (L) 0.9375 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1982, and before January 1, 1984, (M) 1.00 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1983, and before January 1, 1988, (N) 1.06 per centum of the self-employment income (as so defined) so reported for

[10] See P.L. 83–591, §1402 (this volume).

any taxable year beginning after December 31, 1987, and before January 1, 1990, (O) 1.20 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1989, and before January 1, 1994, (P) 1.88 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1993, and before January 1, 1997, (Q) 1.70 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1996, and before January 1, 2000, and (R) 1.80 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1999, which self-employment income shall be certified by the Commissioner of Social Security on the basis of the records of self-employment income established and maintained by the Commissioner of Social Security in accordance with such returns.

(c) With respect to the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund (hereinafter in this title called the "Trust Funds") there is hereby created a body to be known as the Board of Trustees of the Trust Funds (hereinafter in this title called the "Board of Trustees") which Board of Trustees shall be composed of the Commissioner of Social Security, the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, all ex officio, and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of four years and subject to confirmation by the Senate. A member of the Board of Trustees serving as a member of the public and nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term. An individual nominated and confirmed as a member of the public may serve in such position after the expiration of such member's term until the earlier of the time at which the member's successor takes office or the time at which a report of the Board is first issued under paragraph (2) after the expiration of the member's term. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (hereinafter in this title called the "Managing Trustee"). The Deputy Commissioner of Social Security shall serve as Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

(1) Hold the Trust Funds;

(2)[11] Report to the Congress not later than the first day of April of each year on the operation and status of the Trust Funds during the preceding fiscal year and on their expected operation and status during the next ensuing five fiscal years;

(3) Report immediately to the Congress whenever the Board of Trustees is of the opinion that the amount of either of the Trust Funds is unduly small;

(4) Recommend improvements in administrative procedures and policies designed to effectuate the proper coordination of

[11] See Vol. II, P.L. 108-203, §413, with respect to the reinstatement of certain reporting requirements.

the old-age and survivors insurance and Federal-State unemployment compensation program; and

(5) Review the general policies followed in managing the Trust Funds, and recommend changes in such policies, including necessary changes in the provisions of the law which govern the way in which the Trust Funds are to be managed.

The report provided for in paragraph (2) above shall include a statement of the assets of, and the disbursements made from, the Trust Funds during the preceding fiscal year, an estimate of the expected future income to, and disbursements to be made from, the Trust Funds during each of the next ensuing five fiscal years, and a statement of the actuarial status of the Trust Funds. Such statement shall include a finding by the Board of Trustees as to whether the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, individually and collectively, are in close actuarial balance (as defined by the Board of Trustees). Such report shall include an actuarial opinion by the Chief Actuary of the Social Security Administration certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable. Such report shall also include an actuarial analysis of the benefit disbursements made from the Federal Old-Age and Survivors Insurance Trust Fund with respect to disabled beneficiaries. Such report shall be printed as a House document of the session of the Congress to which the report is made. A person serving on the Board of Trustees shall not be considered to be a fiduciary and shall not be personally liable for actions taken in such capacity with respect to the Trust Funds.

(d) It shall be the duty of the Managing Trustee to invest such portion of the Trust Funds as is not, in his judgment, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired (1) on original issue at the issue price, or (2) by purchase of outstanding obligations at the market price. The purposes for which obligations of the United States may be issued under chapter 31 of title 31, United States Code [12], are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Funds. Such obligations issued for purchase by the Trust Funds shall have maturities fixed with due regard for the needs of the Trust Funds and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of four years from the end of such calendar month; except that where such average market yield is not a multiple of one-eighth of 1 per centum, the rate of interest of such obligations shall be the multiple of one-eighth of 1 per centum nearest such market yield. Each obligation issued for purchase by the Trust Funds under this subsection shall be evidenced by a paper instrument in the form of a bond, note, or certificate of indebtedness issued by the Secretary of the Treasury set-

[12] See Vol. II, Title 31, §3111.

ting forth the principal amount, date of maturity, and interest rate of the obligation, and stating on its face that the obligation shall be incontestable in the hands of the Trust Fund to which it is issued, that the obligation is supported by the full faith and credit of the United States, and that the United States is pledged to the payment of the obligation with respect to both principal and interest. The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where he determines that the purchase of such other obligations is in the public interest.

(e) Any obligations acquired by the Trust Funds (except public-debt obligations issued exclusively to the Trust Funds) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

(f) The interest on, and the proceeds from the sale or redemption of, any obligations held in the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund shall be credited to and form a part of the Federal Old-Age and Survivors Insurance Trust Fund and the Disability Insurance Trust Fund, respectively. Payment from the general fund of the Treasury to either of the Trust Funds of any such interest or proceeds shall be in the form of paper checks drawn on such general fund to the order of such Trust Fund.[13]

(g)(1)(A) The Managing Trustee of the Trust Funds (which for purposes of this paragraph shall include also the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund established by title XVIII) is directed to pay from the Trust Funds into the Treasury—

(i) the amounts estimated by the Managing Trustee, the Commissioner of Social Security, and the Secretary of Health and Human Services which will be expended, out of moneys appropriated from the general fund in the Treasury, during a three-month period by the Department of Health and Human Services for the administration of title XVIII of this Act, and by the Department of the Treasury for the administration of titles II and XVIII of this Act and chapters 2 and 21 of the Internal Revenue Code of 1986, less

(ii) the amounts estimated (pursuant to the applicable method prescribed under paragraph (4) of this subsection) by the Commissioner of Social Security which will be expended, out of moneys made available for expenditures from the Trust Funds, during such three-month period to cover the cost of carrying out the functions of the Social Security Administration, specified in section 232, which relate to the administration of provisions of the Internal Revenue Code of 1986 other than those referred to in clause (i) and the functions of the Social Security Administration in connection with the withholding of taxes from benefits, as described in section 207(c), pursuant to requests by per-

[13] For treatment of outstanding obligations, see Vol. II, P.L. 103–296, §301(c)(2).

sons entitled to such benefits or such persons' representative payee.[14]

Such payments shall be carried into the Treasury as the net amount of repayments due the general fund account for reimbursement of expenses incurred in connection with the administration of titles II and XVIII of this Act and chapters 2 and 21 of the Internal Revenue Code of 1986.[15] A final accounting of such payments for any fiscal year shall be made at the earliest practicable date after the close thereof. There are hereby authorized to be made available for expenditure, out of any or all of the Trust Funds, such amounts as the Congress may deem appropriate to pay the costs of the part of the administration of this title, title VIII, title XVI, and title XVIII for which the Commissioner of Social Security is responsible, the costs of title XVIII for which the Secretary of Health and Human Services is responsible, and the costs of carrying out the functions of the Social Security Administration, specified in section 232, which relate to the administration of provisions of the Internal Revenue Code of 1986 other than those referred to in clause (i) of the first sentence of this subparagraph and the functions of the Social Security Administration in connection with the withholding of taxes from benefits, as described in section 207(c), pursuant to requests by persons entitled to such benefits or such persons' representative payee. Of the amounts authorized to be made available out of the Federal Old–Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund under the preceding sentence, there are hereby authorized to be made available from either or both of such Trust Funds for continuing disability reviews—

(i) for fiscal year 1996, $260,000,000;
(ii) for fiscal year 1997, $360,000,000;
(iii) for fiscal year 1998, $570,000,000;
(iv) for fiscal year 1999, $720,000,000;
(v) for fiscal year 2000, $720,000,000;
(vi) for fiscal year 2001, $720,000,000; and
(vii) for fiscal year 2002, $720,000,000.

For purposes of this subparagraph, the term "continuing disability review" means a review conducted pursuant to section 221(i) and a review or disability eligibility redetermination conducted to determine the continuing disability and eligibility of a recipient of benefits under the supplemental security income program under title XVI, including any review or redetermination conducted pursuant to section 207 or 208 of the Social Security Independence and Program Improvements Act of 1994 (Public Law 103–296).[16]

(B) After the close of each fiscal year—

(i) the Commissioner of Social Security shall determine—

(I) the portion of the costs, incurred during such fiscal year, of administration of this title, title VIII, title XVI, and title XVIII for which the Commissioner is responsible and of carrying out the functions of the Social Security

[14] See Vol. II, P.L. 94–202, §8(f), with respect to making the estimates required under this clause.

[15] See Vol. II, P.L. 92–603, §305(b), with respect to repayment of expenditures made from OASDI Trust Funds for costs of administration of title XVI of the Social Security Act.

[16] See Vol. II, P.L. 104–121, §103(d), with respect to use of funds and reports with regard to continuing disability reviews.

Administration, specified in section 232, which relate to the administration of provisions of the Internal Revenue Code of 1986 (other than those referred to in clause (i) of the first sentence of subparagraph (A)) and the functions of the Social Security Administration in connection with the withholding of taxes from benefits, as described in section 207(c), pursuant to requests by persons entitled to such benefits or such persons' representative payee, which should have been borne by the general fund of the Treasury,

(II) the portion of such costs which should have been borne by the Federal Old-Age and Survivors Insurance Trust Fund,

(III) the portion of such costs which should have been borne by the Federal Disability Insurance Trust Fund,

(IV) the portion of such costs which should have been borne by the Federal Hospital Insurance Trust Fund, and

(V) the portion of such costs which should have been borne by the Federal Supplementary Medical Insurance Trust Fund (and, of such portion, the portion of such costs which should have been borne by the Medicare Prescription Drug Account in such Trust Fund)[17], and

(ii) the Secretary of Health and Human Services shall determine—

(I) the portion of the costs, incurred during such fiscal year, of the administration of title XVIII for which the Secretary is responsible, which should have been borne by the general fund of the Treasury,

(II) the portion of such costs which should have been borne by the Federal Hospital Insurance Trust Fund, and

(III) the portion of such costs which should have been borne by the Federal Supplementary Medical Insurance Trust Fund (and, of such portion, the portion of such costs which should have been borne by the Medicare Prescription Drug Account in such Trust Fund)[18] .

(C) After the determinations under subparagraph (B) have been made for any fiscal year, the Commissioner of Social Security and the Secretary shall each certify to the Managing Trustee the amounts, if any, which should be transferred from one to any of the other such Trust Funds and the amounts, if any, which should be transferred between the Trust Funds (or one of the Trust Funds) and the general fund of the Treasury, in order to ensure that each of the Trust Funds and the general fund of the Treasury

[17] P.L. 108-173, §101(e)(3)(A)(i), inserted "(and, of such portion, the portion of such costs which should have been borne by the Medicare Prescription Drug Account in such Trust Fund)", effective December 8, 2003.

[18] P.L. 108-173, §101(e)(3)(A)(ii), inserted "(and, of such portion, the portion of such costs which should have been borne by the Medicare Prescription Drug Account in such Trust Fund)", effective December 8, 2003.

have borne their proper share of the costs, incurred during such fiscal year, for—

(i) the parts of the administration of this title, title VIII, title XVI, and title XVIII for which the Commissioner of Social Security is responsible,

(ii) the parts of the administration of title XVIII for which the Secretary is responsible, and

(iii) carrying out the functions of the Social Security Administration, specified in section 232, which relate to the administration of provisions of the Internal Revenue Code of 1986 (other than those referred to in clause (i) of the first sentence of subparagraph (A)) and the functions of the Social Security Administration in connection with the withholding of taxes from benefits, as described in section 207(c), pursuant to requests by persons entitled to such benefits or such persons' representative payee.

The Managing Trustee shall transfer any such amounts in accordance with any certification so made.

(D) The determinations required under subclauses (IV) and (V) of subparagraph (B)(i) shall be made in accordance with the cost allocation methodology in existence on the date of the enactment of the Social Security Independence and Program Improvements Act of 1994, until such time as the methodology for making the determinations required under such subclauses is revised by agreement of the Commissioner and the Secretary, except that the determination of the amounts to be borne by the general fund of the Treasury with respect to expenditures incurred in carrying out the functions of the Social Security Administration specified in section 232 and the functions of the Social Security Administration in connection with the withholding of taxes from benefits as described in section 207(c) shall be made pursuant to the applicable method prescribed under paragraph (4).

(2) The Managing Trustee is directed to pay from time to time from the Trust Funds into the Treasury the amount estimated by him as taxes imposed under section 3101(a) of the Internal Revenue Code of 1986 which are subject to refund under section 6413(c) of such Code with respect to wages (as defined in section 3121 of such Code).[19] with respect to wages (as defined in section 1426 of the Internal Revenue Code of 1939 and section 3121 of the Internal Revenue Code of 1954) paid after December 31, 1950. Such taxes shall be determined on the basis of the records of wages maintained by the Commissioner of Social Security in accordance with the wages reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of such Code, and the Commissioner of Social Security shall furnish the Managing Trustee such information as may be required by the Trustee for such purpose. The payments by the Managing Trustee shall be covered into the Treasury as repayments to the account for refunding internal revenue collections. Payments pursuant to the first sentence of this paragraph shall be made from the Federal Old-Age and

[19] As in original.

Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund in the ratio in which amounts were appropriated to such Trust Funds under clause (3) of subsection (a) of this section and clause (1) of subsection (b) of this section.

(3) Repayments made under paragraph (1) or (2) shall not be available for expenditures but shall be carried to the surplus fund of the Treasury. If it subsequently appears that the estimates under either such paragraph in any particular period were too high or too low, appropriate adjustments shall be made by the Managing Trustee in future payments.

(4) The Commissioner of Social Security shall utilize the method prescribed pursuant to this paragraph, as in effect immediately before the date of the enactment of the Social Security Independence and Program Improvements Act of 1994, for determining the costs which should be borne by the general fund of the Treasury of carrying out the functions of the Commissioner, specified in section 232, which relate to the administration of provisions of the Internal Revenue Code of 1986 (other than those referred to in clause (i) of the first sentence of paragraph (1)(A)). The Board of Trustees of such Trust Funds shall prescribe the method of determining the costs which should be borne by the general fund in the Treasury of carrying out the functions of the Social Security Administration in connection with the withholding of taxes from benefits, as described in section 207(c), pursuant to requests by persons entitled to such benefits or such persons' representative payee. If at any time or times thereafter the Boards of Trustees of such Trust Funds consider such action advisable, they may modify the method of determining such costs.[20]

(h) Benefit payments required to be made under section 223, and benefit payments required to be made under subsection (b), (c), or (d) of section 202 to individuals entitled to benefits on the basis of the wages and self-employment income of an individual entitled to disability insurance benefits, shall be made only from the Federal Disability Insurance Trust Fund. All other benefit payments required to be made under this title (other than section 226) shall be made only from the Federal Old-Age and Survivors Insurance Trust Fund.

(i)(1) The Managing Trustee may accept on behalf of the United States money gifts and bequests made unconditionally to the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, the Federal Hospital Insurance Trust Fund, or the Federal Supplementary Medical Insurance Trust Fund (and for the Medicare Prescription Drug Account and the Transitional Assistance Account in such Trust Fund)[21] or to the Social Security Administration, the Department of Health and Human Services, or any part or officer thereof, for the benefit of any of such Funds or any activity financed through such Funds.[22]

(2) Any such gift accepted pursuant to the authority granted in paragraph (1) of this subsection shall be deposited in—

(A) the specific trust fund designated by the donor or

[20] See Vol. II, P.L. 94–202, §8(e), with respect to employment of assistants.

[21] P.L. 108-173, §101(e)(3)(B), inserted "(and for the Medicare Prescription Drug Account and the Transitional Assistance Account in such Trust Fund)", effective December 8, 2003.

[22] See Vol. II, P.L. 92–603, §132(g), with respect to tax treatment of gifts or bequests to the Trust Funds.

(B) if the donor has not so designated, the Federal Old-Age and Survivors Insurance Trust Fund.

(j) There are authorized to be made available for expenditure, out of the Federal Old-Age and Survivors Insurance Trust Fund, or the Federal Disability Insurance Trust Fund (as determined appropriate by the Commissioner of Social Security), such amounts as are required to pay travel expenses, either on an actual cost or commuted basis, to individuals for travel incident to medical examinations requested by the Commissioner of Social Security in connection with disability determinations under this title, and to parties, their representatives, and all reasonably necessary witnesses for travel within the United States (as defined in section 210(i)) to attend reconsideration interviews and proceedings before administrative law judges with respect to any determination under this title. The amount available under the preceding sentence for payment for air travel by any person shall not exceed the coach fare for air travel between the points involved unless the use of first-class accommodations is required (as determined under regulations of the Commissioner of Social Security) because of such person's health condition or the unavailability of alternative accommodations; and the amount available for payment for other travel by any person shall not exceed the cost of travel (between the points involved) by the most economical and expeditious means of transportation appropriate to such person's health condition, as specified in such regulations. The amount available for payment under this subsection for travel by a representative to attend an administrative proceeding before an administrative law judge or other adjudicator shall not exceed the maximum amount allowable under this subsection for such travel originating within the geographic area of the office having jurisdiction over such proceeding.

(k) Expenditures made for experiments and demonstration projects under section 234 shall be made from the Federal Disability Insurance Trust Fund and the Federal Old-Age and Survivors Insurance Trust Fund, as determined appropriate by the Commissioner of Social Security.

(l)(1) If at any time prior to January 1988 the Managing Trustee determines that borrowing authorized under this subsection is appropriate in order to best meet the need for financing the benefit payments from the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund, the Managing Trustee may borrow such amounts as he determines to be appropriate from the other such Trust Fund, or, subject to paragraph (5), from the Federal Hospital Insurance Trust Fund established under section 1817, for transfer to and deposit in the Trust Fund whose need for financing is involved.

(2) In any case where a loan has been made to a Trust Fund under paragraph (1), there shall be transferred on the last day of each month after such loan is made, from the borrowing Trust Fund to the lending Trust Fund, the total interest accrued to such day with respect to the unrepaid balance of such loan at a rate equal to the rate which the lending Trust Fund would earn on the amount involved if the loan were an investment under subsection (d) (even if such an investment would earn interest at a rate different than the rate earned by investments redeemed by the lending fund in order to make the loan).

(3)(A) If in any month after a loan has been made to a Trust Fund under paragraph (1), the Managing Trustee determines that the assets of such Trust Fund are sufficient to permit repayment of all or part of any loans made to such Fund under paragraph (1), he shall make such repayments as he determines to be appropriate.

(B)(i) If on the last day of any year after a loan has been made under paragraph (1) by the Federal Hospital Insurance Trust Fund to the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund, the Managing Trustee determines that the OASDI trust fund ratio exceeds 15 percent, he shall transfer from the borrowing Trust Fund to the Federal Hospital Insurance Trust Fund an amount that—

(I) together with any amounts transferred from another borrowing Trust Fund under this paragraph for such year, will reduce the OASDI trust fund ratio to 15 percent; and

(II) does not exceed the outstanding balance of such loan.

(ii) Amounts required to be transferred under clause (i) shall be transferred on the last day of the first month of the year succeeding the year in which the determination described in clause (i) is made.

(iii) For purposes of this subparagraph, the term "OASDI trust fund ratio" means, with respect to any calendar year, the ratio of—

(I) the combined balance in the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, as of the last day of such calendar year, to

(II) the amount estimated by the Commissioner of Social Security to be the total amount to be paid from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund during the calendar year following such calendar year for all purposes authorized by section 201 (other than payments of interest on, and repayments of, loans from the Federal Hospital Insurance Trust Fund under paragraph (1), but excluding any transfer payments between such trust funds and reducing the amount of any transfer to the Railroad Retirement Account by the amount of any transfers into either such trust fund from that Account).

(C)(i) The full amount of all loans made under paragraph (1) (whether made before or after January 1, 1983) shall be repaid at the earliest feasible date and in any event no later than December 31, 1989.

(ii) For the period after December 31, 1987, and before January 1, 1990, the Managing Trustee shall transfer each month to the Federal Hospital Insurance Trust Fund from any Trust Fund with any amount outstanding on a loan made from the Federal Hospital Insurance Trust Fund under paragraph (1) an amount

not less than an amount equal to (I) the amount owed to the Federal Hospital Insurance Trust Fund by such Trust Fund at the beginning of such month (plus the interest accrued on the outstanding balance of such loan during such month), divided by (II) the number of months elapsing after the preceding month and before January 1990. The Managing Trustee may, during this period, transfer larger amounts than prescribed by the preceding sentence.

(4) The Board of Trustees shall make a timely report to the Congress of any amounts transferred (including interest payments) under this subsection.

(5)(A) No amounts may be borrowed from the Federal Hospital Insurance Trust Fund under paragraph (1) during any month if the Hospital Insurance Trust Fund ratio for such month is less than 10 percent.

(B) For purposes of this paragraph, the term "Hospital Insurance Trust Fund ratio" means, with respect to any month, the ratio of—

(i) the balance in the Federal Hospital Insurance Trust Fund, reduced by the outstanding amount of any loan (including interest thereon) theretofore made to such Trust Fund under this subsection, as of the last day of the second month preceding such month, to

(ii) the amount obtained by multiplying by twelve the total amount which (as estimated by the Secretary) will be paid from the Federal Hospital Insurance Trust Fund during the month for which such ratio is to be determined (other than payments of interest on, or repayments of loans from another Trust Fund under this subsection), and reducing the amount of any transfers to the Railroad Retirement Account by the amount of any transfer into the Hospital Insurance Trust Fund from that Account.

(m)(1) The Secretary of the Treasury shall implement procedures to permit the identification of each check issued for benefits under this title that has not been presented for payment by the close of the sixth month following the month of its issuance.

(2) The Secretary of the Treasury shall, on a monthly basis, credit each of the Trust Funds for the amount of all benefit checks (including interest thereon) drawn on such Trust Fund more than 6 months previously but not presented for payment and not previously credited to such Trust Fund, to the extent provided in advance in appropriation Acts.

(3) If a benefit check is presented for payment to the Treasury and the amount thereof has been previously credited pursuant to paragraph (2) to one of the Trust Funds, the Secretary of the Treasury shall nevertheless pay such check, if otherwise proper, recharge such Trust Fund, and notify the Commissioner of Social Security.

(4) A benefit check bearing a current date may be issued to an individual who did not negotiate the original benefit check and who surrenders such check for cancellation if the Secretary of the Treasury determines it is necessary to effect proper payment of benefits.

(n)[23] Not later than July 1, 2004, the Secretary of the Treasury shall transfer, from amounts in the general fund of the Treasury that are not otherwise appropriated—

(1) $624,971,854 to the Federal Old-Age and Survivors Insurance Trust Fund;

(2) $105,379,671 to the Federal Disability Insurance Trust Fund; and

(3) $173,306,134 to the Federal Hospital Insurance Trust Fund.

Amounts transferred in accordance with this subsection shall be in satisfaction of certain outstanding obligations for deemed wage credits for 2000 and 2001.

OLD–AGE AND SURVIVORS INSURANCE BENEFIT PAYMENTS[24]

Old–Age Insurance Benefits

SEC. 202. [42 U.S.C. 402] (a) Every individual who—

(1) is a fully insured individual (as defined in section 214(a)),

(2) has attained age 62, and

(3) has filed application for old–age insurance benefits or was entitled to disability insurance benefits for the month preceding the month in which he attained retirement age (as defined in section 216(l)),

shall be entitled to an old–age insurance benefit for each month, beginning with—

(A) in the case of an individual who has attained retirement age (as defined in section 216(l)), the first month in which such individual meets the criteria specified in paragraphs (1), (2), and (3), or

(B) in the case of an individual who has attained age 62, but has not attained retirement age (as defined in section 216(l)), the first month throughout which such individual meets the criteria specified in paragraphs (1) and (2) (if in that month he meets the criterion specified in paragraph (3)),

and ending with the month preceding the month in which he dies. Except as provided in subsection (q) and subsection (w), such individual's old–age insurance benefit for any month shall be equal to his primary insurance amount (as defined in section 215(a)) for such month.

Wife's Insurance Benefits

(b)(1) The wife (as defined in section 216(b)) and every divorced wife (as defined in section 216(d)) of an individual entitled to old–age or disability insurance benefits, if such wife or such divorced wife—

(A) has filed application for wife's insurance benefits,

[23] P.L. 108–203, §420(a), added subsection (n), effective March 2, 2004.

[24] See Vol. II, P.L. 88–525, §11(i) and (j), with respect to applications for food stamps.

See Vol. II, P.L. 97–377, §156(d), with respect to information furnished for determination of payments to surviving spouses of members of the Armed Forces.

See Vol. II, P.L. 98–21, §131(d)(2), with respect to the application requirement for individuals not entitled to benefits for December 1993.

See Vol. II, P.L. 106–170, §302, with respect to demonstration projects providing for reductions in disability benefits based on earnings.

(B) has attained age 62 or (in the case of a wife) has in her care (individually or jointly with such individual) at the time of filing such application a child entitled to a child's insurance benefit on the basis of the wages and self-employment income of such individual,

(C) in the case of a divorced wife, is not married, and

(D) is not entitled to old–age or disability insurance benefits, or is entitled to old–age or disability insurance benefits based on a primary insurance amount which is less than one-half of the primary insurance amount of such individual,

shall (subject to subsection (s)) be entitled to a wife's insurance benefit for each month, beginning with—

(i) in the case of a wife or divorced wife (as so defined) of an individual entitled to old-age benefits, if such wife or divorced wife has attained retirement age (as defined in section 216(l)), the first month in which she meets the criteria specified in subparagraphs (A), (B), (C), and (D), or

(ii) in the case of a wife or divorced wife (as so defined) of—

(I) an individual entitled to old-age insurance benefits, if such wife or divorced wife has not attained retirement age (as defined in section 216(l)), or

(II) an individual entitled to disability insurance benefits,

the first month throughout which she is such a wife or divorced wife and meets the criteria specified in subparagraphs (B), (C), and (D) (if in such month she meets the criterion specified in subparagraph (A)),

whichever is earlier, and ending with the month preceding the month in which any of the following occurs—

(E) she dies,

(F) such individual dies,

(G) in the case of a wife, they are divorced and either (i) she has not attained age 62, or (ii) she has attained age 62 but has not been married to such individual for a period of 10 years immediately before the date the divorce became effective,

(H) in the case of a divorced wife, she marries a person other than such individual,

(I) in the case of a wife who has not attained age 62, no child of such individual is entitled to a child's insurance benefit,

(J) she becomes entitled to an old-age or disability insurance benefit based on a primary insurance amount which is equal to or exceeds one-half of the primary insurance amount of such individual, or

(K) such individual is not entitled to disability insurance benefits and is not entitled to old-age insurance benefits.

(2) Except as provided in subsections (k)(5) and (q)[25], such wife's insurance benefit for each month shall be equal to one-

[25] P.L. 108–203, §418(b)(1)(A), struck out "subsection (q) and paragraph (4) of this subsection" and substituted "subsections (k)(5) and (q)".

half of the primary insurance amount of her husband (or, in the case of a divorced wife, her former husband) for such month.

(3) In the case of any divorced wife who marries—

(A) an individual entitled to benefits under subsection (c), (f), (g), or (h) of this section, or

(B) an individual who has attained the age of 18 and is entitled to benefits under subsection (d),

such divorced wife's entitlement to benefits under this subsection shall, notwithstanding the provisions of paragraph (1) (but subject to subsection (s)), not be terminated by reason of such marriage.

(4)[26] (A) Notwithstanding the preceding provisions of this subsection, except as provided in subparagraph (B), the divorced wife of an individual who is not entitled to old-age or disability insurance benefits, but who has attained age 62 and is a fully insured individual (as defined in section 214), if such divorced wife—

(i) meets the requirements of subparagraphs (A) through (D) of paragraph (1), and

(ii) has been divorced from such insured individual for not less than 2 years,

shall be entitled to a wife's insurance benefit under this subsection for each month, in such amount, and beginning and ending with such months, as determined (under regulations of the Commissioner of Social Security) in the manner otherwise provided for wife's insurance benefits under this subsection, as if such insured individual had become entitled to old-age insurance benefits on the date on which the divorced wife first meets the criteria for entitlement set forth in clauses (i) and (ii).

(B) A wife's insurance benefit provided under this paragraph which has not otherwise terminated in accordance with subparagraph (E), (F), (H), or (J) of paragraph (1) shall terminate with the month preceding the first month in which the insured individual is no longer a fully insured individual.

Husband's Insurance Benefits

(c)(1) The husband (as defined in section 216(f)) and every divorced husband (as defined in section 216(d)) of an individual entitled to old-age or disability insurance benefits, if such husband or such divorced husband—

(A) has filed application for husband's insurance benefits,

(B) has attained age 62 or (in the case of a husband) has in his care (individually or jointly with such individual) at the time of filing such application a child entitled to child's insurance benefits on the basis of the wages and self-employment income of such individual,

[26] P.L. 108–203, §418(b)(1)(B), struck out the former paragraph (4) and redesignated the former paragraph (5) as paragraph (4). For the effective date, see Vol. II, P.L. 108–203, §418(c).

For paragraph (4), as it formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L. 108-203.

(C) in the case of a divorced husband, is not married, and

(D) is not entitled to old-age or disability insurance benefits, or is entitled to old-age or disability insurance benefits based on a primary insurance amount which is less than one-half of the primary insurance amount of such individual,

shall (subject to subsection (s)) be entitled to a husband's insurance benefit for each month, beginning with—

(i) in the case of a husband or divorced husband (as so defined) of an individual who is entitled to an old-age insurance benefit, if such husband or divorced husband has attained retirement age (as defined in section 216(l)), the first month in which he meets the criteria specified in subparagraphs (A), (B), (C), and (D), or

(ii) in the case of a husband or divorced husband (as so defined) of—

(I) an individual entitled to old-age insurance benefits, if such husband or divorced husband has not attained retirement age (as defined in section 216(l)), or

(II) an individual entitled to disability insurance benefits,

the first month throughout which he is such a husband or divorced husband and meets the criteria specified in subparagraphs (B), (C), and (D) (if in such month he meets the criterion specified in subparagraph (A)),

whichever is earlier, and ending with the month preceding the month in which any of the following occurs:

(E) he dies,

(F) such individual dies,

(G) in the case of a husband, they are divorced and either (i) he has not attained age 62, or (ii) he has attained age 62 but has not been married to such individual for a period of 10 years immediately before the divorce became effective,

(H) in the case of a divorced husband, he marries a person other than such individual,

(I) in the case of a husband who has not attained age 62, no child of such individual is entitled to a child's insurance benefit,

(J) he becomes entitled to an old-age or disability insurance benefit based on a primary insurance amount which is equal to or exceeds one-half of the primary insurance amount of such individual, or

(K) such individual is not entitled to disability insurance benefits and is not entitled to old-age insurance benefits.

(2)[27] Except as provided in subsections (k)(5) and (q)[28], such husband's insurance benefit for each month shall be equal to

[27] P.L. 108–203, §418(b)(2)(A), struck out the former paragraph (2) and redesignated the former paragraphs (3), (4), and (5) as paragraphs (2), (3), and (4), respectively. For the effective date, see Vol. II, P.L. 108-203, §418(c). For paragraph (2) as it formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L. 108-203.

[28] P.L. 108–203, §418(b)(2)(B), struck out "subsection (q) and paragraph (2) of this subsection" and substituted "subsections (k)(5) and (q)".

one-half of the primary insurance amount of his wife (or, in the case of a divorced husband, his former wife) for such month.

(3) In the case of any divorced husband who marries—

(A) an individual entitled to benefits under subsection (b), (e), (g), or (h) of this section, or

(B) an individual who has attained the age of 18 and is entitled to benefits under subsection (d), by reason of paragraph (1)(B)(ii) thereof,

such divorced husband's entitlement to benefits under this subsection, notwithstanding the provisions of paragraph (1) (but subject to subsection (s)), shall not be terminated by reason of such marriage.

(4)(A) Notwithstanding the preceding provisions of this subsection, except as provided in subparagraph (B), the divorced husband of an individual who is not entitled to old-age or disability insurance benefits, but who has attained age 62 and is a fully insured individual (as defined in section 214), if such divorced husband—

(i) meets the requirements of subparagraphs (A) through (D) of paragraph (1), and

(ii) has been divorced from such insured individual for not less than 2 years,

shall be entitled to a husband's insurance benefit under this subsection for each month, in such amount, and beginning and ending with such months, as determined (under regulations of the Commissioner of Social Security) in the manner otherwise provided for husband's insurance benefits under this subsection, as if such insured individual had become entitled to old-age insurance benefits on the date on which the divorced husband first meets the criteria for entitlement set forth in clauses (i) and (ii).

(B) A husband's insurance benefit provided under this paragraph which has not otherwise terminated in accordance with subparagraph (E), (F), (H), or (J) of paragraph (1) shall terminate with the month preceding the first month in which the insured individual is no longer a fully insured individual.

Child's Insurance Benefits

(d)(1) Every child (as defined in section 216(e)) of an individual entitled to old-age or disability insurance benefits, or of an individual who dies a fully or currently insured individual, if such child—

(A) has filed application for child's insurance benefits,

(B) at the time such application was filed was unmarried and (i) either had not attained the age of 18 or was a full-time elementary or secondary school student and had not attained the age of 19, or (ii) is under a disability (as defined in section 223(d)) which began before he attained the age of 22, and

(C) was dependent upon such individual—

(i) if such individual is living, at the time such application was filed,

(ii) if such individual has died, at the time of such death, or

(iii) if such individual had a period of disability which continued until he became entitled to old-age or

disability insurance benefits, or (if he has died) until the month of his death, at the beginning of such period of disability or at the time he became entitled to such benefits,

shall be entitled to a child's insurance benefit for each month, beginning with—

(i) in the case of a child (as so defined) of such an individual who has died, the first month in which such child meets the criteria specified in subparagraphs (A), (B), and (C), or

(ii) in the case of a child (as so defined) of an individual entitled to an old-age insurance benefit or to a disability insurance benefit, the first month throughout which such child is a child (as so defined) and meets the criteria specified in subparagraphs (B) and (C) (if in such month he meets the criterion specified in subparagraph (A)),

whichever is earlier, and ending with the month preceding whichever of the following first occurs—

(D) the month in which such child dies, or marries,

(E) the month in which such child attains the age of 18, but only if he (i) is not under a disability (as so defined) at the time he attains such age, and (ii) is not a full-time elementary or secondary school student during any part of such month,

(F) if such child was not under a disability (as so defined) at the time he attained the age of 18, the earlier of—

(i) the first month during no part of which he is a full-time elementary or secondary school student, or

(ii) the month in which he attains the age of 19,

but only if he was not under a disability (as so defined) in such earlier month;

(G) if such child was under a disability (as so defined) at the time he attained the age of 18 or if he was not under a disability (as so defined) at such time but was under a disability (as so defined) at or prior to the time he attained (or would attain) the age of 22—

(i) the termination month, subject to section 223(e) (and for purposes of this subparagraph, the termination month for any individual shall be the third month following the month in which his disability ceases; except that, in the case of an individual who has a period of trial work which ends as determined by application of section 222(c)(4)(A), the termination month shall be the earlier of (I) the third month following the earliest month after the end of such period of trial work with respect to which such individual is determined to no longer be suffering from a disabling physical or mental impairment, or (II) the third month following the earliest month in which such individual engages or is determined able to engage in substantial gainful activity, but in no event earlier than the first month occurring after the 36 months following such period of trial work in which he engages or is determined able to engage in substantial gainful activity),

or (if later) the earlier of—

(ii) the first month during no part of which he is a full-time elementary or secondary school student, or

(iii) the month in which he attains the age of 19,

but only if he was not under a disability (as so defined) in such earlier month; or

(H) if the benefits under this subsection are based on the wages and self–employment income of a stepparent who is subsequently divorced from such child's natural parent, the month after the month in which such divorce becomes final.

Entitlement of any child to benefits under this subsection on the basis of the wages and self-employment income of an individual entitled to disability insurance benefits shall also end with the month before the first month for which such individual is not entitled to such benefits unless such individual is, for such later month, entitled to old-age insurance benefits or unless he dies in such month. No payment under this paragraph may be made to a child who would not meet the definition of disability in section 223(d) except for paragraph (1)(B) thereof for any month in which he engages in substantial gainful activity.

(2) Such child's insurance benefit for each month shall, if the individual on the basis of whose wages and self-employment income the child is entitled to such benefit has not died prior to the end of such month, be equal to one-half of the primary insurance amount of such individual for such month. Such child's insurance benefit for each month shall, if such individual has died in or prior to such month, be equal to three-fourths of the primary insurance amount of such individual.

(3) A child shall be deemed dependent upon his father or adopting father or his mother or adopting mother at the time specified in paragraph (1)(C) unless, at such time, such individual was not living with or contributing to the support of such child and—

(A) such child is neither the legitimate nor adopted child of such individual, or

(B) such child has been adopted by some other individual.

For purposes of this paragraph, a child deemed to be a child of a fully or currently insured individual pursuant to section 216(h)(2)(B) or section 216(h)(3) shall be deemed to be the legitimate child of such individual.

(4) A child shall be deemed dependent upon his stepfather or stepmother at the time specified in paragraph (1)(C) if, at such time, the child was receiving at least one-half of his support from such stepfather or stepmother.

(5) In the case of a child who has attained the age of eighteen and who marries—

(A) an individual entitled to benefits under subsection (a), (b), (c), (e), (f), (g), or (h) of this section or under section 223(a), or

(B) another individual who has attained the age of eighteen and is entitled to benefits under this subsection,

such child's entitlement to benefits under this subsection shall, notwithstanding the provisions of paragraph (1) but subject to subsection (s), not be terminated by reason of such marriage.

(6) A child whose entitlement to child's insurance benefits on the basis of the wages and self-employment income of an insured individual terminated with the month preceding the month in which such child attained the age of 18, or with a subsequent month, may again become entitled to such benefits (provided no event specified in paragraph (1)(D) has occurred) beginning with the first month thereafter in which he—

(A)(i) is a full-time elementary or secondary school student and has not attained the age of 19, or (ii) is under a disability (as defined in section 223(d)) and has not attained the age of 22, or

(B) is under a disability (as so defined) which began (i)[29] before the close of the 84th month following the month in which his most recent entitlement to child's insurance benefits terminated because he ceased to be under such disability, or (ii) after the close of the 84th month following the month in which his most recent entitlement to child's insurance benefits terminated because he ceased to be under such disability due to performance of substantial gainful activity,[30]

but only if he has filed application for such reentitlement. Such reentitlement shall end with the month preceding whichever of the following first occurs:

(C) the first month in which an event specified in paragraph (1)(D) occurs;

(D) the earlier of (i) the first month during no part of which he is a full-time elementary or secondary school student or (ii) the month in which he attains the age of 19, but only if he is not under a disability (as so defined) in such earlier month; or

(E) if he was under a disability (as so defined), the termination month (as defined in paragraph (1)(G)(i)), subject to section 223(e), or (if later) the earlier of—

(i) the first month during no part of which he is a full-time elementary or secondary school student, or

(ii) the month in which he attains the age of 19.

(7) For the purposes of this subsection—

(A) A "full-time elementary or secondary school student" is an individual who is in full-time attendance as a student at an elementary or secondary school, as determined by the Commissioner of Social Security (in accordance with regulations prescribed by the Commissioner) in the light of the standards and practices of the schools involved, except that no individual shall be considered a "full-time elementary or secondary school student" if he is paid by his employer while attending an elementary or secondary school at the request, or pursuant to a requirement, of his employer. An individual shall not be considered a "full-time elementary or secondary school student" for the purpose of this section while that individual is confined in a jail, prison, or other penal institution or correctional facility, pursuant to his conviction of an offense (committed after the

[29] P.L. 108-203, §420A(a)(i), inserted "(i)".

[30] P.L. 108-203, §420A(a)(2), added "or" and clause (ii) and a comma, effective with respect to benefits payable for months beginning October 2004.

effective date of this sentence[31]) which constituted a felony under applicable law. An individual who is determined to be a full-time elementary or secondary school student shall be deemed to be such a student throughout the month with respect to which such determination is made.

(B) Except to the extent provided in such regulations, an individual shall be deemed to be a full-time elementary or secondary school student during any period of nonattendance at an elementary or secondary school at which he has been in full-time attendance if (i) such period is 4 calendar months or less, and (ii) he shows to the satisfaction of the Commissioner of Social Security that he intends to continue to be in full-time attendance at an elementary or secondary school immediately following such period. An individual who does not meet the requirement of clause (ii) with respect to such period of nonattendance shall be deemed to have met such requirement (as of the beginning of such period) if he is in full-time attendance at an elementary or secondary school immediately following such period.

(C)(i) An "elementary or secondary school" is a school which provides elementary or secondary education, respectively, as determined under the law of the State or other jurisdiction in which it is located.

(ii) For the purpose of determining whether a child is a "full-time elementary or secondary school student" or "intends to continue to be in full-time attendance at an elementary or secondary school", within the meaning of this subsection, there shall be disregarded any education provided, or to be provided, beyond grade 12.

(D) A child who attains age 19 at a time when he is a full-time elementary or secondary school student (as defined in subparagraph (A) of this paragraph and without application of subparagraph (B) of such paragraph) but has not (at such time) completed the requirements for, or received, a diploma or equivalent certificate from a secondary school (as defined in subparagraph (C)(i)) shall be deemed (for purposes of determining whether his entitlement to benefits under this subsection has terminated under paragraph (1)(F) and for purposes of determining his initial entitlement to such benefits under clause (i) of paragraph (1)(B)) not to have attained such age until the first day of the first month following the end of the quarter or semester in which he is enrolled at such time (or, if the elementary or secondary school (as defined in this paragraph) in which he is enrolled is not operated on a quarter or semester system, until the first day of the first month following the completion of the course in which he is so enrolled or until the first day of the third month beginning after such time, whichever first occurs).

(8) In the case of—

[31] October 1, 1980 [P.L. 96–473, §5(b); 94 Stat. 2265].

(A) an individual entitled to old-age insurance benefits (other than an individual referred to in subparagraph (B)), or

(B) an individual entitled to disability insurance benefits, or an individual entitled to old-age insurance benefits who was entitled to disability insurance benefits for the month preceding the first month for which he was entitled to old-age insurance benefits,

a child of such individual adopted after such individual became entitled to such old-age or disability insurance benefits shall be deemed not to meet the requirements of clause (i) or (iii) of paragraph (1)(C) unless such child—

(C) is the natural child or stepchild of such individual (including such a child who was legally adopted by such individual), or

(D)(i) was legally adopted by such individual in an adoption decreed by a court of competent jurisdiction within the United States, and

(ii) in the case of a child who attained the age of 18 prior to the commencement of proceedings for adoption, the child was living with or receiving at least one-half of the child's support from such individual for the year immediately preceding the month in which the adoption is decreed.

(9)(A) A child who is a child of an individual under clause (3) of the first sentence of section 216(e) and is not a child of such individual under clause (1) or (2) of such first sentence shall be deemed not to be dependent on such individual at the time specified in subparagraph (1)(C) of this subsection unless (i) such child was living with such individual in the United States and receiving at least one-half of his support from such individual (I) for the year immediately before the month in which such individual became entitled to old-age insurance benefits or disability insurance benefits or died, or (II) if such individual had a period of disability which continued until he had become entitled to old-age insurance benefits, or disability insurance benefits, or died, for the year immediately before the month in which such period of disability began, and (ii) the period during which such child was living with such individual began before the child attained age 18.

(B) In the case of a child who was born in the one-year period during which such child must have been living with and receiving at least one-half of his support from such individual, such child shall be deemed to meet such requirements for such period if, as of the close of such period, such child has lived with such individual in the United States and received at least one-half of his support from such individual for substantially all of the period which begins on the date of such child's birth.

(10) For purposes of paragraph (1)(H)—

(A) each stepparent shall notify the Commissioner of Social Security of any divorce upon such divorce becoming final; and

(B) the Commissioner shall annually notify any stepparent of the rule for termination described in paragraph

(1)(H) and of the requirement described in subparagraph (A).

Widow's Insurance Benefits

(e)(1) The widow (as defined in section 216(c)) and every surviving divorced wife (as defined in section 216(d)) of an individual who died a fully insured individual, if such widow or such surviving divorced wife—

(A) is not married,

(B)(i) has attained age 60, or (ii) has attained age 50 but has not attained age 60 and is under a disability (as defined in section 223(d)) which began before the end of the period specified in paragraph (4),

(C)(i) has filed application for widow's insurance benefits,

(ii) was entitled to wife's insurance benefits, on the basis of the wages and self-employment income of such individual, for the month preceding the month in which such individual died, and—

(I) has attained retirement age (as defined in section 216(l)),

(II) is not entitled to benefits under subsection (a) or section 223, or

(III) has in effect a certificate (described in paragraph (8)) filed by her with the Commissioner of Social Security, in accordance with regulations prescribed by the Commissioner of Social Security, in which she elects to receive widow's insurance benefits (subject to reduction as provided in subsection (q)), or

(iii) was entitled, on the basis of such wages and self-employment income, to mother's insurance benefits for the month preceding the month in which she attained retirement age (as defined in section 216(l)), and

(D) is not entitled to old-age insurance benefits or is entitled to old-age insurance benefits each of which is less than the primary insurance amount (as determined after application of subparagraphs (B) and (C) of paragraph (2)) of such deceased individual,

shall be entitled to a widow's insurance benefit for each month, beginning with—

(E) if she satisfies subparagraph (B) by reason of clause (i) thereof, the first month in which she becomes so entitled to such insurance benefits, or

(F) if she satisfies subparagraph (B) by reason of clause (ii) thereof—

(i) the first month after her waiting period (as defined in paragraph (5)) in which she becomes so entitled to such insurance benefits, or

(ii) the first month during all of which she is under a disability and in which she becomes so entitled to such insurance benefits, but only if she was previously entitled to insurance benefits under this subsection on the basis of being under a disability and such first

month occurs (I) in the period specified in paragraph (4) and (II) after the month in which a previous entitlement to such benefits on such basis terminated,

and ending with the month preceding the first month in which any of the following occurs: she remarries, dies, becomes entitled to an old-age insurance benefit equal to or exceeding the primary insurance amount (as determined after application of subparagraphs (B) and (C) of paragraph (2)) of such deceased individual, or, if she became entitled to such benefits before she attained age 60, subject to section 223(e), the termination month (unless she attains retirement age (as defined in section 216(l)) on or before the last day of such termination month). For purposes of the preceding sentence, the termination month for any individual shall be the third month following the month in which her disability ceases; except that, in the case of an individual who has a period of trial work which ends as determined by application of section 222(c)(4)(A), the termination month shall be the earlier of (I) the third month following the earliest month after the end of such period of trial work with respect to which such individual is determined to no longer be suffering from a disabling physical or mental impairment, or (II) the third month following the earliest month in which such individual engages or is determined able to engage in substantial gainful activity, but in no event earlier than the first month occurring after the 36 months following such period of trial work in which she engages or is determined able to engage in substantial gainful activity.

(2)(A) Except as provided in subsection (k)(5), subsection (q),[32] and subparagraph (D) of this paragraph, such widow's insurance benefit for each month shall be equal to the primary insurance amount (as determined for purposes of this subsection after application of subparagraphs (B) and (C)) of such deceased individual.

(B)(i) For purposes of this subsection, in any case in which such deceased individual dies before attaining age 62 and section 215(a)(1) (as in effect after December 1978) is applicable in determining such individual's primary insurance amount—

(I) such primary insurance amount shall be determined under the formula set forth in section 215(a)(1)(B)(i) and (ii) which is applicable to individuals who initially become eligible for old-age insurance benefits in the second year after the year specified in clause (ii),

(II) the year specified in clause (ii) shall be substituted for the second calendar year specified in section 215(b)(3)(A)(ii)(I), and

(III) such primary insurance amount shall be increased under section 215(i) as if it were the primary insurance amount referred to in section 215(i)(2)(A)(ii)(II), except that it shall be increased only for years beginning after the first year after the year specified in clause (ii).

[32] P.L. 108–203, §418(b)(3)(A), struck out "subsection (q), paragraph (7) of this subsection," and substituted "subsection (k)(5), subsection (q),".

(ii) The year specified in this clause is the earlier of—

(I) the year in which the deceased individual attained age 60, or would have attained age 60 had he lived to that age, or

(II) the second year preceding the year in which the widow or surviving divorced wife first meets the requirements of paragraph (1)(B) or the second year preceding the year in which the deceased individual died, whichever is later.

(iii) This subparagraph shall apply with respect to any benefit under this subsection only to the extent its application does not result in a primary insurance amount for purposes of this subsection which is less than the primary insurance amount otherwise determined for such deceased individual under section 215.

(C) If such deceased individual was (or upon application would have been) entitled to an old-age insurance benefit which was increased (or subject to being increased) on account of delayed retirement under the provisions of subsection (w), then, for purposes of this subsection, such individual's primary insurance amount, if less than the old-age insurance benefit (increased, where applicable, under section 215(f)(5), 215(f)(6), or 215(f)(9)(B) and under section 215(i) as if such individual were still alive in the case of an individual who has died) which he was receiving (or would upon application have received) for the month prior to the month in which he died, shall be deemed to be equal to such old-age insurance benefit, and (notwithstanding the provisions of paragraph (3) of such subsection (w)) the number of increment months shall include any month in the months of the calendar year in which he died, prior to the month in which he died, which satisfy the conditions in paragraph (2) of such subsection (w).

(D) If the deceased individual (on the basis of whose wages and self-employment income a widow or surviving divorced wife is entitled to widow's insurance benefits under this subsection) was, at any time, entitled to an old-age insurance benefit which was reduced by reason of the application of subsection (q), the widow's insurance benefit of such widow or surviving divorced wife for any month shall, if the amount of the widow's insurance benefit of such widow or surviving divorced wife (as determined under subparagraph (A) and after application of subsection (q)) is greater than—

(i) the amount of the old-age insurance benefit to which such deceased individual would have been entitled (after application of subsection (q)) for such month if such individual were still living and section 215(f)(5), 215(f)(6), or 215(f)(9)(B) were applied, where applicable, and

(ii) 82 ½ percent of the primary insurance amount (as determined without regard to subparagraph (C)) of such deceased individual,

be reduced to the amount referred to in clause (i), or (if greater) the amount referred to in clause (ii).

(3) For purposes of paragraph (1), if—

(A) a widow or surviving divorced wife marries after attaining age 60 (or after attaining age 50 if she was entitled before such marriage occurred to benefits based on disability under this subsection), or

(B) a disabled widow or disabled surviving divorced wife described in paragraph (1)(B)(ii) marries after attaining age 50,

such marriage shall be deemed not to have occurred.

(4) The period referred to in paragraph (1)(B)(ii), in the case of any widow or surviving divorced wife, is the period beginning with whichever of the following is the latest:

(A) the month in which occurred the death of the fully insured individual referred to in paragraph (1) on whose wages and self-employment income her benefits are or would be based, or

(B) the last month for which she was entitled to mother's insurance benefits on the basis of the wages and self-employment income of such individual, or

(C) the month in which a previous entitlement to widow's insurance benefits on the basis of such wages and self-employment income terminated because her disability had ceased,

and ending with the month before the month in which she attains age 60, or, if earlier, with the close of the eighty-fourth month following the month with which such period began.

(5)(A) The waiting period referred to in paragraph (1)(F), in the case of any widow or surviving divorced wife, is the earliest period of five consecutive calendar months—

(i) throughout which she has been under a disability, and

(ii) which begins not earlier than with whichever of the following is the later: (I) the first day of the seventeenth month before the month in which her application is filed, or (II) the first day of the fifth month before the month in which the period specified in paragraph (4) begins.

(B) For purposes of paragraph (1)(F)(i), each month in the period commencing with the first month for which such widow or surviving divorced wife is first eligible for supplemental security income benefits under title XVI, or State supplementary payments of the type referred to in section 1616(a) (or payments of the type described in section 212(a) of Public Law 93–66) which are paid by the Commissioner of Social Security under an agreement referred to in section 1616(a) (or in section 212(b) of Public Law 93–66), shall be included as one of the months of such waiting period for which the requirements of subparagraph (A) have been met.

(6) In the case of an individual entitled to monthly insurance benefits payable under this section for any month prior to January 1973 whose benefits were not redetermined under section 102(g) of the Social Security Amendments of 1972[33], such benefits shall not be redetermined pursuant to such section, but

[33] See Vol. II, P.L. 92–603.

shall be increased pursuant to any general benefit increase (as defined in section 215(i)(3)) or any increase in benefits made under or pursuant to section 215(i), including for this purpose the increase provided effective for March 1974, as though such redetermination had been made.

(7)[34] Any certificate filed pursuant to paragraph (1)(C)(ii)(III) shall be effective for purposes of this subsection—

(A) for the month in which it is filed and for any month thereafter, and

(B) for months, in the period designated by the individual filing such certificate, of one or more consecutive months (not exceeding 12) immediately preceding the month in which such certificate is filed;

except that such certificate shall not be effective for any month before the month in which she attains age 62.

(8) An individual shall be deemed to be under a disability for purposes of paragraph (1)(B)(ii) if such individual is eligible for supplemental security income benefits under title XVI, or State supplementary payments of the type referred to in section 1616(a) (or payments of the type described in section 212(a) of Public Law 93–66)[35] which are paid by the Commissioner of Social Security under an agreement referred to in section 1616(a) (or in section 212(b) of Public Law 93–66), for the month for which all requirements of paragraph (1) for entitlement to benefits under this subsection (other than being under a disability) are met.

Widower's Insurance Benefits

(f)(1) The widower (as defined in section 216(g)) and every surviving divorced husband (as defined in section 216(d)) of an individual who died a fully insured individual, if such widower or such surviving divorced husband—

(A) is not married,

(B)(i) has attained age 60, or (ii) has attained age 50 but has not attained age 60 and is under a disability (as defined in section 223(d)) which began before the end of the period specified in paragraph (4)[36],

(C)(i) has filed application for widower's insurance benefits,

(ii) was entitled to husband's insurance benefits, on the basis of the wages and self-employment income of such individual, for the month preceding the month in which such individual died, and—

(I) has attained retirement age (as defined in section 216(l)),

(II) is not entitled to benefits under subsection (a) or section 223, or

(III) has in effect a certificate (described in paragraph (8)) filed by him with the Commissioner of Social Security, in accordance

[34] P.L. 108–203, §418(b)(3)(B), struck out the former paragraph (7), and redesignated the former paragraphs (8) and (9) as paragraphs (7) and (8), respectively. For the effective date, see Vol. II, P.L. 108-203, §418(c). For paragraph (7) as it formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L.108-203.

[35] See Vol. II, P.L. 93–66.

[36] P.L. 108–203, §418(b)(4)(B)(i), struck out "paragraph (5)" and substituted "paragraph (4)".

with regulations prescribed by the Commissioner of Social Security, in which he elects to receive widower's insurance benefits (subject to reduction as provided in subsection (q)), or

(iii) was entitled, on the basis of such wages and self-employment income, to father's insurance benefits for the month preceding the month in which he attained retirement age (as defined in section 216(l)), and

(D) is not entitled to old-age insurance benefits, or is entitled to old-age insurance benefits each of which is less than the primary insurance amount (as determined after application of subparagraphs (B) and (C) of paragraph (3)) of such deceased individual,

shall be entitled to a widower's insurance benefit for each month, beginning with—

(E) if he satisfies subparagraph (B) by reason of clause (i) thereof, the first month in which he becomes so entitled to such insurance benefits, or

(F) if he satisfies subparagraph (B) by reason of clause (ii) thereof—

(i) the first month after his waiting period (as defined in paragraph (5)[37]) in which he becomes so entitled to such insurance benefits, or

(ii) the first month during all of which he is under a disability and in which he becomes so entitled to such insurance benefits, but only if he was previously entitled to insurance benefits under this subsection on the basis of being under a disability and such first month occurs (I) in the period specified in paragraph (4)[38] and (II) after the month in which a previous entitlement to such benefits on such basis terminated,

and ending with the month preceding the first month in which any of the following occurs: he remarries, dies, or becomes entitled to an old-age insurance benefit equal to or exceeding the primary insurance amount (as determined after application of subparagraphs (B) and (C) of paragraph (3)) of such deceased individual, or, if he became entitled to such benefits before he attained age 60, subject to section 223(e), the termination month (unless he attains retirement age (as defined in section 216(l)) on or before the last day of such termination month). For purposes of the preceding sentence, the termination month for any individual shall be the third month following the month in which his disability ceases; except that, in the case of an individual who has a period of trial work which ends as determined by application of section 222(c)(4)(A), the termination month shall be the earlier of (I) the third month following the earliest month after the end of such period of trial work with respect to which such individual is determined to no longer be suffering from a disabling physical or mental impairment, or (II) the third month following the earliest month in which such individual engages or is determined able to engage in substantial gainful activity, but in no event earlier than the first month occurring after the 36 months following such period of trial work in which he en-

[37] P.L. 108–203, §418(b)(4)(B)(ii), struck out "paragraph (6)" and substituted "paragraph (5)".
[38] P.L. 108–203, §418(b)(4)(B)(ii), struck out "paragraph (5)" and substituted "paragraph (4)".

gages or is determined able to engage in substantial gainful activity.

(2)[39](A) Except as provided in subsection (k)(5), subsection (q),[40] and subparagraph (D) of this paragraph, such widower's insurance benefit for each month shall be equal to the primary insurance amount (as determined for purposes of this subsection after application of subparagraphs (B) and (C)) of such deceased individual.

(B)(i) For purposes of this subsection, in any case in which such deceased individual dies before attaining age 62 and section 215(a)(1) (as in effect after December 1978) is applicable in determining such individual's primary insurance amount—

(I) such primary insurance amount shall be determined under the formula set forth in section 215(a)(1)(B)(i) and (ii) which is applicable to individuals who initially become eligible for old-age insurance benefits in the second year after the year specified in clause (ii),

(II) the year specified in clause (ii) shall be substituted for the second calendar year specified in section 215(b)(3)(A)(ii)(I), and

(III) such primary insurance amount shall be increased under section 215(i) as if it were the primary insurance amount referred to in section 215(i)(2)(A)(ii)(II), except that it shall be increased only for years beginning after the first year after the year specified in clause (ii).

(ii) The year specified in this clause is the earlier of—

(I) the year in which the deceased individual attained age 60, or would have attained age 60 had she lived to that age, or

(II) the second year preceding the year in which the widower or surviving divorced husband first meets the requirements of paragraph (1)(B) or the second year preceding the year in which the deceased individual died, whichever is later.

(iii) This subparagraph shall apply with respect to any benefit under this subsection only to the extent its application does not result in a primary insurance amount for purposes of this subsection which is less than the primary insurance amount otherwise determined for such deceased individual under section 215.

(C) If such deceased individual was (or upon application would have been) entitled to an old-age insurance benefit which was increased (or subject to being increased) on account of delayed retirement under the provisions of subsection (w), then, for purposes of this subsection, such individual's primary insurance amount, if less than the old-age insurance benefit (increased, where applicable, under sec-

[39] P.L. 108–203, §418(b)(4)(A)(i), struck out paragraph (2), and redesignated paragraphs (3) through (9) as paragraphs (2) through (8), respectively. For the effective date, see Vol. II, P.L. 108-203, §418(c). For paragraph (2) as it formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L.108-203.

[40] P.L. 108–203, §418(b)(4)(A)(ii), struck out "subsection (q), paragraph (2) of this subsection," and substituted "subsection (k)(5), subsection (q),".

tion 215(f)(5), 215(f)(6), or 215(f)(9)(B) and under section 215(i) as if such individual were still alive in the case of an individual who has died) which she was receiving (or would upon application have received) for the month prior to the month in which she died, shall be deemed to be equal to such old-age insurance benefit, and (notwithstanding the provisions of paragraph (3) of such subsection (w)) the number of increment months shall include any month in the months of the calendar year in which she died, prior to the month in which she died, which satisfy the conditions in paragraph (2) of such subsection (w).

(D) If the deceased individual (on the basis of whose wages and self-employment income a widower or surviving divorced husband is entitled to widower's insurance benefits under this subsection) was, at any time, entitled to an old-age insurance benefit which was reduced by reason of the application of subsection (q), the widower's insurance benefit of such widower or surviving divorced husband for any month shall, if the amount of the widower's insurance benefit of such widower or surviving divorced husband (as determined under subparagraph (A) and after application of subsection (q)) is greater than—

(i) the amount of the old-age insurance benefit to which such deceased individual would have been entitled (after application of subsection (q)) for such month if such individual were still living and section 215(f)(5), 215(f)(6), or 215(f)(9)(B) were applied, where applicable, and

(ii) 82 ½ percent of the primary insurance amount (as determined without regard to subparagraph (C)) of such deceased individual;

be reduced to the amount referred to in clause (i), or (if greater) the amount referred to in clause (ii).

(3) For purposes of paragraph (1), if—

(A) a widower or surviving divorced husband marries after attaining age 60 (or after attaining age 50 if he was entitled before such marriage occurred to benefits based on disability under this subsection), or

(B) a disabled widower or surviving divorced husband described in paragraph (1)(B)(ii) marries after attaining age 50,

such marriage shall be deemed not to have occurred.

(4) The period referred to in paragraph (1)(B)(ii), in the case of any widower or surviving divorced husband, is the period beginning with whichever of the following is the latest:

(A) the month in which occurred the death of the fully insured individual referred to in paragraph (1) on whose wages and self-employment income his benefits are or would be based,

(B) the last month for which he was entitled to father's insurance benefits on the basis of the wages and self-employment income of such individual, or

(C) the month in which a previous entitlement to widower's insurance benefits on the basis of such wages and self-employment income terminated because his disability had ceased,

and ending with the month before the month in which he attains age 60, or, if earlier, with the close of the eighty-fourth month following the month with which such period began.

(5)(A) The waiting period referred to in paragraph (1)(F), in the case of any widower or surviving divorced husband, is the earliest period of five consecutive calendar months—

(i) throughout which he has been under a disability, and

(ii) which begins not earlier than with whichever of the following is the later: (I) the first day of the seventeenth month before the month in which his application is filed, or (II) the first day of the fifth month before the month in which the period specified in paragraph (4)[41] begins.

(B) For purposes of paragraph (1)(F)(i), each month in the period commencing with the first month for which such widower or surviving divorced husband is first eligible for supplemental security income benefits under title XVI, or State supplementary payments of the type referred to in section 1616(a) (or payments of the type described in section 212(a) of Public Law 93–66[42]) which are paid by the Commissioner of Social Security under an agreement referred to in section 1616(a) (or in section 212(b) of Public Law 93–66), shall be included as one of the months of such waiting period for which the requirements of subparagraph (A) have been met.

(6) In the case of an individual entitled to monthly insurance benefits payable under this section for any month prior to January 1973 whose benefits were not redetermined under section 102(g) of the Social Security Amendments of 1972[43], such benefits shall not be redetermined pursuant to such section, but shall be increased pursuant to any general benefit increase (as defined in section 215(i)(3)) or any increase in benefits made under or pursuant to section 215(i), including for this purpose the increase provided effective for March 1974, as though such redetermination had been made.

(7) Any certificate filed pursuant to paragraph (1)(C)(ii)(III) shall be effective for purposes of this subsection—

(A) for the month in which it is filed and for any month thereafter, and

(B) for months, in the period designated by the individual filing such certificate, of one or more consecutive months (not exceeding 12) immediately preceding the month in which such certificate is filed;

except that such certificate shall not be effective for any month before the month in which he attains age 62.

(8) An individual shall be deemed to be under a disability for purposes of paragraph (1)(B)(ii) if such individual is eligible for supplemental security income benefits under title XVI, or State supplementary payments of the type referred to in section 1616(a) (or payments of the type described in section 212(a) of Public Law 93–66) which are paid by the Commissioner of Social Security under an agreement referred to in such section

[41] P.L. 108-203, §418(b)(4)(A)(iii), struck out "paragraph (5)" and substituted "paragraph (4)".
[42] See Vol. II, P.L. 93–66.
[43] See Vol. II, P.L. 92–603.

1616(a) (or in section 212(b) of Public Law 93–66), for the month for which all requirements of paragraph (1) for entitlement to benefits under this subsection (other than being under a disability) are met.

Mother's and Father's Insurance Benefits

(g)(1) The surviving spouse and every surviving divorced parent (as defined in section 216(d)) of an individual who died a fully or currently insured individual, if such surviving spouse or surviving divorced parent—

(A) is not married,

(B) is not entitled to a surviving spouse's insurance benefit,

(C) is not entitled to old-age insurance benefits, or is entitled to old-age insurance benefits each of which is less than three-fourths of the primary insurance amount of such individual,

(D) has filed application for mother's or father's insurance benefits, or was entitled to a spouse's insurance benefit on the basis of the wages and self-employment income of such individual for the month preceding the month in which such individual died,

(E) at the time of filing such application has in his or her care a child of such individual entitled to a child's insurance benefit, and

(F) in the case of a surviving divorced parent—

(i) the child referred to in subparagraph (E) is his or her son, daughter, or legally adopted child, and

(ii) the benefits referred to in such subparagraph are payable on the basis of such individual's wages and self-employment income,

shall (subject to subsection (s)) be entitled to a mother's or father's insurance benefit for each month, beginning with the first month in which he or she becomes so entitled to such insurance benefits and ending with the month preceding the first month in which any of the following occurs: no child of such deceased individual is entitled to a child's insurance benefit, such surviving spouse or surviving divorced parent becomes entitled to an old-age insurance benefit equal to or exceeding three-fourths of the primary insurance amount of such deceased individual, he or she becomes entitled to a surviving spouse's insurance benefit, he or she remarries, or he or she dies. Entitlement to such benefits shall also end, in the case of a surviving divorced parent, with the month immediately preceding the first month in which no son, daughter, or legally adopted child of such surviving divorced parent is entitled to a child's insurance benefit on the basis of the wages and self-employment income of such deceased individual.

(2) Such[44] mother's or father's insurance benefit for each month shall be equal to three-fourths of the primary insurance amount of such deceased individual.

(3) In the case of a surviving spouse or surviving divorced parent who marries—

[44] P.L. 108-203, §418(b)(5)(A), struck out "Except as provided in paragraph (4) of this subsection, such" and substituted "Such".

(A) an individual entitled to benefits under this subsection or subsection (a), (b), (c), (e), (f), or (h), or under section 223(a), or

(B) an individual who has attained the age of eighteen and is entitled to benefits under subsection (d),

the entitlement of such surviving spouse or surviving divorced parent to benefits under this subsection shall, notwithstanding the provisions of paragraph (1) but subject to subsection (s), not be terminated by reason of such marriage.

[(4) Stricken.[45]]

Parent's Insurance Benefits

(h)(1) Every parent (as defined in this subsection) of an individual who died a fully insured individual, if such parent—

(A) has attained age 62,

(B)(i) was receiving at least one-half of his support from such individual at the time of such individual's death or, if such individual had a period of disability which did not end prior to the month in which he died, at the time such period began or at the time of such death, and (ii) filed proof of such support within two years after the date of such death, or, if such individual had such a period of disability, within two years after the month in which such individual filed application with respect to such period of disability or two years after the date of such death, as the case may be,

(C) has not married since such individual's death,

(D) is not entitled to old-age insurance benefits, or is entitled to old-age insurance benefits each of which is less than 82 ½ percent of the primary insurance amount of such deceased individual if the amount of the parent's insurance benefit for such month is determinable under paragraph (2)(A) (or 75 percent of such primary insurance amount in any other case), and

(E) has filed application for parent's insurance benefits,

shall be entitled to a parent's insurance benefit for each month beginning with the first month after August 1950 in which such parent becomes so entitled to such parent's insurance benefits and ending with the month preceding the first month in which any of the following occurs: such parent dies, marries, or becomes entitled to an old-age insurance benefit equal to or exceeding 82 ½ percent of the primary insurance amount of such deceased individual if the amount of the parent's insurance benefit for such month is determinable under paragraph (2)(A) (or 75 percent of such primary insurance amount in any other case).

(2)(A) Except as provided in subparagraphs (B) and (C), such parent's insurance benefit for each month shall be equal to 82 ½ percent of the primary insurance amount of such deceased individual.

(B) For any month for which more than one parent is entitled to parent's insurance benefits on the basis of such deceased individual's wages and self-employment income,

[45] P.L. 108-203, §418(b)(5)(B), struck out paragraph (4). For the effective date, see Vol. II, P.L. 108-203, §418(c). For paragraph (4) as it formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L.108-203.

such benefit for each such parent for such month shall (except as provided in subparagraph (C)) be equal to 75 percent of the primary insurance amount of such deceased individual.

(C) In any case in which—

(i) any parent is entitled to a parent's insurance benefit for a month on the basis of a deceased individual's wages and self-employment income, and

(ii) another parent of such deceased individual is entitled to a parent's insurance benefit for such month on the basis of such wages and self-employment income, and on the basis of an application filed after such month and after the month in which the application for the parent's benefits referred to in clause (i) was filed,

the amount of the parent's insurance benefit of the parent referred to in clause (i) for the month referred to in such clause shall be determined under subparagraph (A) instead of subparagraph (B) and the amount of the parent's insurance benefit of a parent referred to in clause (ii) for such month shall be equal to 150 percent of the primary insurance amount of the deceased individual minus the amount (before the application of section 203(a)) of the benefit for such month of the parent referred to in clause (i).

(3) As used in this subsection, the term "parent" means the mother or father of an individual, a stepparent of an individual by a marriage contracted before such individual attained the age of sixteen, or an adopting parent by whom an individual was adopted before he attained the age of sixteen.

(4) In the case of a parent who marries—

(A) an individual entitled to benefits under this subsection or subsection (b), (c), (e), (f), or (g), or

(B) an individual who has attained the age of eighteen and is entitled to benefits under subsection (d),

such parent's entitlement to benefits under this subsection shall, notwithstanding the provisions of paragraph (1) but subject to subsection (s), not be terminated by reason of such marriage.

Lump-Sum Death Payments

(i) Upon the death, after August 1950, of an individual who died a fully or currently insured individual, an amount equal to three times such individual's primary insurance amount (as determined without regard to the amendments made by section 2201 of the Omnibus Budget Reconciliation Act of 1981[46], relating to the repeal of the minimum benefit provisions), or an amount equal to $255, whichever is the smaller, shall be paid in a lump sum to the person, if any, determined by the Commissioner of Social Security to be the widow or widower of the deceased and to have been living in the same household with the deceased at the time of death. If there is no such person, or if such person dies before receiving payment, then such amount shall be paid—

(1) to a widow (as defined in section 216(c)) or widower (as defined in section 216(g)) who is entitled (or would have been so entitled had a timely application been filed), on the basis of the wages and self-employment income of such insured individ-

[46] P.L. 97–35.

ual, to benefits under subsection (e), (f), or (g) of this section for the month in which occurred such individual's death; or

(2) if no person qualifies for payment under paragraph (1), or if such person dies before receiving payment, in equal shares to each person who is entitled (or would have been so entitled had a timely application been filed), on the basis of the wages and self-employment income of such insured individual, to benefits under subsection (d) of this section for the month in which occurred such individual's death.

No payment shall be made to any person under this subsection unless application therefor shall have been filed, by or on behalf of such person (whether or not legally competent), prior to the expiration of two years after the date of death of such insured individual, or unless such person was entitled to wife's or husband's insurance benefits, on the basis of the wages and self-employment income of such insured individual, for the month preceding the month in which such individual died. In the case of any individual who died outside the forty-eight States and the District of Columbia after December 1953 and before January 1, 1957, whose death occurred while he was in the active military or naval service of the United States, and who is returned to any of such States, the District of Columbia, Alaska, Hawaii, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa for interment or reinterment, the provisions of the preceding sentence shall not prevent payment to any person under the second sentence of this subsection if application for a lump-sum death payment with respect to such deceased individual is filed by or on behalf of such person (whether or not legally competent) prior to the expiration of two years after the date of such interment or reinterment. In the case of any individual who died outside the fifty States and the District of Columbia after December 1956 while he was performing service, as a member of a uniformed service, to which the provisions of section 210(l)(1) are applicable, and who is returned to any State, or to any Territory or possession of the United States, for interment or reinterment, the provisions of the third sentence of this subsection shall not prevent payment to any person under the second sentence of this subsection if application for a lump-sum death payment with respect to such deceased individual is filed by or on behalf of such person (whether or not legally competent) prior to the expiration of two years after the date of such interment or reinterment.

Application for Monthly Insurance Benefits

(j)(1) Subject to the limitations contained in paragraph (4), an individual who would have been entitled to a benefit under subsection (a), (b), (c), (d), (e), (f), (g), or (h) for any month after August 1950 had he filed application therefor prior to the end of such month shall be entitled to such benefit for such month if he files application therefor prior to—

(A) the end of the twelfth month immediately succeeding such month in any case where the individual (i) is filing application for a benefit under subsection (e) or (f), and satisfies paragraph (1)(B) of such subsection by reason of clause (ii) thereof, or (ii) is filing application for a benefit under subsection (b), (c), or (d) on the basis of the wages

and self-employment income of a person entitled to disability insurance benefits, or

(B) the end of the sixth month immediately succeeding such month in any case where subparagraph (A) does not apply.

Any benefit under this title for a month prior to the month in which application is filed shall be reduced, to any extent that may be necessary, so that it will not render erroneous any benefit which, before the filing of such application, the Commissioner of Social Security has certified for payment for such prior month.

(2) An application for any monthly benefits under this section filed before the first month in which the applicant satisfies the requirements for such benefits shall be deemed a valid application (and shall be deemed to have been filed in such first month) only if the applicant satisfies the requirements for such benefits before the Commissioner of Social Security makes a final decision on the application and no request under section 205(b) for notice and opportunity for a hearing thereon is made or, if such a request is made, before a decision based upon the evidence adduced at the hearing is made (regardless of whether such decision becomes the final decision of the Commissioner of Social Security).

(3) Notwithstanding the provisions of paragraph (1), an individual may, at his option, waive entitlement to any benefit referred to in paragraph (1) for any one or more consecutive months (beginning with the earliest month for which such individual would otherwise be entitled to such benefit) which occur before the month in which such individual files application for such benefit; and, in such case, such individual shall not be considered as entitled to such benefits for any such month or months before such individual filed such application. An individual shall be deemed to have waived such entitlement for any such month for which such benefit would, under the second sentence of paragraph (1), be reduced to zero.

(4)(A) Except as provided in subparagraph (B), no individual shall be entitled to a monthly benefit under subsection (a), (b), (c), (e), or (f) for any month prior to the month in which he or she files an application for benefits under that subsection if the amount of the monthly benefit to which such individual would otherwise be entitled for any such month would be subject to reduction pursuant to subsection (q).

(B) (i) If the individual applying for retroactive benefits is a widow, surviving divorced wife, or widower and is under a disability (as defined in section 223(d)), and such individual would, except for subparagraph (A), be entitled to retroactive benefits as a disabled widow or widower or disabled surviving divorced wife for any month before attaining the age of 60, then subparagraph (A) shall not apply with respect to such month or any subsequent month.

(ii) Subparagraph (A) does not apply to a benefit under subsection (e) or (f) for the month immediately preceding the month of application, if the insured individual died in that preceding month.

(iii) As used in this subparagraph, the term "retroactive benefits" means benefits to which an individual

becomes entitled for a month prior to the month in which application for such benefits is filed.

(5) In any case in which it is determined to the satisfaction of the Commissioner of Social Security that an individual failed as of any date to apply for monthly insurance benefits under this title by reason of misinformation provided to such individual by any officer or employee of the Social Security Administration relating to such individual's eligibility for benefits under this title, such individual shall be deemed to have applied for such benefits on the later of—

(A) the date on which such misinformation was provided to such individual, or

(B) the date on which such individual met all requirements for entitlement to such benefits (other than application therefor).

Simultaneous Entitlement to Benefits

(k)(1) A child, entitled to child's insurance benefits on the basis of the wages and self-employment income of an insured individual, who would be entitled, on filing application, to child's insurance benefits on the basis of the wages and self-employment income of some other insured individual, shall be deemed entitled, subject to the provisions of paragraph (2) hereof, to child's insurance benefits on the basis of the wages and self-employment income of such other individual if an application for child's insurance benefits on the basis of the wages and self-employment income of such other individual has been filed by any other child who would, on filing application, be entitled to child's insurance benefits on the basis of the wages and self-employment income of both such insured individuals.

(2)(A) Any child who under the preceding provisions of this section is entitled for any month to child's insurance benefits on the wages and self-employment income of more than one insured individual shall, notwithstanding such provisions, be entitled to only one of such child's insurance benefits for such month. Such child's insurance benefits for such month shall be the benefit based on the wages and self-employment income of the insured individual who has the greatest primary insurance amount, except that such child's insurance benefits for such month shall be the largest benefit to which such child could be entitled under subsection (d) (without the application of section 203(a)) or subsection (m) if entitlement to such benefit would not, with respect to any person, result in a benefit lower (after the application of section 203(a)) than the benefit which would be applicable if such child were entitled on the wages and self-employment income of the individual with the greatest primary insurance amount. Where more than one child is entitled to child's insurance benefits pursuant to the preceding provisions of this paragraph, each such child who is entitled on the wages and self-employment income of the same insured individuals shall be entitled on the wages and self-employment income of the same such insured individual.

(B) Any individual (other than an individual to whom subsection (e)(3) or (f)(3)[47] applies) who, under the preced-

[47] P.L. 108–203, §418(b)(4)(B)(iv), struck out "or (f)(4)" and substituted "or (f)(3)".

ing provisions of this section and under the provisions of section 223, is entitled for any month to more than one monthly insurance benefit (other than an old-age or disability insurance benefit) under this title shall be entitled to only one such monthly benefit for such month, such benefit to be the largest of the monthly benefits to which he (but for this subparagraph (B)) would otherwise be entitled for such month. Any individual who is entitled for any month to more than one widow's or widower's insurance benefit to which subsection (e)(3) or (f)(3)[48] applies shall be entitled to only one such benefit for such month, such benefit to be the largest of such benefits.

(3)(A) If an individual is entitled to an old-age or disability insurance benefit for any month and to any other monthly insurance benefit for such month, such other insurance benefit for such month, after any reduction under subsection (q), subsection (e)(2) or (f)(2)[49], and any reduction under section 203(a), shall be reduced, but not below zero, by an amount equal to such old-age or disability insurance benefit (after reduction under such subsection (q)).

(B) If an individual is entitled for any month to a widow's or widower's insurance benefit to which subsection (e)(3) or (f)(3)[50] applies and to any other monthly insurance benefit under section 202 (other than an old-age insurance benefit), such other insurance benefit for such month, after any reduction under subparagraph (A), any reduction under subsection (q), and any reduction under section 203(a), shall be reduced, but not below zero, by an amount equal to such widow's or widower's insurance benefit after any reduction or reductions under such subparagraph (A) and such section 203(a).

(4) Any individual who, under this section and section 223, is entitled for any month to both an old-age insurance benefit and a disability insurance benefit under this title shall be entitled to only the larger of such benefits for such month, except that, if such individual so elects, he shall instead be entitled to only the smaller of such benefits for such month.

(5)[51](A) The amount of a monthly insurance benefit of any individual for each month under subsection (b), (c), (e), (f), or (g) (as determined after application of the provisions of subsection (q) and the preceding provisions of this subsection) shall be reduced (but not below zero) by an amount equal to two-thirds of the amount of any monthly periodic benefit payable to such individual for such month which is based upon such individual's earnings while in the service of the Federal Government or any State (or political subdivision thereof, as defined in section 218(b)(2)) if, during any portion of the last 60 months of such service ending with the last day such individual was employed by such entity—

(i) such service did not constitute "employment" as defined in section 210, or

[48] P.L. 108–203, §418(b)(4)(B)(iv), struck out "or (f)(4)" and substituted "or (f)(3)".
[49] P.L. 108–203, §418(b)(4)(B)(v), struck out "or (f)(3)" and substituted "or (f)(2)".
[50] P.L. 108–203, §418(b)(4)(B)(vi), struck out "or (f)(4)" and substituted "or (f)(3)".
[51] P.L. 108–203, §418(a), added paragraph (5). For the effective date, see Vol. II, P.L. 108-203, §418(c).

(ii) such service was being performed while in the service of the Federal Government, and constituted "employment" as so defined solely by reason of—

(I) clause (ii) or (iii) of subparagraph (G) of section 210(a)(5), where the lump-sum payment described in such clause (ii) or the cessation of coverage described in such clause (iii) (whichever is applicable) was received or occurred on or after January 1, 1988, or

(II) an election to become subject to the Federal Employees' Retirement System provided in chapter 84 of title 5, United States Code, or the Foreign Service Pension System provided in subchapter II of chapter 8 of title I of the Foreign Service Act of 1980 made pursuant to law after December 31, 1987,

unless subparagraph (B) applies.

The amount of the reduction in any benefit under this subparagraph, if not a multiple of $0.10, shall be rounded to the next higher multiple of $0.10.

(B)(i) Subparagraph (A)(i) shall not apply with respect to monthly periodic benefits based wholly on service as a member of a uniformed service (as defined in section 210(m)).

(ii) Subparagraph (A)(ii) shall not apply with respect to monthly periodic benefits based in whole or in part on service which constituted "employment" as defined in section 210 if such service was performed for at least 60 months in the aggregate during the period beginning January 1, 1988, and ending with the close of the first calendar month as of the end of which such individual is eligible for benefits under this subsection and has made a valid application for such benefits.

(C) For purposes of this paragraph, any periodic benefit which otherwise meets the requirements of subparagraph (A), but which is paid on other than a monthly basis, shall be allocated on a basis equivalent to a monthly benefit (as determined by the Commissioner of Social Security) and such equivalent monthly benefit shall constitute a monthly periodic benefit for purposes of subparagraph (A). For purposes of this subparagraph, the term "periodic benefit" includes a benefit payable in a lump sum if it is a commutation of, or a substitute for, periodic payments.

Entitlement to Survivor Benefits Under Railroad Retirement Act

(l) If any person would be entitled, upon filing application therefor to an annuity under section 2 of the Railroad Retirement Act of 1974[52], or to a lump–sum payment under section 6(b) of such Act, with respect to the death of an employee (as defined in such Act) no lump–sum death payment, and no monthly benefit for the month in which such employee died or for any month thereafter, shall be paid under this section to any person on the basis of the wages and self–employment income of such employee.

[52] See Vol. II, P.L. 75–162 [as amended by P.L. 93–445].

(m) [Repealed.[53]]

Termination of Benefits Upon Removal[54] of Primary Beneficiary

(n)(1) If any individual is (after the date of enactment of this subsection[55]) removed[56] under section 237(a) of the Immigration and Nationality Act (other than under paragraph (1)(C) of such section) or under section 212(a)(6)(A) of such Act[57], then, notwithstanding any other provisions of this title—

(A) no monthly benefit under this section or section 223 shall be paid to such individual, on the basis of his wages and self–employment income, for any month occurring (i) after the month in which the Commissioner of Social Security is notified by the Attorney General or the Secretary of Homeland Security[58] that such individual has been so removed[59] , and (ii) before the month in which such individual is thereafter lawfully admitted to the United States for permanent residence,

(B) if no benefit could be paid to such individual (or if no benefit could be paid to him if he were alive) for any month by reason of subparagraph (A), no monthly benefit under this section shall be paid, on the basis of his wages and self–employment income, for such month to any other person who is not a citizen of the United States and is outside the United States for any part of such month, and

(C) no lump–sum death payment shall be made on the basis of such individual's wages and self–employment income if he dies (i) in or after the month in which such notice is received, and (ii) before the month in which he is thereafter lawfully admitted to the United States for permanent residence.

Section 203(b), (c), and (d) of this Act shall not apply with respect to any such individual for any month for which no monthly benefit may be paid to him by reason of this paragraph.

(2) As soon as practicable after the removal[60] of any individual under any of the paragraphs of section 237(a) of the Immigration and Nationality Act (other than under paragraph (1)(C) of such section) or under section 212(a)(6)(A) of such Act[61], the

[53] P.L. 97–35, §2201(b)(10); 95 Stat. 831;P.L. 97–123, §2(j)(1); 95 Stat. 1661.

[54] P.L. 108–203, §412(b)(1)(C), struck out "Deportation" and substituted "Removal", effective as if enacted on April 1, 1997.

[55] September 1, 1954 [P.L. 83–761, §107; 68 Stat. 1083].

[56] P.L. 108–203, §412(b)(1)(B), struck out "deported" and substituted "removed", effective as if enacted on April 1, 1997.

[57] P.L. 108–203, §412(a)(1), struck out "section 241(a) (other than under paragraph (1)(C) or (1)(E) thereof) of the Immigration and Nationality Act" and substituted "section 237(a) of the Immigration and Nationality Act (other than under paragraph (1)(C) of such section) or under section 212(a)(6)(A) of such Act", applicable to individuals with respect to whom the Commissioner of Social Security receives a removal notice after March 2, 2004.

[58] P.L. 108–203, §412(b)(2), inserted "or the Secretary of Homeland Security", effective as if enacted on March 1, 2003.

[59] P.L. 108–203, §412(b)(1)(B), struck out "deported" and substituted "removed", effective as if enacted on April 1, 1997.

[60] P.L. 108–203, §412(b)(1)(A), struck out "deportation" and substituted "removal", effective as if enacted on April 1, 1997.

[61] P.L. 108–203, §412(a)(2), struck out "section 241(a) of the Immigration and Nationality Act (other than under paragraph (1)(C) or (1)(E) thereof" and substituted "section 237(a) of the Immigration and Nationality Act (other than under paragraph (1)(C) of such section) or under section 212(a)(6)(A) of such Act", applicable with respect to notifications of removals received by the Commissioner of Social Security after March 2, 2004.

Attorney General or the Secretary of Homeland Security[62] shall notify the Commissioner of Social Security of such removal.

(3) For purposes of paragraphs (1) and (2) of this subsection, an individual against whom a final order of removal[63] has been issued under paragraph (4)(D) of section 237(a) of the Immigration and Nationality Act (relating to participating in Nazi persecutions or genocide) shall be considered to have been removed under such paragraph (4)(D)[64] as of the date on which such order became final.

Application for Benefits by Survivors of Members and Former Members of the Uniformed Services

(o) In the case of any individual who would be entitled to benefits under subsection (d), (e), (g), or (h) upon filing proper application therefor, the filing with the Administrator of Veterans' Affairs by or on behalf of such individual of an application for such benefits, on the form described in section 3005 of title 38, United States Code[65], shall satisfy the requirement of such subsection (d), (e), (g), or (h) that an application for such benefits be filed.

Extension of Period for Filing Proof of Support and Applications for Lump-Sum Death Payment

(p) In any case in which there is a failure—

(1) to file proof of support under subparagraph (B) of subsection (h)(1), or under clause (B) of subsection (f)(1) of this section as in effect prior to the Social Security Act Amendments of 1950[66], within the period prescribed by such subparagraph or clause, or

(2) to file, in the case of a death after 1946, application for a lump-sum death payment under subsection (i), or under subsection (g) of this section as in effect prior to the Social Security Act Amendments of 1950, within the period prescribed by such subsection,

any such proof or application, as the case may be, which is filed after the expiration of such period shall be deemed to have been filed within such period if it is shown to the satisfaction of the Commissioner of Social Security that there was good cause for failure to file such proof or application within such period. The determination of what constitutes good cause for purposes of this subsection shall be made in accordance with regulations of the Commissioner of Social Security.

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[62] P.L. 108–203, §412(b)(1)(A), struck out "deportation" and substituted "removal", effective as if enacted on April 1, 1997.

[63] P.L. 108–203, §412(b)(1)(A), struck out "deportation" and substituted "removal", effective as if enacted on April 1, 1997.

[64] P.L. 108–203, §412(a)(3), struck out "paragraph (19) of section 241(a) of the Immigration and Nationality Act (relating to persecution of others on account of race, religion, national origin, or political opinion, under the direction of or in association with the Nazi government of Germany or its allies) shall be considered to have been deported under such paragraph (19)" and substituted "paragraph (4)(D) of section 241(a)* of the Immigration and Nationality Act (relating to participating in Nazi persecutions or genocide) shall be considered to have been deported** under such paragraph (4)(D)", effective as if enacted on March 1, 1991.

*P.L. 108–203, §412(a)(4), struck out "241(a)" and substituted "237(a)", effective as if enacted on April 1, 1997.

**P.L. 108–203, §412(b)(1)(B), struck out "deported" and substituted "removed", effective as if enacted on April 1, 1997.

[65] See Vol. II, Title 38.

[66] P.L. 81–734.

Reduction of Benefit Amounts for Certain Beneficiaries

(q)(1) Subject to paragraph (9), if the first month for which an individual is entitled to an old-age, wife's, husband's, widow's, or widower's insurance benefit is a month before the month in which such individual attains retirement age, the amount of such benefit for such month and for any subsequent month shall, subject to the succeeding paragraphs of this subsection, be reduced by—

(A) 5/9 of 1 percent of such amount if such benefit is an old-age insurance benefit, 25/36 of 1 percent of such amount if such benefit is a wife's or husband's insurance benefit, or 19/40 of 1 percent of such amount if such benefit is a widow's or widower's insurance benefit, multiplied by

(B)(i) the number of months in the reduction period for such benefit (determined under paragraph (6)), if such benefit is for a month before the month in which such individual attains retirement age, or

(ii) if less, the number of such months in the adjusted reduction period for such benefit (determined under paragraph (7)), if such benefit is (I) for the month in which such individual attains age 62, or (II) for the month in which such individual attains retirement age.

(2) If an individual is entitled to a disability insurance benefit for a month after a month for which such individual was entitled to an old-age insurance benefit, such disability insurance benefit for each month shall be reduced by the amount such old-age insurance benefit would be reduced under paragraphs (1) and (4) for such month had such individual attained retirement age (as defined in section 216(l)) in the first month for which he most recently became entitled to a disability insurance benefit.

(3)(A) If the first month for which an individual both is entitled to a wife's, husband's, widow's, or widower's insurance benefit and has attained age 62 (in the case of a wife's or husband's insurance benefit) or age 50 (in the case of a widow's or widower's insurance benefit) is a month for which such individual is also entitled to—

(i) an old-age insurance benefit (to which such individual was first entitled for a month before he attains retirement age (as defined in section 216(l))), or

(ii) a disability insurance benefit,

then in lieu of any reduction under paragraph (1) (but subject to the succeeding paragraphs of this subsection) such wife's, husband's, widow's, or widower's insurance benefit for each month shall be reduced as provided in subparagraph (B), (C), or (D).

(B) For any month for which such individual is entitled to an old-age insurance benefit and is not entitled to a disability insurance benefit, such individual's wife's or husband's insurance benefit shall be reduced by the sum of—

(i) the amount by which such old-age insurance benefit is reduced under paragraph (1) for such month, and

(ii) the amount by which such wife's or husband's insurance benefit would be reduced under paragraph (1) for such month if it were equal to the excess of such wife's or husband's insurance benefit (before reduction

under this subsection) over such old-age insurance benefit (before reduction under this subsection).

(C) For any month for which such individual is entitled to a disability insurance benefit, such individual's wife's, husband's, widow's, or widower's insurance benefit shall be reduced by the sum of—

(i) the amount by which such disability insurance benefit is reduced under paragraph (2) for such month (if such paragraph applied to such benefit), and

(ii) the amount by which such wife's, husband's, widow's, or widower's insurance benefit would be reduced under paragraph (1) for such month if it were equal to the excess of such wife's, husband's, widow's, or widower's insurance benefit (before reduction under this subsection) over such disability insurance benefit (before reduction under this subsection).

(D) For any month for which such individual is entitled neither to an old-age insurance benefit nor to a disability insurance benefit, such individual's wife's, husband's, widow's, or widower's insurance benefit shall be reduced by the amount by which it would be reduced under paragraph (1).

(E) Notwithstanding subparagraph (A) of this paragraph, if the first month for which an individual is entitled to a widow's or widower's insurance benefit is a month for which such individual is also entitled to an old-age insurance benefit to which such individual was first entitled for that month or for a month before she or he became entitled to a widow's or widower's benefit, the reduction in such widow's or widower's insurance benefit shall be determined under paragraph (1).

(4) If—

(A) an individual is or was entitled to a benefit subject to reduction under paragraph (1) or (3) of this subsection, and

(B) such benefit is increased by reason of an increase in the primary insurance amount of the individual on whose wages and self-employment income such benefit is based,

then the amount of the reduction of such benefit (after the application of any adjustment under paragraph (7)) for each month beginning with the month of such increase in the primary insurance amount shall be computed under paragraph (1) or (3), whichever applies, as though the increased primary insurance amount had been in effect for and after the month for which the individual first became entitled to such monthly benefit reduced under such paragraph (1) or (3).

(5)(A) No wife's or husband's insurance benefit shall be reduced under this subsection—

(i) for any month before the first month for which there is in effect a certificate filed by him or her with the Commissioner of Social Security, in accordance with regulations prescribed by the Commissioner of Social Security, in which he or she elects to receive wife's or husband's insurance benefits reduced as provided in this subsection, or

(ii) for any month in which he or she has in his or her care (individually or jointly with the person on whose wages and self-employment income the wife's or husband's insurance benefit is based) a child of such person entitled to child's insurance benefits.

(B) Any certificate described in subparagraph (A)(i) shall be effective for purposes of this subsection (and for purposes of preventing deductions under section 203(c)(2))—

(i) for the month in which it is filed and for any month thereafter, and

(ii) for months, in the period designated by the individual filing such certificate, of one or more consecutive months (not exceeding 12) immediately preceding the month in which such certificate is filed;

except that such certificate shall not be effective for any month before the month in which he or she attains age 62, nor shall it be effective for any month to which subparagraph (A)(ii) applies.

(C) If an individual does not have in his or her care a child described in subparagraph (A)(ii) in the first month for which he or she is entitled to a wife's or husband's insurance benefit, and if such first month is a month before the month in which he or she attains retirement age (as defined in section 216(l)), he or she shall be deemed to have filed in such first month the certificate described in subparagraph (A)(i).

(D) No widow's or widower's insurance benefit for a month in which he or she has in his or her care a child of his or her deceased spouse (or deceased former spouse) entitled to child's insurance benefits shall be reduced under this subsection below the amount to which he or she would have been entitled had he or she been entitled for such month to mother's or father's insurance benefits on the basis of his or her deceased spouse's (or deceased former spouse's) wages and self-employment income.

(6) For purposes of this subsection, the "reduction period" for an individual's old-age, wife's, husband's, widow's, or widower's insurance benefit is the period—

(A) beginning—

(i) in the case of an old-age insurance benefit, with the first day of the first month for which such individual is entitled to such benefit,

(ii) in the case of a wife's or husband's insurance benefit, with the first day of the first month for which a certificate described in paragraph (5)(A)(i) is effective, or

(iii) in the case of a widow's or widower's insurance benefit, with the first day of the first month for which such individual is entitled to such benefit or the first day of the month in which such individual attains age 60, whichever is the later, and

(B) ending with the last day of the month before the month in which such individual attains retirement age.

(7) For purposes of this subsection, the "adjusted reduction period" for an individual's old-age, wife's, husband's, widow's, or widower's insurance benefit is the reduction period prescribed in paragraph (6) for such benefit, excluding—

(A) any month in which such benefit was subject to deductions under section 203(b), 203(c)(1), 203(d)(1), or 222(b),

(B) in the case of wife's or husband's insurance benefits, any month in which such individual had in his or her care (individually or jointly with the person on whose wages and self-employment income such benefit is based) a child of such person entitled to child's insurance benefits,

(C) in the case of wife's or husband's insurance benefits, any month for which such individual was not entitled to such benefits because of the occurrence of an event that terminated her or his entitlement to such benefits,

(D) in the case of widow's or widower's insurance benefits, any month in which the reduction in the amount of such benefit was determined under paragraph (5)(D),

(E) in the case of widow's or widower's insurance benefits, any month before the month in which she or he attained age 62, and also for any later month before the month in which she or he attained retirement age, for which she or he was not entitled to such benefit because of the occurrence of an event that terminated her or his entitlement to such benefits, and

(F) in the case of old-age insurance benefits, any month for which such individual was entitled to a disability insurance benefit.

(8) This subsection shall be applied after reduction under section 203(a) and before application of section 215(g). If the amount of any reduction computed under paragraph (1), (2), or (3) is not a multiple of $0.10, it shall be increased to the next higher multiple of $0.10.

(9) The amount of the reduction for early retirement specified in paragraph (1)—

(A) for old-age insurance benefits, wife's insurance benefits, and husband's insurance benefits, shall be the amount specified in such paragraph for the first 36 months of the reduction period (as defined in paragraph (6)) or adjusted reduction period (as defined in paragraph (7)), and five-twelfths of 1 percent for any additional months included in such periods; and

(B) for widow's insurance benefits and widower's insurance benefits, shall be periodically revised by the Commissioner of Social Security such that—

(i) the amount of the reduction at early retirement age as defined in section 216(l) shall be 28.5 percent of the full benefit; and

(ii) the amount of the reduction for each month in the reduction period (specified in paragraph (6)) or the adjusted reduction period (specified in paragraph (7)) shall be established by linear interpolation between 28.5 percent at the month of attainment of early retirement age and 0 percent at the month of attainment of retirement age.

(10) For purposes of applying paragraph (4), with respect to monthly benefits payable for any month after December 1977 to an individual who was entitled to a monthly benefit as reduced under paragraph (1) or (3) prior to January 1978, the

amount of reduction in such benefit for the first month for which such benefit is increased by reason of an increase in the primary insurance amount of the individual on whose wages and self-employment income such benefit is based and for all subsequent months (and similarly for all subsequent increases) shall be increased by a percentage equal to the percentage increase in such primary insurance amount (such increase being made in accordance with the provisions of paragraph (8)). In the case of an individual whose reduced benefit under this section is increased as a result of the use of an adjusted reduction period (in accordance with paragraphs (1) and (3) of this subsection), then for the first month for which such increase is effective, and for all subsequent months, the amount of such reduction (after the application of the previous sentence, if applicable) shall be determined—

(A) in the case of old-age, wife's, and husband's insurance benefits, by multiplying such amount by the ratio of (i) the number of months in the adjusted reduction period to (ii) the number of months in the reduction period,

(B) in the case of widow's and widower's insurance benefits for the month in which such individual attains age 62, by multiplying such amount by the ratio of (i) the number of months in the reduction period beginning with age 62 multiplied by 19/40 of 1 percent, plus the number of months in the adjusted reduction period prior to age 62 multiplied by 19/40 of 1 percent to (ii) the number of months in the reduction period multiplied by 19/40 of 1 percent, and

(C) in the case of widow's and widower's insurance benefits for the month in which such individual attains retirement age (as defined in section 216(l)), by multiplying such amount by the ratio of (i) the number of months in the adjusted reduction period multiplied by 19/40 of 1 percent to (ii) the number of months in the reduction period beginning with age 62 multiplied by 19/40 of 1 percent, plus the number of months in the adjusted reduction period prior to age 62 multiplied by 19/40 of 1 percent,

such determination being made in accordance with the provisions of paragraph (8).

(11) When an individual is entitled to more than one monthly benefit under this title and one or more of such benefits are reduced under this subsection, paragraph (10) shall apply separately to each such benefit reduced under this subsection before the application of subsection (k) (pertaining to the method by which monthly benefits are offset when an individual is entitled to more than one kind of benefit) and the application of this paragraph shall operate in conjunction with paragraph (3).

Presumed Filing of Application by Individuals Eligible for Old-Age Insurance Benefits and for Wife's or Husband's Insurance Benefits

(r)(1) If the first month for which an individual is entitled to an old-age insurance benefit is a month before the month in which such individual attains retirement age (as defined in section 216(l)), and if such individual is eligible for a wife's or husband's insurance benefit for such first month, such individual shall be

deemed to have filed an application in such month for wife's or husband's insurance benefits.

(2) If the first month for which an individual is entitled to a wife's or husband's insurance benefit reduced under subsection (q) is a month before the month in which such individual attains retirement age (as defined in section 216(l)), and if such individual is eligible (but for section 202(k)(4)) for an old-age insurance benefit for such first month, such individual shall be deemed to have filed an application for old-age insurance benefits—

(A) in such month, or

(B) if such individual is also entitled to a disability insurance benefit for such month, in the first subsequent month for which such individual is not entitled to a disability insurance benefit.

(3) For purposes of this subsection, an individual shall be deemed eligible for a benefit for a month if, upon filing application therefor in such month, he would be entitled to such benefit for such month.

Child Over Specified Age to be Disregarded for Certain Benefit Purposes Unless Disabled

(s)(1) For the purposes of subsections (b)(1), (c)(1), (g)(1), (q)(5), and (q)(7) of this section and paragraphs (2), (3), and (4) of section 203(c), a child who is entitled to child's insurance benefits under subsection (d) for any month, and who has attained the age of 16 but is not in such month under a disability (as defined in section 223(d)), shall be deemed not entitled to such benefits for such month, unless he was under such a disability in the third month before such month.

(2) So much of subsections (b)(3), (c)(4), (d)(5), (g)(3), and (h)(4) of this section as precedes the semicolon, shall not apply in the case of any child unless such child, at the time of the marriage referred to therein, was under a disability (as defined in section 223(d)) or had been under such a disability in the third month before the month in which such marriage occurred.

(3) The last sentence of subsection (c) of section 203, subsection (f)(1)(C) of section 203, and subsections (b)(3)(B), (c)(6)(B), (f)(3)(B), and (g)(6)(B) of section 216 shall not apply in the case of any child with respect to any month referred to therein unless in such month or the third month prior thereto such child was under a disability (as defined in section 223(d)).

Suspension of Benefits of Aliens Who Are Outside the United States; Residency Requirements for Dependents and Survivors

(t)(1) Notwithstanding any other provision of this title, no monthly benefits shall be paid under this section or under section 223 to any individual who is not a citizen or national of the United States for any month which is—

(A) after the sixth consecutive calendar month during all of which the Commissioner of Social Security finds, on the basis of information furnished to the Commissioner by the Attorney General or information which otherwise comes to

the Commissioner's attention, that such individual is outside the United States, and

(B) prior to the first month thereafter for all of which such individual has been in the United States.

For purposes of the preceding sentence, after an individual has been outside the United States for any period of thirty consecutive days he shall be treated as remaining outside the United States until he has been in the United States for a period of thirty consecutive days.

(2) Subject to paragraph (11), paragraph (1) shall not apply to any individual who is a citizen of a foreign country which the Commissioner of Social Security finds has in effect a social insurance or pension system which is of general application in such country and under which—

(A) periodic benefits, or the actuarial equivalent thereof, are paid on account of old age, retirement, or death, and

(B) individuals who are citizens of the United States but not citizens of such foreign country and who qualify for such benefits are permitted to receive such benefits or the actuarial equivalent thereof while outside such foreign country without regard to the duration of the absence.

(3) Paragraph (1) shall not apply in any case where its application would be contrary to any treaty obligation of the United States in effect on the date of the enactment of this subsection[67].

(4) Subject to paragraph (11), paragraph (1) shall not apply to any benefit for any month if—

(A) not less than forty of the quarters elapsing before such month are quarters of coverage for the individual on whose wages; and self-employment income such benefit is based, or

(B) the individual on whose wages and self-employment income such benefit is based has, before such month, resided in the United States for a period or periods aggregating ten years or more, or

(C) the individual entitled to such benefit is outside the United States while in the active military or naval service of the United States, or

(D) the individual on whose wages and self-employment income such benefit is based died, before such month, either (i) while on active duty or inactive duty training (as those terms are defined in section 210(l)(2) and (3)) as a member of a uniformed service (as defined in section 210(m)), or (ii) as the result of a disease or injury which the Secretary of Veterans Affairs determines was incurred or aggravated in line of duty while on active duty (as defined in section 210(l)(2)), or an injury which he determines was incurred or aggravated in line of duty while on inactive duty training (as defined in section 210(l)(3)), as a member of a uniformed service (as defined in section 210(m)), if the Secretary of Veterans Affairs determines that such individual was discharged or released from the period of such active duty or inactive duty training under conditions other than dishonorable, and if the Secretary of

[67] August 1, 1956 [P.L. 84–880, §118(a); 70 Stat. 835, 856].

Veterans Affairs certifies to the Commissioner of Social Security his determinations with respect to such individual under this clause, or

(E) the individual on whose employment such benefit is based had been in service covered by the Railroad Retirement Act of 1937 or 1974[68] which was treated as employment covered by this Act pursuant to the provisions of section 5(k)(1) of the Railroad Retirement Act of 1937 or section 18(2) of the Railroad Retirement Act of 1974[69];

except that subparagraphs (A) and (B) of this paragraph shall not apply in the case of any individual who is a citizen of a foreign country that has in effect a social insurance or pension system which is of general application in such country and which satisfies subparagraph (A) but not subparagraph (B) of paragraph (2), or who is a citizen of a foreign country that has no social insurance or pension system of general application if at any time within five years prior to the month in which the Social Security Amendments of 1967 are enacted[70] (or the first month thereafter for which his benefits are subject to suspension under paragraph (1)) payments to individuals residing in such country were withheld by the Treasury Department under the first section of the Act of October 9, 1940 (31 U.S.C. 123)[71].

(5) No person who is, or upon application would be, entitled to a monthly benefit under this section for December 1956 shall be deprived, by reason of paragraph (1), of such benefit or any other benefit based on the wages and self-employment income of the individual on whose wages and self-employment income such monthly benefit for December 1956 is based.

(6) If an individual is outside the United States when he dies and no benefit may, by reason of paragraph (1) or (10), be paid to him for the month preceding the month in which he dies, no lump-sum death payment may be made on the basis of such individual's wages and self-employment income.

(7) Subsections (b), (c), and (d) of section 203 shall not apply with respect to any individual for any month for which no monthly benefit may be paid to him by reason of paragraph (1) of this subsection.

(8) The Attorney General shall certify to the Commissioner of Social Security such information regarding aliens who depart from the United States to any foreign country (other than a foreign country which is territorially contiguous to the continental United States) as may be necessary to enable the Commissioner of Social Security to carry out the purposes of this subsection and shall otherwise aid, assist, and cooperate with the Commissioner of Social Security in obtaining such other information as may be necessary to enable the Commissioner of Social Security to carry out the purposes of this subsection.

(9) No payments shall be made under part A of title XVIII with respect to items or services furnished to an individual in any month for which the prohibition in paragraph (1) against

[68] P.L. 75–162.
[69] See Vol. II, P.L. 75–162, §18(2).
[70] January 2, 1968 [P.L. 90–248; 81 Stat. 821].
[71] P.L. 97–258, §5(b), repealed the Act of October 9, 1940. See, instead, Vol. II, 31 U.S.C. 3329.

payment of benefits to him is applicable (or would be if he were entitled to any such benefits).

(10) Notwithstanding any other provision of this title, no monthly benefits shall be paid under this section or under section 223, for any month beginning after June 30, 1968, to an individual who is not a citizen or national of the United States and who resides during such month in a foreign country if payments for such month to individuals residing in such country are withheld by the Treasury Department under the first section of the Act of October 9, 1940 (31 U.S.C. 123)[72].

(11)(A) Paragraph (2) and subparagraphs (A), (B), (C), and (E) of paragraph (4) shall apply with respect to an individual's monthly benefits under subsection (b), (c), (d), (e), (f), (g), or (h) only if such individual meets the residency requirements of this paragraph with respect to those benefits.

(B) An individual entitled to benefits under subsection (b), (c), (e), (f), or (g) meets the residency requirements of this paragraph with respect to those benefits only if such individual has resided in the United States, and while so residing bore a spousal relationship to the person on whose wages and self-employment income such entitlement is based, for a total period of not less than 5 years. For purposes of this subparagraph, a period of time for which an individual bears a spousal relationship to another person consists of a period throughout which the individual has been, with respect to such other person, a wife, a husband, a widow, a widower, a divorced wife, a divorced husband, a surviving divorced wife, a surviving divorced husband, a surviving divorced mother, a surviving divorced father, or (as applicable in the course of such period) any two or more of the foregoing.

(C) An individual entitled to benefits under subsection (d) meets the residency requirements of this paragraph with respect to those benefits only if—

(i)(I) such individual has resided in the United States (as the child of the person on whose wages and self-employment income such entitlement is based) for a total period of not less than 5 years, or

(II) the person on whose wages and self-employment income such entitlement is based, and the individual's other parent (within the meaning of subsection (h)(3)), if any, have each resided in the United States for a total period of not less than 5 years (or died while residing in the United States), and

(ii) in the case of an individual entitled to such benefits as an adopted child, such individual was adopted within the United States by the person on whose wages and self-employment income such entitlement is based, and has lived in the United States with such person and received at least one-half of his or her support from such person for a period (beginning before such individual attained age 18) consisting of—

[72] P.L. 97–258, §5(b), repealed the Act of October 9, 1940. See, instead, Vol. II, 31 U.S.C. 3329.

(I) the year immediately before the month in which such person became eligible for old-age insurance benefits or disability insurance benefits or died, whichever occurred first, or

(II) if such person had a period of disability which continued until he or she became entitled to old-age insurance benefits or disability insurance benefits or died, the year immediately before the month in which such period of disability began.

(D) An individual entitled to benefits under subsection (h) meets the residency requirements of this paragraph with respect to those benefits only if such individual has resided in the United States, and while so residing was a parent (within the meaning of subsection (h)(3)) of the person on whose wages and self-employment income such entitlement is based, for a total period of not less than 5 years.

(E) This paragraph shall not apply with respect to any individual who is a citizen or resident of a foreign country with which the United States has an agreement in force concluded pursuant to section 233, except to the extent provided by such agreement.

Conviction of Subversive Activities, Etc.

(u)(1) If any individual is convicted of any offense (committed after the date of the enactment of this subsection[73]) under—

(A) chapter 37 (relating to espionage and censorship), chapter 105 (relating to sabotage), or chapter 115 (relating to treason, sedition, and subversive activities) of title 18 of the United States Code[74], or

(B) section 4 of the Internal Security Act of 1950[75], as amended,

then the court may, in addition to all other penalties provided by law, impose a penalty that in determining whether any monthly insurance benefit under this section or section 223 is payable to such individual for the month in which he is convicted or for any month thereafter, in determining the amount of any such benefit payable to such individual for any such month, and in determining whether such individual is entitled to insurance benefits under part A of title XVIII for any such month, there shall not be taken into account—

(C) any wages paid to such individual or to any other individual in the calendar year in which such conviction occurs or in any prior calendar year, and

(D) any net earnings from self-employment derived by such individual or by any other individual during a taxable year in which such conviction occurs or during any prior taxable year.

(2) As soon as practicable after an additional penalty has, pursuant to paragraph (1), been imposed with respect to any individual, the Attorney General shall notify the Commissioner of Social Security of such imposition.

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[73] August 1, 1956 [P.L. 84–880,§121(a); 70 Stat. 838, 856].
[74] See Vol. II, Title 18.
[75] See Vol. II, P.L. 81–831.

(3) If any individual with respect to whom an additional penalty has been imposed pursuant to paragraph (1) is granted a pardon of the offense by the President of the United States, such additional penalty shall not apply for any month beginning after the date on which such pardon is granted.

Waiver of Benefits

(v)(1) Notwithstanding any other provisions of this title, and subject to paragraph (3), in the case of any individual who files a waiver pursuant to section 1402(g) of the Internal Revenue Code of 1986[76] and is granted a tax exemption thereunder, no benefits or other payments shall be payable under this title to him, no payments shall be made on his behalf under part A of title XVIII, and no benefits or other payments under this title shall be payable on the basis of his wages and self-employment income to any other person, after the filing of such waiver.

(2) Notwithstanding any other provision of this title, and subject to paragraph (3), in the case of any individual who files a waiver pursuant to section 3127 of the Internal Revenue Code of 1986 and is granted a tax exemption thereunder, no benefits or other payments shall be payable under this title to him, no payments shall be made on his behalf under part A of title XVIII, and no benefits or other payments under this title shall be payable on the basis of his wages and self-employment income to any other person, after the filing of such waiver.

(3) If, after an exemption referred to in paragraph (1) or (2) is granted to an individual, such exemption ceases to be effective, the waiver referred to in such paragraph shall cease to be applicable in the case of benefits and other payments under this title and part A of title XVIII to the extent based on—

(A) his wages for and after the calendar year following the calendar year in which occurs the failure to meet the requirements of section 1402(g) or 3127 of the Internal Revenue Code of 1986[77] on which the cessation of such exemption is based, and

(B) his self-employment income for and after the taxable year in which occurs such failure.

Increase in Old-Age Insurance Benefit Amounts on Account of Delayed Retirement

(w)(1) The amount of an old-age insurance benefit (other than a benefit based on a primary insurance amount determined under section 215(a)(3) as in effect in December 1978 or section 215(a)(1)(C)(i) as in effect thereafter) which is payable without regard to this subsection to an individual shall be increased by—

(A) the applicable percentage (as determined under paragraph (6)) of such amount, multiplied by

(B) the number (if any) of the increment months for such individual.

(2) For purposes of this subsection, the number of increment months for any individual shall be a number equal to the total number of the months—

[76] See P.L. 83–591, §1402(g) (this volume).
[77] See P.L. 83–591 (this volume).

(A) which have elapsed after the month before the month in which such individual attained retirement age (as defined in section 216(l)) or (if later) December 1970 and prior to the month in which such individual attained age 70, and

(B) with respect to which—

(i) such individual was a fully insured individual (as defined in section 214(a)),

(ii) such individual either was not entitled to an old-age insurance benefit or, if so entitled, did not receive benefits pursuant to a request by such individual that benefits not be paid, and

(iii) such individual was not subject to a penalty imposed under section 1129A.

(3) For purposes of applying the provisions of paragraph (1), a determination shall be made under paragraph (2) for each year, beginning with 1972, of the total number of an individual's increment months through the year for which the determination is made and the total so determined shall be applicable to such individual's old-age insurance benefits beginning with benefits for January of the year following the year for which such determination is made; except that the total number applicable in the case of an individual who attains age 70 after 1972 shall be determined through the month before the month in which he attains such age and shall be applicable to his old-age insurance benefit beginning with the month in which he attains such age.

(4) This subsection shall be applied after reduction under section 203(a).

(5) If an individual's primary insurance amount is determined under paragraph (3) of section 215(a) as in effect in December 1978, or section 215(a)(1)(C)(i) as in effect thereafter, and, as a result of this subsection, he would be entitled to a higher old-age insurance benefit if his primary insurance amount were determined under section 215(a) (whether before, in, or after December 1978) without regard to such paragraph, such individual's old-age insurance benefit based upon his primary insurance amount determined under such paragraph shall be increased by an amount equal to the difference between such benefit and the benefit to which he would be entitled if his primary insurance amount were determined under such section without regard to such paragraph.

(6) For purposes of paragraph (1)(A), the "applicable percentage" is—

(A) 1/12 of 1 percent in the case of an individual who first becomes eligible for an old-age insurance benefit in any calendar year before 1979;

(B) 1/4 of 1 percent in the case of an individual who first becomes eligible for an old-age insurance benefit in any calendar year after 1978 and before 1987;

(C) in the case of an individual who first becomes eligible for an old-age insurance benefit in a calendar year after 1986 and before 2005, a percentage equal to the applicable percentage in effect under this paragraph for persons who first became eligible for an old-age insurance benefit in the preceding calendar year (as increased pursu-

ant to this subparagraph), plus 1/24 of 1 percent if the calendar year in which that particular individual first becomes eligible for such benefit is not evenly divisible by 2; and

(D) 2/3 of 1 percent in the case of an individual who first becomes eligible for an old-age insurance benefit in a calendar year after 2004.

Limitation on Payments to Prisoners, Certain Other Inmates of Publicly Funded Institutions, Fugitives, Probationers, and Parolees [78]

(x)(1)(A) Notwithstanding any other provision of this title, no monthly benefits shall be paid under this section or under section 223 to any individual for any month ending with or during or beginning with or during a period of more than 30 days throughout all of which such individual—

(i) is confined in a jail, prison, or other penal institution or correctional facility pursuant to his conviction of a criminal offense,

(ii) is confined by court order in an institution at public expense in connection with—

(I) a verdict or finding that the individual is guilty but insane, with respect to a criminal offense,

(II) a verdict or finding that the individual is not guilty of such an offense by reason of insanity,

(III) a finding that such individual is incompetent to stand trial under an allegation of such an offense, or

(IV) a similar verdict or finding with respect to such an offense based on similar factors (such as a mental disease, a mental defect, or mental incompetence), [79]

(iii) immediately upon completion of confinement as described in clause (i) pursuant to conviction of a criminal offense an element of which is sexual activity, is confined by court order in an institution at public expense pursuant to a finding that the individual is a sexually dangerous person or a sexual predator or a similar finding, [80]

(iv) [81] is fleeing to avoid prosecution, or custody or confinement after conviction, under the laws of the place from which the person flees, for a crime, or an attempt to commit a crime, which is a felony under the laws of the place from which the person flees, or, in jurisdictions that do not define crimes as felonies, is punishable by death or imprisonment for a term exceeding 1 year regardless of the actual sentence imposed, or

[78] P.L. 108–203, §203(a)(1), struck out "Prisoners and Certain Other Inmates of Publicly Funded Institutions" and substituted "Prisoners, Certain Other Inmates of Publicly Funded Institutions, Fugitives, Probationers, and Parolees", effective December 1, 2004.

[79] P.L. 108–203, §203(a)(2), struck out "or".

[80] P.L. 108–203, §203(a)(3), struck out the period and substituted a comma.

[81] P.L. 108–203, §203(a)(4), added clause (iv), effective December 1, 2004.

(v)[82] is violating a condition of probation or parole imposed under Federal or State law.

(B)(i) For purposes of clause (i) of subparagraph (A), an individual shall not be considered confined in an institution comprising a jail, prison, or other penal institution or correctional facility during any month throughout which such individual is residing outside such institution at no expense (other than the cost of monitoring) to such institution or the penal system or to any agency to which the penal system has transferred jurisdiction over the individual.

(ii) For purposes of clause (ii) of subparagraph (A), an individual confined in an institution as described in such clause (ii) shall be treated as remaining so confined until—

(I) he or she is released from the care and supervision of such institution, and

(II) such institution ceases to meet the individual's basic living needs.

(iii)[83] Notwithstanding subparagraph (A), the Commissioner shall, for good cause shown, pay the individual benefits that have been withheld or would otherwise be withheld pursuant to clause (iv) or (v) of subparagraph (A) if the Commissioner determines that—

(I) a court of competent jurisdiction has found the individual not guilty of the criminal offense, dismissed the charges relating to the criminal offense, vacated the warrant for arrest of the individual for the criminal offense, or issued any similar exonerating order (or taken similar exonerating action), or

(II) the individual was erroneously implicated in connection with the criminal offense by reason of identity fraud.

(iv)[84] Notwithstanding subparagraph (A), the Commissioner may, for good cause shown based on mitigating circumstances, pay the individual benefits that have been withheld or would otherwise be withheld pursuant to clause (iv) or (v) of subparagraph (A) if the Commissioner determines that—

(I) the offense described in clause (iv) or underlying the imposition of the probation or parole described in clause (v) was nonviolent and not drug-related, and

(II) in the case of an individual from whom benefits have been withheld or otherwise would be withheld pursuant to subparagraph (A)(v), the action that resulted in the violation of a condition of probation or parole was nonviolent and not drug-related.

(2) Benefits which would be payable to any individual (other than a confined individual to whom benefits are not payable by reason of paragraph (1)) under this title on the basis of the

[82] P.L. 108–203, §203(a)(4), also added clause (v), effective December 1, 2004.
[83] P.L. 108–203, §203(a)(5), added clause (iii), effective December 1, 2004.
[84] P.L. 108–203, §203(a)(5), also added clause (iv), effective December 1, 2004.

wages and self-employment income of such a confined individual but for the provisions of paragraph (1), shall be payable as though such confined individual were receiving such benefits under this section or section 223.

(3)(A) Notwithstanding the provisions of section 552a of title 5, United States Code[85], or any other provision of Federal or State law, any agency of the United States Government or of any State (or political subdivision thereof) shall make available to the Commissioner of Social Security, upon written request, the name and social security account number of any individual who is confined as described in paragraph (1) if the confinement is under the jurisdiction of such agency and the Commissioner of Social Security requires such information to carry out the provisions of this section.

(B)(i) The Commissioner shall enter into an agreement under this subparagraph with any interested State or local institution comprising a jail, prison, penal institution, or correctional facility, or comprising any other institution a purpose of which is to confine individuals as described in paragraph (1)(A)(ii). Under such agreement—

(I) the institution shall provide to the Commissioner, on a monthly basis and in a manner specified by the Commissioner, the names, Social Security account numbers, dates of birth, confinement commencement dates, and, to the extent available to the institution, such other identifying information concerning the individuals confined in the institution as the Commissioner may require for the purpose of carrying out paragraph (1) and other provisions of this title; and

(II) the Commissioner shall pay to the institution, with respect to information described in subclause (I) concerning each individual who is confined therein as described in paragraph (1)(A), who receives a benefit under this title for the month preceding the first month of such confinement, and whose benefit under this title is determined by the Commissioner to be not payable by reason of confinement based on the information provided by the institution, $400 (subject to reduction under clause (ii)) if the institution furnishes the information to the Commissioner within 30 days after the date such individual's confinement in such institution begins, or $200 (subject to reduction under clause (ii)) if the institution furnishes the information after 30 days after such date but within 90 days after such date.

(ii) The dollar amounts specified in clause (i)(II) shall be reduced by 50 percent if the Commissioner is also required to make a payment to the institution with respect to the same individual under an agreement entered into under section 1611(e)(1)(I).

[85] See Vol. II, Title §552a.

(iii) There are authorized to be transferred from the Federal Old–Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, as appropriate, such sums as may be necessary to enable the Commissioner to make payments to institutions required by clause (i)(II).

(iv) The Commissioner shall maintain, and shall provide on a reimbursable basis, information obtained pursuant to agreements entered into under this paragraph to any agency administering a Federal or federally–assisted cash, food, or medical assistance program for eligibility and other administrative purposes under such program.

(C)[86] Notwithstanding the provisions of section 552a of title 5, United States Code, or any other provision of Federal or State law (other than section 6103 of the Internal Revenue Code of 1986 and section 1106(c) of this Act), the Commissioner shall furnish any Federal, State, or local law enforcement officer, upon the written request of the officer, with the current address, Social Security number, and photograph (if applicable) of any beneficiary under this title, if the officer furnishes the Commissioner with the name of the beneficiary, and other identifying information as reasonably required by the Commissioner to establish the unique identity of the beneficiary, and notifies the Commissioner that—

(i) the beneficiary is described in clause (iv) or (v) of paragraph (1)(A); and

(ii) the location or apprehension of the beneficiary is within the officer's official duties.

(y) Notwithstanding any other provision of law, no monthly benefit under this title shall be payable to any alien in the United States for any month during which such alien is not lawfully present in the United States as determined by the Attorney General.

REDUCTION OF INSURANCE BENEFITS

Maximum Benefits

SEC. 203. [42 U.S.C. 403] (a)(1) In the case of an individual whose primary insurance amount has been computed or recomputed under section 215(a)(1) or (4), or section 215(d), as in effect after December 1978, the total monthly benefits to which beneficiaries may be entitled under section 202 or 223 for a month on the basis of the wages and self–employment income of such individual shall, except as provided by paragraphs (3) and (6) (but prior to any increases resulting from the application of paragraph (2)(A)(ii)(III) of section 215(i)), be reduced as necessary so as not to exceed—

(A) 150 percent of such individual's primary insurance amount to the extent that it does not exceed the amount established with respect to this subparagraph by paragraph (2),

[86] P.L. 108–203, §203(a)(6), added subparagraph (C), effective December 1, 2004.

(B) 272 percent of such individual's primary insurance amount to the extent that it exceeds the amount established with respect to subparagraph (A) but does not exceed the amount established with respect to this subparagraph by paragraph (2),

(C) 134 percent of such individual's primary insurance amount to the extent that it exceeds the amount established with respect to subparagraph (B) but does not exceed the amount established with respect to this subparagraph by paragraph (2), and

(D) 175 percent of such individual's primary insurance amount to the extent that it exceeds the amount established with respect to subparagraph (C).

Any such amount that is not a multiple of $0.10 shall be decreased to the next lower multiple of $0.10.

(2)(A) For individuals who initially become eligible for old-age or disability insurance benefits, or who die (before becoming so eligible for such benefits), in the calendar year 1979, the amounts established with respect to subparagraphs (A), (B), and (C) of paragraph (1) shall be $230, $332, and $433, respectively.

(B) For individuals who initially become eligible for old-age or disability insurance benefits, or who die (before becoming so eligible for such benefits), in any calendar year after 1979, each of the amounts so established shall equal the product of the corresponding amount established for the calendar year 1979 by subparagraph (A) of this paragraph and the quotient obtained under subparagraph (B)(ii) of section 215(a)(1), with such product being rounded in the manner prescribed by section 215(a)(1)(B)(iii).

(C) In each calendar year after 1978 the Commissioner of Social Security shall publish in the Federal Register, on or before November 1, the formula which (except as provided in section 215(i)(2)(D)) is to be applicable under this paragraph to individuals who become eligible for old-age or disability insurance benefits, or who die (before becoming eligible for such benefits), in the following calendar year.

(D) A year shall not be counted as the year of an individual's death or eligibility for purposes of this paragraph or paragraph (8) in any case where such individual was entitled to a disability insurance benefit for any of the 12 months immediately preceding the month of such death or eligibility (but there shall be counted instead the year of the individual's eligibility for the disability insurance benefits to which he was entitled during such 12 months).

(3)(A) When an individual who is entitled to benefits on the basis of the wages and self-employment income of any insured individual and to whom this subsection applies would (but for the provisions of section 202(k)(2)(A)) be entitled to child's insurance benefits for a month on the basis of the wages and self-employment income of one or more other insured individuals, the total monthly benefits to which all beneficiaries are entitled on the basis of such wages and self-employment income shall not be reduced under this subsection to less than the smaller of—

(i) the sum of the maximum amounts of benefits payable on the basis of the wages and self-employment income of all such insured individuals, or

(ii) an amount (I) initially equal to the product of 1.75 and the primary insurance amount that would be computed under section 215(a)(1), for January of the year determined for purposes of this clause under the following two sentences, with respect to average indexed monthly earnings equal to one-twelfth of the contribution and benefit base determined for that year under section 230, and (II) thereafter increased in accordance with the provisions of section 215(i)(2)(A)(ii).

The year established for purposes of clause (ii) shall be 1983 or, if it occurs later with respect to any individual, the year in which occurred the month that the application of the reduction provisions contained in this subparagraph began with respect to benefits payable on the basis of the wages and self-employment income of the insured individual. If for any month subsequent to the first month for which clause (ii) applies (with respect to benefits payable on the basis of the wages and self-employment income of the insured individual) the reduction under this subparagraph ceases to apply, then the year determined under the preceding sentence shall be redetermined (for purposes of any subsequent application of this subparagraph with respect to benefits payable on the basis of such wages and self-employment income) as though this subparagraph had not been previously applicable.

(B) When two or more persons were entitled (without the application of section 202(j)(1) and section 223(b)) to monthly benefits under section 202 or 223 for January 1971 or any prior month on the basis of the wages and self-employment income of such insured individual and the provisions of this subsection as in effect for any such month were applicable in determining the benefit amount of any persons on the basis of such wages and self-employment income, the total of benefits for any month after January 1971 shall not be reduced to less than the largest of—

(i) the amount determined under this subsection without regard to this subparagraph,

(ii) the largest amount which has been determined for any month under this subsection for persons entitled to monthly benefits on the basis of such insured individual's wages and self-employment income, or

(iii) if any persons are entitled to benefits on the basis of such wages and self-employment income for the month before the effective month (after September 1972) of a general benefit increase under this title (as defined in section 215(i)(3)) or a benefit increase under the provisions of section 215(i), an amount equal to the sum of amounts derived by multiplying the benefit amount determined under this title (excluding any part thereof determined under section 202(w)) for the month before such effective month (including this subsection, but without the application of section 222(b), section 202(q), and subsections (b), (c), and (d) of this section), for each such person for such month, by a percentage equal to the percentage of the increase pro-

vided under such benefit increase (with any such increased amount which is not a multiple of $0.10 being rounded to the next lower multiple of $0.10);

but in any such case (I) subparagraph (A) of this paragraph shall not be applied to such total of benefits after the application of clause (ii) or (iii), and (II) if section 202(k)(2)(A) was applicable in the case of any such benefits for a month, and ceases to apply for a month after such month, the provisions of clause (ii) or (iii) shall be applied, for and after the month in which section 202(k)(2)(A) ceases to apply, as though subparagraph (A) of this paragraph had not been applicable to such total of benefits for the last month for which clause (ii) or (iii) was applicable.

(C) When any of such individuals is entitled to monthly benefits as a divorced spouse under section 202(b) or (c) or as a surviving divorced spouse under section 202(e) or (f) for any month, the benefit to which he or she is entitled on the basis of the wages and self-employment income of such insured individual for such month shall be determined without regard to this subsection, and the benefits of all other individuals who are entitled for such month to monthly benefits under section 202 on the wages and self-employment income of such insured individual shall be determined as if no such divorced spouse or surviving divorced spouse were entitled to benefits for such month.

(D) In any case in which—

(i) two or more individuals are entitled to monthly benefits for the same month as a spouse under subsection (b) or (c) of section 202, or as a surviving spouse under subsection (e), (f), or (g) of section 202,

(ii) at least one of such individuals is entitled by reason of subparagraph (A)(ii) or (B) of section 216(h)(1), and

(iii) such entitlements are based on the wages and self-employment income of the same insured individual,

the benefit of the entitled individual whose entitlement is based on a valid marriage (as determined without regard to subparagraphs (A)(ii) and (B) of section 216(h)(1)) to such insured individual shall, for such month and all months thereafter, be determined without regard to this subsection, and the benefits of all other individuals who are entitled, for such month or any month thereafter, to monthly benefits under section 202 based on the wages and self-employment income of such insured individual shall be determined as if such entitled individual were not entitled to benefits for such month.

(4) In any case in which benefits are reduced pursuant to the provisions of this subsection, the reduction shall be made after any deductions under this section and after any deductions under section 222(b). Notwithstanding the preceding sentence, any reduction under this subsection in the case of an individual who is entitled to a benefit under subsection (b), (c), (d), (e), (f), (g), or (h) of section 202 for any month on the basis of the same wages and self-employment income as another person—

(A) who also is entitled to a benefit under subsection (b), (c), (d), (e), (f), (g), or (h) of section 202 for such month,

(B) who does not live in the same household as such individual, and

(C) whose benefit for such month is suspended (in whole or in part) pursuant to subsection (h)(3) of this section,

shall be made before the suspension under subsection (h)(3). Whenever a reduction is made under this subsection in the total of monthly benefits to which individuals are entitled for any month on the basis of the wages and self-employment income of an insured individual, each such benefit other than the old-age or disability insurance benefit shall be proportionately decreased.

(5) Notwithstanding any other provision of law, when—

(A) two or more persons are entitled to monthly benefits for a particular month on the basis of the wages and self-employment income of an insured individual and (for such particular month) the provisions of this subsection are applicable to such monthly benefits, and

(B) such individual's primary insurance amount is increased for the following month under any provision of this title,

then the total of monthly benefits for all persons on the basis of such wages and self-employment income for such particular month, as determined under the provisions of this subsection, shall for purposes of determining the total monthly benefits for all persons on the basis of such wages and self-employment income for months subsequent to such particular month be considered to have been increased by the smallest amount that would have been required in order to assure that the total of monthly benefits payable on the basis of such wages and self-employment income for any such subsequent month will not be less (after the application of the other provisions of this subsection and section 202(q)) than the total of monthly benefits (after the application of the other provisions of this subsection and section 202(q)) payable on the basis of such wages and self-employment income for such particular month.

(6) Notwithstanding any of the preceding provisions of this subsection other than paragraphs (3)(A), (3)(C), (3)(D), (4), and (5) (but subject to section 215(i)(2)(A)(ii)), the total monthly benefits to which beneficiaries may be entitled under sections 202 and 223 for any month on the basis of the wages and self-employment income of an individual entitled to disability insurance benefits shall be reduced (before the application of section 224) to the smaller of—

(A) 85 percent of such individual's average indexed monthly earnings (or 100 percent of his primary insurance amount, if larger), or

(B) 150 percent of such individual's primary insurance amount.

(7) In the case of any individual who is entitled for any month to benefits based upon the primary insurance amounts of two or more insured individuals, one or more of which primary insurance amounts were determined under section 215(a) or 215(d) as in effect (without regard to the table contained therein) prior to January 1979 and one or more of which primary insurance amounts were determined under section 215(a)(1) or (4), or section 215(d), as in effect after December 1978, the total benefits payable to that individual and all other individuals entitled to benefits for that month based upon

those primary insurance amounts shall be reduced to an amount equal to the amount determined in accordance with the provisions of paragraph (3)(A)(ii) of this subsection, except that for this purpose the references to subparagraph (A) in the last two sentences of paragraph (3)(A) shall be deemed to be references to paragraph (7).

(8) Subject to paragraph (7) and except as otherwise provided in paragraph (10)(C), this subsection as in effect in December 1978 shall remain in effect with respect to a primary insurance amount computed under section 215(a) or (d), as in effect (without regard to the table contained therein) in December 1978 and as amended by section 5117 of the Omnibus Budget Reconciliation Act of 1990,[87] except that a primary insurance amount so computed with respect to an individual who first becomes eligible for an old-age or disability insurance benefit, or dies (before becoming eligible for such a benefit), after December 1978, shall instead be governed by this section as in effect after December 1978. For purposes of the preceding sentence, the phrase "rounded to the next higher multiple of $0.10", as it appeared in subsection (a)(2)(C) of this section as in effect in December 1978, shall be deemed to read "rounded to the next lower multiple of $0.10".

(9) When—

(A) one or more persons were entitled (without the application of section 202(j)(1)) to monthly benefits under section 202 for May 1978 on the basis of the wages and self-employment income of an individual,

(B) the benefit of at least one such person for June 1978 is increased by reason of the amendments made by section 204 of the Social Security Amendments of 1977[88]; and

(C) the total amount of benefits to which all such persons are entitled under such section 202 are reduced under the provisions of this subsection (or would be so reduced except for the first sentence of section 203(a)(4)),

then the amount of the benefit to which each such person is entitled for months after May 1978 shall be increased (after such reductions are made under this subsection) to the amount such benefits would have been if the benefit of the person or persons referred to in subparagraph (B) had not been so increased.

(10)(A) Subject to subparagraphs (B) and (C)—

(i) the total monthly benefits to which beneficiaries may be entitled under sections 202 and 223 for a month on the basis of the wages and self-employment income of an individual whose primary insurance amount is computed under section 215(a)(2)(B)(i) shall equal the total monthly benefits which were authorized by this section with respect to such individual's primary insurance amount for the last month of his prior entitlement to disability insurance benefits, increased for this purpose by the general benefit increases and other increases under section 215(i) that would have applied to such total monthly benefits had the individual remained entitled to disability insur-

[87] P.L. 101–508.
[88] P.L. 95–216.

ance benefits until the month in which he became entitled to old-age insurance benefits or reentitled to disability insurance benefits or died, and

(ii) the total monthly benefits to which beneficiaries ay be entitled under sections 202 and 223 for a month on the basis of the wages and self-employment income of an individual whose primary insurance amount is computed under section 215(a)(2)(C) shall equal the total monthly benefits which were authorized by this section with respect to such individual's primary insurance amount for the last month of his prior entitlement to disability insurance benefits.

(B) In any case in which—

(i) the total monthly benefits with respect to such individual's primary insurance amount for the last month of his prior entitlement to disability insurance benefits was computed under paragraph (6), and

(ii) the individual's primary insurance amount is computed under subparagraph (B)(i) or (C) of section 215(a)(2) by reason of the individual's entitlement to old-age insurance benefits or death,

the total monthly benefits shall equal the total monthly benefits that would have been authorized with respect to the primary insurance amount for the last month of his prior entitlement to disability insurance benefits if such total monthly benefits had been computed without regard to paragraph (6).

(C) This paragraph shall apply before the application of paragraph (3)(A), and before the application of section 203(a)(1) of this Act as in effect in December 1978.

Deductions on Account of Work

(b)(1) Deductions, in such amounts and at such time or times as the Commissioner of Social Security shall determine, shall be made from any payment or payments under this title to which an individual is entitled, and from any payment or payments to which any other persons are entitled on the basis of such individual's wages and self-employment income, until the total of such deductions equals—

(A) such individual's benefit or benefits under section 202 for any month, and

(B) if such individual was entitled to old-age insurance benefits under section 202(a) for such month, the benefit or benefits of all other persons for such month under section 202 based on such individual's wages and self-employment income,

if for such month he is charged with excess earnings, under the provisions of subsection (f) of this section, equal to the total of benefits referred to in clauses (A) and (B). If the excess earnings so charged are less than such total of benefits, such deductions with respect to such month shall be equal only to the amount of such excess earnings. If a child who has attained the age of 18 and is entitled to child's insurance benefits, or a person who is entitled to mother's or father's insurance benefits, is married to an individual entitled to old-age insurance benefits under section 202(a), such child or such person, as the case may be, shall, for the purposes

of this subsection and subsection (f), be deemed to be entitled to such benefits on the basis of the wages and self-employment income of such individual entitled to old-age insurance benefits. If a deduction has already been made under this subsection with respect to a person's benefit or benefits under section 202 for a month, he shall be deemed entitled to payments under such section for such month for purposes of further deductions under this subsection, and for purposes of charging of each person's excess earnings under subsection (f), only to the extent of the total of his benefits remaining after such earlier deductions have been made. For purposes of this subsection and subsection (f)—

(i) an individual shall be deemed to be entitled to payments under section 202 equal to the amount of the benefit or benefits to which he is entitled under such section after the application of subsection (a) of this section, but without the application of the first sentence of paragraph (4) thereof; and

(ii) if a deduction is made with respect to an individual's benefit or benefits under section 202 because of the occurrence in any month of an event specified in subsection (c) or (d) of this section or in section 222(b), such individual shall not be considered to be entitled to any benefits under such section 202 for such month.

(2)(A) Except as provided in subparagraph (B), in any case in which—

(i) any of the other persons referred to in paragraph (1)(B) is entitled to monthly benefits as a divorced spouse under section 202(b) or (c) for any month, and

(ii) such person has been divorced for not less than 2 years,

the benefit to which he or she is entitled on the basis of the wages and self-employment income of the individual referred to in paragraph (1) for such month shall be determined without regard to deductions under this subsection as a result of excess earnings of such individual, and the benefits of all other individuals who are entitled for such month to monthly benefits under section 202 on the basis of the wages and self-employment income of such individual referred to in paragraph (1) shall be determined as if no such divorced spouse were entitled to benefits for such month.

(B) Clause (ii) of subparagraph (A) shall not apply with respect to any divorced spouse in any case in which the individual referred to in paragraph (1) became entitled to old-age insurance benefits under section 202(a) before the date of the divorce.

Deductions on Account of Noncovered Work Outside the United States or Failure to Have Child in Care

(c) Deductions, in such amounts and at such time or times as the Commissioner of Social Security shall determine, shall be made from any payment or payments under this title to which an individual is entitled, until the total of such deductions equals such individual's benefits or benefit under section 202 for any month—

(1) in which such individual is under retirement age (as defined in section 216(l)) and for more than forty-five hours of

which such individual engaged in noncovered remunerative activity outside the United States;

(2) in which such individual, if a wife or husband under retirement age (as defined in section 216(l)) entitled to a wife's or husband's insurance benefit, did not have in his or her care (individually or jointly with his or her spouse) a child of such spouse entitled to a child's insurance benefit and such wife's or husband's insurance benefit for such month was not reduced under the provisions of section 202(q);

(3) in which such individual, if a widow or widower entitled to a mother's or father's insurance benefit, did not have in his or her care a child of his or her deceased spouse entitled to a child's insurance benefit; or

(4) in which such an individual, if a surviving divorced mother or father entitled to a mother's or father's insurance benefit, did not have in his or her care a child of his or her deceased former spouse who (A) is his or her son, daughter, or legally adopted child and (B) is entitled to a child's insurance benefit on the basis of the wages and self-employment income of such deceased former spouse.

For purposes of paragraphs (2), (3), and (4) of this subsection, a child shall not be considered to be entitled to a child's insurance benefit for any month in which paragraph (1) of section 202(s) applies or an event specified in section 222(b) occurs with respect to such child. Subject to paragraph (3) of such section 202(s), no deduction shall be made under this subsection from any child's insurance benefit for the month in which the child entitled to such benefit attained the age of eighteen or any subsequent month; nor shall any deduction be made under this subsection from any widow's or widower's insurance benefit if the widow, surviving divorced wife, widower, or surviving divorced husband involved became entitled to such benefit prior to attaining age 60.

Deductions From Dependents' Benefits on Account of Noncovered Work Outside the United States by Old–Age Insurance Beneficiary

(d)(1)(A) Deductions shall be made from any wife's, husband's, or child's insurance benefit, based on the wages and self–employment income of an individual entitled to old–age insurance benefits, to which a wife, divorced wife, husband, divorced husband, or child is entitled, until the total of such deductions equals such wife's, husband's, or child's insurance benefit or benefits under section 202 for any month in which such individual is under retirement age (as defined in section 216(l)) and for more than forty–five hours of which such individual engaged in noncovered remunerative activity outside the United States.

(B)(i) Except as provided in clause (ii), in any case in which—

(I) a divorced spouse is entitled to monthly benefits under section 202(b) or (c) for any month, and

(II) such divorced spouse has been divorced for not less than 2 years,

the benefit to which he or she is entitled for such month on the basis of the wages and self-employment income of the individual entitled to old-age insurance benefits referred to in subparagraph

(A) shall be determined without regard to deductions under this paragraph as a result of excess earnings of such individual, and the benefits of all other individuals who are entitled for such month to monthly benefits under section 202 on the basis of the wages and self-employment income of such individual referred to in subparagraph (A) shall be determined as if no such divorced spouse were entitled to benefits for such month.

(ii) Subclause (II) of clause (i) shall not apply with respect to any divorced spouse in any case in which the individual entitled to old-age insurance benefits referred to in subparagraph (A) became entitled to such benefits before the date of the divorce.

(2) Deductions shall be made from any child's insurance benefit to which a child who has attained the age of eighteen is entitled, or from any mother's or father's insurance benefit to which a person is entitled, until the total of such deductions equals such child's insurance benefit or benefits or mother's or father's insurance benefit or benefits under section 202 for any month in which such child or person entitled to mother's or father's insurance benefits is married to an individual under retirement age (as defined in section 216(l)), who is entitled to old-age insurance benefits and for more than forty-five hours of which such individual engaged in noncovered remunerative activity outside the United States.

Occurrence of More Than One Event

(e) If more than one of the events specified in subsections (c) and (d) and section 222(b) occurs in any one month which would occasion deductions equal to a benefit for such month, only an amount equal to such benefit shall be deducted.

Months to Which Earnings Are Charged

(f) For purposes of subsection (b)—

(1) The amount of an individual's excess earnings (as defined in paragraph (3)) shall be charged to months as follows: There shall be charged to the first month of such taxable year an amount of his excess earnings equal to the sum of the payments to which he and all other persons (excluding divorced spouses referred to in subsection (b)(2)) are entitled for such month under section 202 on the basis of his wages and self-employment income (or the total of his excess earnings if such excess earnings are less than such sum), and the balance, if any, of such excess earnings shall be charged to each succeeding month in such year to the extent, in the case of each such month, of the sum of the payments to which such individual and all such other persons are entitled for such month under section 202 on the basis of his wages and self-employment income, until the total of such excess has been so charged. Where an individual is entitled to benefits under section 202(a) and other persons (excluding divorced spouses referred to in subsection (b)(2)) are entitled to benefits under section 202(b), (c), or (d) on the basis of the wages and self-employment income of such individual, the excess earnings of such individual for any taxable year shall be charged in accordance with the provisions of this subsection before the excess earnings of such per-

sons for a taxable year are charged to months in such individual's taxable year. Notwithstanding the preceding provisions of this paragraph but subject to section 202(s), no part of the excess earnings of an individual shall be charged to any month (A) for which such individual was not entitled to a benefit under this title, (B) in which such individual was at or above retirement age (as defined in section 216(l)), (C) in which such individual, if a child entitled to child's insurance benefits, has attained the age of 18, (D) for which such individual is entitled to widow's or widower's insurance benefits if such individual became so entitled prior to attaining age 60, (E) in which such individual did not engage in self-employment and did not render services for wages (determined as provided in paragraph (5) of this subsection) of more than the applicable exempt amount as determined under paragraph (8), if such month is in the taxable year in which occurs the first month after December 1977 that is both (i) a month for which the individual is entitled to benefits under subsection (a), (b), (c), (d), (e), (f), (g), or (h) of section 202 (without having been entitled for the preceding month to a benefit under any other of such subsections), and (ii) a month in which the individual did not engage in self-employment and did not render services for wages (determined as provided in paragraph (5)) of more than the applicable exempt amount as determined under paragraph (8), or (F) in which such individual did not engage in self-employment and did not render services for wages (determined as provided in paragraph (5) of this subsection) of more than the applicable exempt amount as determined under paragraph (8), in the case of an individual entitled to benefits under section 202(b) or (c) (but only by reason of having a child in his or her care within the meaning of paragraph (1)(B) of subsection (b) or (c), as may be applicable) or under section 202(d) or (g), if such month is in a year in which such entitlement ends for a reason other than the death of such individual, and such individual is not entitled to any benefits under this title for the month following the month during which such entitlement under section 202(b), (d), or (g) ended.

(2) As used in paragraph (1), the term "first month of such taxable year" means the earliest month in such year to which the charging of excess earnings described in such paragraph is not prohibited by the application of clauses (A), (B), (C), (D), (E), and (F) thereof.

(3) For purposes of paragraph (1) and subsection (h), an individual's excess earnings for a taxable year shall be 33 ⅓ percent of his earnings for such year in excess of the product of the applicable exempt amount as determined under paragraph (8) in the case of an individual who has attained (or, but for the individual's death, would have attained) retirement age (as defined in section 216(l)) before the close of such taxable year, or 50 percent of his earnings for such year in excess of such product in the case of any other individual, multiplied by the number of months in such year, except that, in determining an individual's excess earnings for the taxable year in which he attains retirement age (as defined in section 216(l)), there shall be excluded any earnings of such individual for the month in which he attains such age and any subsequent month (with

any net earnings or net loss from self-employment in such year being prorated in an equitable manner under regulations of the Commissioner of Social Security). For purposes of the preceding sentence, notwithstanding section 211(e), the number of months in the taxable year in which an individual dies shall be 12. The excess earnings as derived under the first sentence of this paragraph, if not a multiple of $1, shall be reduced to the next lower multiple of $1.

(4) For purposes of clause (E) of paragraph (1)—

(A) An individual will be presumed, with respect to any month, to have been engaged in self-employment in such month until it is shown to the satisfaction of the Commissioner of Social Security that such individual rendered no substantial services in such month with respect to any trade or business the net income or loss of which is includible in computing (as provided in paragraph (5) of this subsection) his net earnings or net loss from self-employment for any taxable year. The Commissioner of Social Security shall by regulations prescribe the methods and criteria for determining whether or not an individual has rendered substantial services with respect to any trade or business.

(B) An individual will be presumed, with respect to any month, to have rendered services for wages (determined as provided in paragraph (5) of this subsection) of more than the applicable exempt amount as determined under paragraph (8) until it is shown to the satisfaction of the Commissioner of Social Security that such individual did not render such services in such month for more than such amount.

(5)(A) An individual's earnings for a taxable year shall be (i) the sum of his wages for services rendered in such year and his net earnings from self-employment for such year, minus (ii) any net loss from self-employment for such year.

(B) For purposes of this section—

(i) an individual's net earnings from self-employment for any taxable year shall be determined as provided in section 211, except that paragraphs (1), (4), and (5) of section 211(c) shall not apply and the gross income shall be computed by excluding the amounts provided by subparagraph (D), and

(ii) an individual's net loss from self-employment for any taxable year is the excess of the deductions (plus his distributive share of loss described in section 702(a)(8) of the Internal Revenue Code of 1986[89] taken into account under clause (i) over the gross income (plus his distributive share of income so described) taken into account under clause (i).

(C) For purposes of this subsection, an individual's wages shall be computed without regard to the limitations as to amounts of remuneration specified in paragraphs (1), (6)(B), (6)(C), (7)(B), and (8) of section 209(a); and in making such computation services which do not constitute employment as defined in section 210, performed within the United States by the individual as an employee or per-

[89] See Vol. II, P.L. 83–591, §702(a)(8).

formed outside the United States in the active military or naval service of the United States, shall be deemed to be employment as so defined if the remuneration for such services is not includible in computing his net earnings or net loss from self-employment. The term "wages" does not include—

(i) the amount of any payment made to, or on behalf of, an employee or any of his dependents (including any amount paid by an employer for insurance or annuities, or into a fund, to provide for any such payment) on account of retirement, or

(ii) any payment or series of payments by an employer to an employee or any of his dependents upon or after the termination of the employee's employment relationship because of retirement after attaining an age specified in a plan referred to in section 209(a)(11)(B) or in a pension plan of the employer.

(D) In the case of—

(i) an individual who has attained retirement age (as defined in section 216(l)) on or before the last day of the taxable year, and who shows to the satisfaction of the Commissioner of Social Security that he or she is receiving royalties attributable to a copyright or patent obtained before the taxable year in which he or she attained such age and that the property to which the copyright or patent relates was created by his or her own personal efforts, or

(ii) an individual who has become entitled to insurance benefits under this title, other than benefits under section 223 or benefits payable under section 202(d) by reason of being under a disability, and who shows to the satisfaction of the Commissioner of Social Security that he or she is receiving, in a year after his or her initial year of entitlement to such benefits, any other income not attributable to services performed after the month in which he or she initially became entitled to such benefits,

there shall be excluded from gross income any such royalties or other income.

(E) For purposes of this section, any individual's net earnings from self-employment which result from or are attributable to the performance of services by such individual as a director of a corporation during any taxable year shall be deemed to have been derived (and received) by such individual in that year, at the time the services were performed, regardless of when the income, on which the computation of such net earnings from self-employment is based, is actually paid to or received by such individual (unless such income was actually paid and received prior to that year).

(6) For purposes of this subsection, wages (determined as provided in paragraph (5)(C)) which, according to reports received by the Commissioner of Social Security, are paid to an individual during a taxable year shall be presumed to have been paid to him for services performed in such year until it is shown to the satisfaction of the Commissioner of Social Se-

curity that they were paid for services performed in another taxable year. If such reports with respect to an individual show his wages for a calendar year, such individual's taxable year shall be presumed to be a calendar year for purposes of this subsection until it is shown to the satisfaction of the Commissioner of Social Security that his taxable year is not a calendar year.

(7) Where an individual's excess earnings are charged to a month and the excess earnings so charged are less than the total of the payments (without regard to such charging) to which all persons (excluding divorced spouses referred to in subsection (b)(2)) are entitled under section 202 for such month on the basis of his wages and self-employment income, the difference between such total and the excess so charged to such month shall be paid (if it is otherwise payable under this title) to such individual and other persons in the proportion that the benefit to which each of them is entitled (without regard to such charging, without the application of section 202(k)(3), and prior to the application of section 203(a)) bears to the total of the benefits to which all of them are entitled.

(8)(A) Whenever the Commissioner of Social Security pursuant to section 215(i) increases benefits effective with the month of December following a cost-of-living computation quarter he shall also determine and publish in the Federal Register on or before November 1 of the calendar year in which such quarter occurs the new exempt amounts (separately stated for individuals described in subparagraph (D) and for other individuals) which are to be applicable (unless prevented from becoming effective by subparagraph (C)) with respect to taxable years ending in (or with the close of) the calendar year after the calendar year in which such benefit increase is effective (or, in the case of an individual who dies during the calendar year after the calendar year in which the benefit increase is effective, with respect to such individual's taxable year which ends, upon his death, during such year).

(B) Except as otherwise provided in subparagraph (D), the exempt amount which is applicable to individuals described in such subparagraph and the exempt amount which is applicable to other individuals, for each month of a particular taxable year, shall each be whichever of the following is the larger—

(i) the corresponding exempt amount which is in effect with respect to months in the taxable year in which the determination under subparagraph (A) is made, or

(ii) the product of the corresponding exempt amount which is in effect with respect to months in the taxable year ending after 2001 and before 2003 (with respect to individuals described in subparagraph (D)) or the taxable year ending after 1993 and before 1995 (with respect to other individuals), and the ratio of—

(I) the national average wage index (as defined in section 209(k)(1)) for the calendar year before the calendar year in which the determination under subparagraph (A) is made, to

(II) the national average wage index (as so defined) for 2000 (with respect to individuals described in subparagraph (D)) or 1992 (with respect to other individuals),

with such product, if not a multiple of $10, being rounded to the next higher multiple of $10 where such product is a multiple of $5 but not of $10 and to the nearest multiple of $10 in any other case. Whenever the Commissioner of Social Security determines that an exempt amount is to be increased in any year under this paragraph, he shall notify the House Committee on Ways and Means and the Senate Committee on Finance within 30 days after the close of the base quarter (as defined in section 215(i)(1)(A)) in such year of the estimated amount of such increase, indicating the new exempt amount, the actuarial estimates of the effect of the increase, and the actuarial assumptions and methodology used in preparing such estimates.

(C) Notwithstanding the determination of a new exempt amount by the Commissioner of Social Security under subparagraph (A) (and notwithstanding any publication thereof under such subparagraph or any notification thereof under the last sentence of subparagraph (B)), such new exempt amount shall not take effect pursuant thereto if during the calendar year in which such determination is made a law increasing the exempt amount is enacted.

(D) Notwithstanding any other provision of this subsection, the exempt amount which is applicable to an individual who has attained retirement age (as defined in section 216(l)) before the close of the taxable year involved shall be—

(i) for each month of any taxable year ending after 1995 and before 1997, $1,041.66 ⅔ ,

(ii) for each month of any taxable year ending after 1996 and before 1998, $1,125.00,

(iii) for each month of any taxable year ending after 1997 and before 1999, $1,208.33 ⅓ ,

(iv) for each month of any taxable year ending after 1998 and before 2000, $1,291.66 ⅔ ,

(v) for each month of any taxable year ending after 1999 and before 2001, $1,416.66 ⅔ ,

(vi) for each month of any taxable year ending after 2000 and before 2002, $2,083.33 ⅓ ,

(vii) for each month of any taxable year ending after 2001 and before 2003, $2,500.00.

(E) Notwithstanding subparagraph (D), no deductions in benefits shall be made under subsection (b) with respect to the earnings of any individual in any month beginning with the month in which the individual attains retirement age (as defined in section 216(l)).

(9) For purposes of paragraphs (3), (5)(D)(i), (8)(D), and (8)(E), the term "retirement age (as defined in section 216(l))", with respect to any individual entitled to monthly insurance benefits under section 202, means the retirement age (as so defined) which is applicable in the case of old-age insurance benefits, regardless of whether or not the particular benefits to

which the individual is entitled (or the only such benefits) are old-age insurance benefits.

Penalty for Failure To Report Certain Events

(g) Any individual in receipt of benefits subject to deduction under subsection (c), (or who is in receipt of such benefits on behalf of another individual), because of the occurrence of an event specified therein, who fails to report such occurrence to the Commissioner of Social Security prior to the receipt and acceptance of an insurance benefit for the second month following the month in which such event occurred, shall suffer deductions in addition to those imposed under subsection (c) as follows:

(1) if such failure is the first one with respect to which an additional deduction is imposed by this subsection, such additional deduction shall be equal to his benefit or benefits for the first month of the period for which there is a failure to report even though such failure is with respect to more than one month;

(2) if such failure is the second one with respect to which an additional deduction is imposed by this subsection, such additional deduction shall be equal to two times his benefit or benefits for the first month of the period for which there is a failure to report even though such failure is with respect to more than two months; and

(3) if such failure is the third or a subsequent one for which an additional deduction is imposed under this subsection, such additional deduction shall be equal to three times his benefit or benefits for the first month of the period for which there is a failure to report even though the failure to report is with respect to more than three months;

except that the number of additional deductions required by this subsection shall not exceed the number of months in the period for which there is a failure to report. As used in this subsection, the term "period for which there is a failure to report" with respect to any individual means the period for which such individual received and accepted insurance benefits under section 202 without making a timely report and for which deductions are required under subsection (c).

Report of Earnings to Commissioner of Social Security

(h)(1)(A) If an individual is entitled to any monthly insurance benefit under section 202 during any taxable year in which he has earnings or wages, as computed pursuant to paragraph (5) of subsection (f), in excess of the product of the applicable exempt amount as determined under subsection (f)(8) times the number of months in such year, such individual (or the individual who is in receipt of such benefit on his behalf) shall make a report to the Commissioner of Social Security of his earnings (or wages) for such taxable year. Such report shall be made on or before the fifteenth day of the fourth month following the close of such year, and shall contain such information and be made in such manner as the Commissioner of Social Security may by regulations prescribe. Such report need not be made for any taxable year—

(i) beginning with or after the month in which such individual attained retirement age (as defined in section 216(l)), or

(ii) if benefit payments for all months (in such taxable year) in which such individual is under retirement age (as defined in section 216(l)) have been suspended under the provisions of the first sentence of paragraph (3) of this subsection, unless—

(I) such individual is entitled to benefits under subsection (b), (c), (d), (e), (f), (g), or (h) of section 202,

(II) such benefits are reduced under subsection (a) of this section for any month in such taxable year, and

(III) in any such month there is another person who also is entitled to benefits under subsection (b), (c), (d), (e), (f), (g), or (h) of section 202 on the basis of the same wages and self-employment income and who does not live in the same household as such individual.

The Commissioner of Social Security may grant a reasonable extension of time for making the report of earnings required in this paragraph if the Commissioner finds that there is valid reason for a delay, but in no case may the period be extended more than four months.

(B) If the benefit payments of an individual have been suspended for all months in any taxable year under the provisions of the first sentence of paragraph (3) of this subsection, no benefit payment shall be made to such individual for any such month in such taxable year after the expiration of the period of three years, three months, and fifteen days following the close of such taxable year unless within such period the individual, or some other person entitled to benefits under this title on the basis of the same wages and self-employment income, files with the Commissioner of Social Security information showing that a benefit for such month is payable to such individual.

(2) If an individual fails to make a report required under paragraph (1), within the time prescribed by or in accordance with such paragraph, for any taxable year and any deduction is imposed under subsection (b) by reason of his earnings for such year, he shall suffer additional deductions as follows:

(A) if such failure is the first one with respect to which an additional deduction is imposed under this paragraph, such additional deduction shall be equal to his benefit or benefits for the last month of such year for which he was entitled to a benefit under section 202, except that if the deduction imposed under subsection (b) by reason of his earnings for such year is less than the amount of his benefit (or benefits) for the last month of such year for which he was entitled to a benefit under section 202, the additional deduction shall be equal to the amount of the deduction imposed under subsection (b) but not less than $10;

(B) if such failure is the second one for which an additional deduction is imposed under this paragraph, such additional deduction shall be equal to two times his benefit

or benefits for the last month of such year for which he was entitled to a benefit under section 202;

(C) if such failure is the third or a subsequent one for which an additional deduction is imposed under this paragraph, such additional deduction shall be equal to three times his benefit or benefits for the last month of such year for which he was entitled to a benefit under section 202;

except that the number of the additional deductions required by this paragraph with respect to a failure to report earnings for a taxable year shall not exceed the number of months in such year for which such individual received and accepted insurance benefits under section 202 and for which deductions are imposed under subsection (b) by reason of his earnings. In determining whether a failure to report earnings is the first or a subsequent failure for any individual, all taxable years ending prior to the imposition of the first additional deduction under this paragraph, other than the latest one of such years, shall be disregarded.

(3) If the Commissioner of Social Security determines, on the basis of information obtained by or submitted to him, that it may reasonably be expected that an individual entitled to benefits under section 202 for any taxable year will suffer deductions imposed under subsection (b) by reason of his earnings for such year, the Commissioner of Social Security may, before the close of such taxable year, suspend the total or less than the total payment for each month in such year (or for only such months as the Commissioner of Social Security may specify) of the benefits payable on the basis of such individual's wages and self-employment income; and such suspension shall remain in effect with respect to the benefits for any month until the Commissioner of Social Security has determined whether or not any deduction is imposed for such month under subsection (b). The Commissioner of Social Security is authorized, before the close of the taxable year of an individual entitled to benefits during such year, to request of such individual that he make, at such time or times as the Commissioner of Social Security may specify, a declaration of his estimated earnings for the taxable year and that he furnish to the Commissioner of Social Security such other information with respect to such earnings as the Commissioner of Social Security may specify. A failure by such individual to comply with any such request shall in itself constitute justification for a determination under this paragraph that it may reasonably be expected that the individual will suffer deductions imposed under subsection (b) by reason of his earnings for such year. If, after the close of a taxable year of an individual entitled to benefits under section 202 for such year, the Commissioner of Social Security requests such individual to furnish a report of his earnings (as computed pursuant to paragraph (5) of subsection (f)) for such taxable year or any other information with respect to such earnings which the Commissioner of Social Security may specify, and the individual fails to comply with such request, such failure shall in itself constitute justification for a determination that such individual's benefits are subject to deductions under subsection (b) for each month in such taxable year (or only for

such months thereof as the Commissioner of Social Security may specify) by reason of his earnings for such year.

(4) The Commissioner of Social Security shall develop and implement procedures in accordance with this subsection to avoid paying more than the correct amount of benefits to any individual under this title as a result of such individual's failure to file a correct report or estimate of earnings or wages. Such procedures may include identifying categories of individuals who are likely to be paid more than the correct amount of benefits and requesting that they estimate their earnings or wages more frequently than other persons subject to deductions under this section on account of earnings or wages.

(i) [Repealed.[90]]

Attainment of Retirement Age

(j) For the purposes of this section, an individual shall be considered as having attained retirement age (as defined in section 216(l)) during the entire month in which he attains such age.

Noncovered Remunerative Activity Outside the United States

(k) An individual shall be considered to be engaged in noncovered remunerative activity outside the United States if he performs services outside the United States as an employee and such services do not constitute employment as defined in section 210 and are not performed in the active military or naval service of the United States, or if he carries on a trade or business outside the United States (other than the performance of service as an employee) the net income or loss of which (1) is not includible in computing his net earnings from self-employment for a taxable year and (2) would not be excluded from net earnings from self-employment, if carried on in the United States, by any of the numbered paragraphs of section 211(a). When used in the preceding sentence with respect to a trade or business (other than the performance of service as an employee), the term "United States" does not include the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa in the case of an alien who is not a resident of the United States (including the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa); and the term "trade or business" shall have the same meaning as when used in section 162 of the Internal Revenue Code of 1986[91].

Good Cause for Failure To Make Reports Required

(l) The failure of an individual to make any report required by subsection (g) or (h)(1)(A) within the time prescribed therein shall not be regarded as such a failure if it is shown to the satisfaction of the Commissioner of Social Security that he had good cause for failing to make such report within such time. The determination of what constitutes good cause for purposes of this subsection shall be made in accordance with regulations of the Commissioner of Social Security, except that in making any such determination, the Commissioner of Social Security shall specifically take into account any

[90] P.L. 103–296, §309(a); 108 Stat. 1523.
[91] See Vol. II, P.L. 83–591, §162.

physical, mental, educational, or linguistic limitation such individual may have (including any lack of facility with the English language).

OVERPAYMENTS AND UNDERPAYMENTS[92]

SEC. 204. [42 U.S.C. 404] (a)(1) Whenever the Commissioner of Social Security finds that more or less than the correct amount of payment has been made to any person under this title, proper adjustment or recovery shall be made, under regulations prescribed by the Commissioner of Social Security, as follows:

(A) With respect to payment to a person of more than the correct amount, the Commissioner of Social Security shall decrease any payment under this title to which such overpaid person is entitled, or shall require such overpaid person or his estate to refund the amount in excess of the correct amount, or shall decrease any payment under this title payable to his estate or to any other person on the basis of the wages and self-employment income which were the basis of the payments to such overpaid person, or shall obtain recovery by means of reduction in tax refunds based on notice to the Secretary of the Treasury as permitted under section 3720A of title 31, United States Code[93], or shall apply any combination of the foregoing. A payment made under this title on the basis of an erroneous report of death by the Department of Defense of an individual in the line of duty while he is a member of the uniformed services (as defined in section 210(m)) on active duty (as defined in section 210(l)) shall not be considered an incorrect payment for any month prior to the month such Department notifies the Commissioner of Social Security that such individual is alive.

(B) With respect to payment to a person of less than the correct amount, the Commissioner of Social Security shall make payment of the balance of the amount due such underpaid person, or, if such person dies before payments are completed or before negotiating one or more checks representing correct payments, disposition of the amount due shall be made in accordance with subsection (d).

(2) Notwithstanding any other provision of this section, when any payment of more than the correct amount is made to or on behalf of an individual who has died, and such payment—

(A) is made by direct deposit to a financial institution;

(B) is credited by the financial institution to a joint account of the deceased individual and another person; and

(C) such other person was entitled to a monthly benefit on the basis of the same wages and self-employment income as the deceased individual for the month preceding the month in which the deceased individual died,

the amount of such payment in excess of the correct amount shall be treated as a payment of more than the correct amount to such other person. If any payment of more than the correct amount is made to a representative payee on behalf of an individual after the individual's death, the representative payee shall be liable for the repayment of the overpayment, and the Commissioner of Social Se-

[92] See §1870 with respect to adjustment of Title XVIII overpayments against payment of benefits under Title II.

[93] See Vol. II, Title 31.

curity shall establish an overpayment control record under the social security account number of the representative payee.

(b) In any case in which more than the correct amount of payment has been made, there shall be no adjustment of payments to, or recovery by the United States from, any person who is without fault if such adjustment or recovery would defeat the purpose of this title or would be against equity and good conscience. In making for purposes of this subsection any determination of whether any individual is without fault, the Commissioner of Social Security shall specifically take into account any physical, mental, educational, or linguistic limitation such individual may have (including any lack of facility with the English language).

(c) No certifying or disbursing officer shall be held liable for any amount certified or paid by him to any person where the adjustment or recovery of such amount is waived under subsection (b), or where adjustment under subsection (a) is not completed prior to the death of all persons against whose benefits deductions are authorized.

(d) If an individual dies before any payment due him under this title is completed, payment of the amount due (including the amount of any unnegotiated checks) shall be made—

(1) to the person, if any, who is determined by the Commissioner of Social Security to be the surviving spouse of the deceased individual and who either (i) was living in the same household with the deceased at the time of his death or (ii) was, for the month in which the deceased individual died, entitled to a monthly benefit on the basis of the same wages and self-employment income as was the deceased individual;

(2) if there is no person who meets the requirements of paragraph (1), or if the person who meets such requirements dies before the payment due him under this title is completed, to the child or children, if any, of the deceased individual who were, for the month in which the deceased individual died, entitled to monthly benefits on the basis of the same wages and self-employment income as was the deceased individual (and, in case there is more than one such child, in equal parts to each such child);

(3) if there is no person who meets the requirements of paragraph (1) or (2), or if each person who meets such requirements dies before the payment due him under this title is completed, to the parent or parents, if any, of the deceased individual who were, for the month in which the deceased individual died, entitled to monthly benefits on the basis of the same wages and self-employment income as was the deceased individual (and, in case there is more than one such parent, in equal parts to each such parent);

(4) if there is no person who meets the requirements of paragraph (1), (2), or (3), or if each person who meets such requirements dies before the payment due him under this title is completed, to the person, if any, determined by the Commissioner of Social Security to be the surviving spouse of the deceased individual;

(5) if there is no person who meets the requirements of paragraph (1), (2), (3), or (4), or if each person who meets such requirements dies before the payment due him under this title is completed, to the person or persons, if any, determined by

the Commissioner of Social Security to be the child or children of the deceased individual (and, in case there is more than one such child, in equal parts to each such child);

(6) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), or (5), or if each person who meets such requirements dies before the payment due him under this title is completed, to the parent or parents, if any, of the deceased individual (and, in case there is more than one such parent, in equal parts to each such parent); or

(7) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), (5), or (6), or if each person who meets such requirements dies before the payment due him under this title is completed, to the legal representative of the estate of the deceased individual, if any.

(e) For payments which are adjusted by reason of payment of benefits under the supplemental security income program established by title XVI, see section 1127.

(f)(1) With respect to any deliquent[94] amount, the Commissioner of Social Security may use the collection practices described in sections 3711(f), 3716, 3717, and 3718 of title 31, United States Code, and in section 5514 of title 5, United States Code, all as in effect immediately after the enactment of the Debt Collection Improvement Act of 1996[95].

(2) For purposes of paragraph (1), the term "delinquent amount" means an amount—

(A) in excess of the correct amount of payment under this title;

(B) paid to a person after such person has attained 18 years of age; and

(C) determined by the Commissioner of Social Security, under regulations, to be otherwise unrecoverable under this section after such person ceases to be a beneficiary under this title.

(g)[96] For provisions relating to the cross-program recovery of overpayments made under programs administered by the Commissioner of Social Security, see section 1147.

EVIDENCE, PROCEDURE, AND CERTIFICATION FOR PAYMENT[97]

SEC. 205. [42 U.S.C. 405] (a) The Commissioner of Social Security shall have full power and authority to make rules and regula-

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[94] As in original.

[95] P.L. 104–134 was enacted April 26, 1996.

[96] P.L. 108-203, §210(b)(1), amended subsection (g) in its entirety, effective on March 2, 2004, with respect to overpayments under titles II, VIII, and XVI that are outstanding on or after March 2, 2004. For subsection (g) as it formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L. 108-203.

[97] See Vol. II, P.L. 84–885, §33, with respect to evidence of United States citizenship.

See Vol. II, P.L. 90–321, §913(2), with respect to electronic fund transfers.

See Vol. II, P.L. 95–630, §§1101–1121, with respect to an individual's right to financial privacy.

See Vol. II, P.L. 97–455, §5, with respect to conduct of face-to-face reconsiderations in disability cases.

See Vol. II, P.L. 98–473, §1212, with respect to the requirement for printed notices regarding the commission of forgery in conjunction with the cashing or attempted cashing of title II checks.

See Vol. II, P.L. 103–296, §201(a)(1)(C)-(E), with respect to restrictions on payment of benefits based on disability to substance abusers; and §206(g), with respect to annual reports on reviews of OASDI and SSI cases.

Continued

tions and to establish procedures, not inconsistent with the provisions of this title, which are necessary or appropriate to carry out such provisions, and shall adopt reasonable and proper rules and regulations to regulate and provide for the nature and extent of the proofs and evidence and the method of taking and furnishing the same in order to establish the right to benefits hereunder.

(b)(1) The Commissioner of Social Security is directed to make findings of fact, and decisions as to the rights of any individual applying for a payment under this title. Any such decision by the Commissioner of Social Security which involves a determination of disability and which is in whole or in part unfavorable to such individual shall contain a statement of the case, in understandable language, setting forth a discussion of the evidence, and stating the Commissioner's determination and the reason or reasons upon which it is based. Upon request by any such individual or upon request by a wife, divorced wife, widow, surviving divorced wife, surviving divorced mother, surviving divorced father, husband, divorced husband, widower, surviving divorced husband, child, or parent who makes a showing in writing that his or her rights may be prejudiced by any decision the Commissioner of Social Security has rendered, the Commissioner shall give such applicant and such other individual reasonable notice and opportunity for a hearing with respect to such decision, and, if a hearing is held, shall, on the basis of evidence adduced at the hearing, affirm, modify, or reverse the Commissioner's findings of fact and such decision. Any such request with respect to such a decision must be filed within sixty days after notice of such decision is received by the individual making such request. The Commissioner of Social Security is further authorized, on the Commissioner's own motion, to hold such hearings and to conduct such investigations and other proceedings as the Commissioner may deem necessary or proper for the administration of this title. In the course of any hearing, investigation, or other proceeding, the Commissioner may administer oaths and affirmations, examine witnesses, and receive evidence. Evidence may be received at any hearing before the Commissioner of Social Security even though inadmissible under rules of evidence applicable to court procedure.

(2) In any case where—

(A) an individual is a recipient of disability insurance benefits, or of child's, widow's, or widower's insurance benefits based on disability,

(B) the physical or mental impairment on the basis of which such benefits are payable is found to have ceased, not to have existed, or to no longer be disabling, and

(C) as a consequence of the finding described in subparagraph (B), such individual is determined by the Commissioner of Social Security not to be entitled to such benefits,

any reconsideration of the finding described in subparagraph (B), in connection with a reconsideration by the Commissioner of Social Security (before any hearing under paragraph (1) on the issue of such entitlement) of the Commissioner's deter-

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See Vol. II, P.L. 104–193, §111, with respect to the requirement for development of a prototype of a counterfeit–resistant social security card.

See Vol. II, P.L. 108-203, §103(a) with respect to a report evaluating existing procedures and reviews for qualification of representative payees.

See Vol. II, P.L. 108-458, §7213, with respect to security enhancements and other improvements with respect to social security cards and numbers.

mination described in subparagraph (C), shall be made only after opportunity for an evidentiary hearing, with regard to the finding described in subparagraph (B), which is reasonably accessible to such individual. Any reconsideration of a finding described in subparagraph (B) may be made either by the State agency or the Commissioner of Social Security where the finding was originally made by the State agency, and shall be made by the Commissioner of Social Security where the finding was originally made by the Commissioner of Social Security. In the case of a reconsideration by a State agency of a finding described in subparagraph (B) which was originally made by such State agency, the evidentiary hearing shall be held by an adjudicatory unit of the State agency other than the unit that made the finding described in subparagraph (B). In the case of a reconsideration by the Commissioner of Social Security of a finding described in subparagraph (B) which was originally made by the Commissioner of Social Security, the evidentiary hearing shall be held by a person other than the person or persons who made the finding described in subparagraph (B).

(3)(A) A failure to timely request review of an initial adverse determination with respect to an application for any benefit under this title or an adverse determination on reconsideration of such an initial determination shall not serve as a basis for denial of a subsequent application for any benefit under this title if the applicant demonstrates that the applicant, or any other individual referred to in paragraph (1), failed to so request such a review acting in good faith reliance upon incorrect, incomplete, or misleading information, relating to the consequences of reapplying for benefits in lieu of seeking review of an adverse determination, provided by any officer or employee of the Social Security Administration or any State agency acting under section 221.

(B) In any notice of an adverse determination with respect to which a review may be requested under paragraph (1), the Commissioner of Social Security shall describe in clear and specific language the effect on possible entitlement to benefits under this title of choosing to reapply in lieu of requesting review of the determination.

(c)(1) For the purposes of this subsection—

(A) The term "year" means a calendar year when used with respect to wages and a taxable year when used with respect to self-employment income.

(B) The term "time limitation" means a period of three years, three months, and fifteen days.

(C) The term "survivor" means an individual's spouse, surviving divorced wife, surviving divorced husband, surviving divorced mother, surviving divorced father, child, or parent, who survives such individual.

(D) The term "period" when used with respect to self-employment income means a taxable year and when used with respect to wages means—

(i) a quarter if wages were reported or should have been reported on a quarterly basis on tax returns filed with the Secretary of the Treasury or his delegate under section 6011 of the Internal Revenue Code of

1986[98] or regulations thereunder (or on reports filed by a State under section 218(e) (as in effect prior to December 31, 1986) or regulations thereunder),

(ii) a year if wages were reported or should have been reported on a yearly basis on such tax returns or reports, or

(iii) the half year beginning January 1 or July 1 in the case of wages which were reported or should have been reported for calendar year 1937.

(2)(A) On the basis of information obtained by or submitted to the Commissioner of Social Security, and after such verification thereof as the Commissioner deems necessary, the Commissioner of Social Security shall establish and maintain records of the amounts of wages paid to, and the amounts of self-employment income derived by, each individual and of the periods in which such wages were paid and such income was derived and, upon request, shall inform any individual or his survivor, or the legal representative of such individual or his estate, of the amounts of wages and self-employment income of such individual and the periods during which such wages were paid and such income was derived, as shown by such records at the time of such request.

(B)(i) In carrying out the Commissioner's duties under subparagraph (A) and subparagraph (F), the Commissioner of Social Security shall take affirmative measures to assure that social security account numbers will, to the maximum extent practicable, be assigned to all members of appropriate groups or categories of individuals by assigning such numbers (or ascertaining that such numbers have already been assigned):

(I) to aliens at the time of their lawful admission to the United States either for permanent residence or under other authority of law permitting them to engage in employment in the United States and to other aliens at such time as their status is so changed as to make it lawful for them to engage in such employment;

(II) to any individual who is an applicant for or recipient of benefits under any program financed in whole or in part from Federal funds including any child on whose behalf such benefits are claimed by another person; and

(III) to any other individual when it appears that he could have been but was not assigned an account number under the provisions of subclauses (I) or (II) but only after such investigation as is necessary to establish to the satisfaction of the Commissioner of Social Security, the identity of such individual, the fact that an account number has not already been assigned to such individual, and the fact that such individual is a citizen or a noncitizen who is not, because of his alien status, prohibited from engaging in employment;

[98] See Vol. II, P.L. 83–591, §6011.

and, in carrying out such duties, the Commissioner of Social Security is authorized to take affirmative measures to assure the issuance of social security numbers:

(IV) to or on behalf of children who are below school age at the request of their parents or guardians; and

(V) to children of school age at the time of their first enrollment in school.

(ii) The Commissioner of Social Security shall require of applicants for social security account numbers such evidence as may be necessary to establish the age, citizenship, or alien status, and true identity of such applicants, and to determine which (if any) social security account number has previously been assigned to such individual. With respect to an application for a social security account number for an individual who has not attained the age of 18 before such application, such evidence shall include the information described in subparagraph (C)(ii).

(iii) In carrying out the requirements of this subparagraph, the Commissioner of Social Security shall enter into such agreements as may be necessary with the Attorney General and other officials and with State and local welfare agencies and school authorities (including nonpublic school authorities).

(C)(i)[99] It is the policy of the United States that any State (or political subdivision thereof) may, in the administration of any tax, general public assistance, driver's license, or motor vehicle registration law within its jurisdiction, utilize the social security account numbers issued by the Commissioner of Social Security for the purpose of establishing the identification of individuals affected by such law, and may require any individual who is or appears to be so affected to furnish to such State (or political subdivision thereof) or any agency thereof having administrative responsibility for the law involved, the social security account number (or numbers, if he has more than one such number) issued to him by the Commissioner of Social Security.

(ii) In the administration of any law involving the issuance of a birth certificate, each State shall require each parent to furnish to such State (or political subdivision thereof) or any agency thereof having administrative responsibility for the law involved, the social security account number (or numbers, if the parent has more than one such number) issued to the parent unless the State (in accordance with regulations prescribed by the Commissioner of Social Security) finds good cause for not requiring the furnishing of such number. The State shall make numbers furnished under this subclause available to the Commissioner of

[99] See Vol. II, P.L. 80–759, §12(e), with respect to disclosure of the social security number for individuals required to submit to registration.

See Vol. II, P.L. 83–591, §6109, with respect to use of a social security number as a "taxpayer identifying number" as that term is used in the "Debt Collection Act of 1982" [P.L. 97–365].

See Vol. II, P.L. 88–525, §16(e), with respect to use of the social security number for participation in the food stamp program.

Social Security and the agency administering the State's plan under part D of title IV in accordance with Federal or State law and regulation. Such numbers shall not be recorded on the birth certificate. A State shall not use any social security account number, obtained with respect to the issuance by the State of a birth certificate, for any purpose other than for the enforcement of child support orders in effect in the State, unless section 7(a) of the Privacy Act of 1974 [100] does not prohibit the State from requiring the disclosure of such number, by reason of the State having adopted, before January 1, 1975, a statute or regulation requiring such disclosure.

(iii)(I) In the administration of section 9 of the Food Stamp Act of 1977 (7 U.S.C. 2018) involving the determination of the qualifications of applicants under such Act, the Secretary of Agriculture may require each applicant retail store or wholesale food concern to furnish to the Secretary of Agriculture the social security account number of each individual who is an officer of the store or concern and, in the case of a privately owned applicant, furnish the social security account numbers of the owners of such applicant. No officer or employee of the Department of Agriculture shall have access to any such number for any purpose other than the establishment and maintenance of a list of the names and social security account numbers of such individuals for use in determining those applicants who have been previously sanctioned or convicted under section 12 or 15 of such Act (7 U.S.C. 2021 or 2024).

(II) The Secretary of Agriculture may share any information contained in any list referred to in subclause (I) with any other agency or instrumentality of the United States which otherwise has access to social security account numbers in accordance with this subsection or other applicable Federal law, except that the Secretary of Agriculture may share such information only to the extent that such Secretary determines such sharing would assist in verifying and matching such information against information maintained by such other agency or instrumentality. Any such information shared pursuant to this subclause may be used by such other agency or instrumentality only for the purpose of effective administration and enforcement of the Food Stamp Act of 1977 or for the purpose of investigation of violations of other Federal laws or enforcement of such laws.

(III) The Secretary of Agriculture, and the head of any other agency or instrumentality referred to in this subclause, shall restrict, to the satisfaction of the Commissioner of Social Security, access to social security account numbers obtained

[100] See Vol. II, P.L. 93–579.

pursuant to this clause only to officers and employees of the United States whose duties or responsibilities require access for the purposes described in subclause (II).

(IV) The Secretary of Agriculture, and the head of any agency or instrumentality with which information is shared pursuant to clause (II), shall provide such other safeguards as the Commissioner of Social Security determines to be necessary or appropriate to protect the confidentiality of the social security account numbers.

(iv) In the administration of section 506 of the Federal Crop Insurance Act, the Federal Crop Insurance Corporation may require each policyholder and each reinsured company to furnish to the insurer or to the Corporation the social security account number of such policyholder, subject to the requirements of this clause. No officer or employee of the Federal Crop Insurance Corporation shall have access to any such number for any purpose other than the establishment of a system of records necessary for the effective administration of such Act. The Manager of the Corporation may require each policyholder to provide to the Manager, at such times and in such manner as prescribed by the Manager, the social security account number of each individual that holds or acquires a substantial beneficial interest in the policyholder. For purposes of this clause, the term "substantial beneficial interest" means not less than 5 percent of all beneficial interest in the policyholder. The Secretary of Agriculture shall restrict, to the satisfaction of the Commissioner of Social Security, access to social security account numbers obtained pursuant to this clause only to officers and employees of the United States or authorized persons whose duties or responsibilities require access for the administration of the Federal Crop Insurance Act. The Secretary of Agriculture shall provide such other safeguards as the Commissioner of Social Security determines to be necessary or appropriate to protect the confidentiality of such social security account numbers. For purposes of this clause the term "authorized person" means an officer or employee of an insurer whom the Manager of the Corporation designates by rule, subject to appropriate safeguards including a prohibition against the release of such social security account number (other than to the Corporation) by such person.

(v) If and to the extent that any provision of Federal law heretofore enacted is inconsistent with the policy set forth in clause (i), such provision shall, on and after the date of the enactment of this subparagraph [101] , be null, void, and of no effect. If and to the extent that any such provision is inconsistent with the

[101] October 4, 1976 [P.L. 94–455, §1211(b); 90 Stat. 1711].

requirement set forth in clause (ii), such provision shall, on and after the date of the enactment of such subclause [102], be null, void, and of no effect.

(vi)(I) [103] For purposes of clause of this subparagraph, an agency of a State (or political subdivision thereof) charged with the administration of any general public assistance, driver's license, or motor vehicle registration law which did not use the social security account number for identification under a law or regulation adopted before January 1, 1975, may require an individual to disclose his or her social security number to such agency solely for the purpose of administering the laws referred to in clause above and for the purpose of responding to requests for information from an agency administering a program funded under part A of title IV or an agency operating pursuant to the provisions of part D of such title.

(II) [104] Any State or political subdivision thereof (and any person acting as an agent of such an agency or instrumentality), in the administration of any driver's license or motor vehicle registration law within its jurisdiction, may not display a social security account number issued by the Commissioner of Social Security (or any derivative of such number) on any driver's license, motor vehicle registration, or personal identification card (as defined in section 7212(a)(2) of the 9/11 Commission Implementation Act of 2004), or include, on any such license, registration, or personal identification card, a magnetic strip, bar code, or other means of communication which conveys such number (or derivative thereof).

(vii) For purposes of this subparagraph, the term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Commonwealth of the Northern Marianas, and the Trust Territory of the Pacific Islands.

(viii)(I) Social security account numbers and related records that are obtained or maintained by authorized persons pursuant to any provision of law enacted on or after October 1, 1990, shall be confidential, and no authorized person shall disclose any such social security account number or related record.

(II) Paragraphs (1), (2), and (3) of section 7213(a) of the Internal Revenue Code of 1986 shall apply with respect to the unauthorized willful disclosure to any person of social security account numbers and related records obtained or maintained by an authorized person pursuant to a provision of law enacted on or after October 1,

[102] Subclause (II) of clause (i) was enacted in October 13, 1988. [P.L. 100–485; 102 Stat. 2353].

[103] P.L. 108-458, §7214(a)(1), inserted "(I)".

[104] P.L. 108-458, §7214(a)(2), added subclause II, applicable with respect to licenses, registrations, and identification cards issued or reissued December 17, 2005.

1990, in the same manner and to the same extent as such paragraphs apply with respect to unauthorized disclosures of return and return information described in such paragraphs. Paragraph (4) of section 7213(a) of such Code shall apply with respect to the willful offer of any item of material value in exchange for any such social security account number or related record in the same manner and to the same extent as such paragraph applies with respect to offers (in exchange for any return or return information) described in such paragraph.

(III) For purposes of this clause, the term "authorized person" means an officer or employee of the United States, an officer or employee of any State, political subdivision of a State, or agency of a State or political subdivision of a State, and any other person (or officer or employee thereof), who has or had access to social security account numbers or related records pursuant to any provision of law enacted on or after October 1, 1990. For purposes of this subclause, the term "officer or employee" includes a former officer or employee.

(IV) For purposes of this clause, the term "related record" means any record, list, or compilation that indicates, directly or indirectly, the identity of any individual with respect to whom a social security account number or a request for a social security account number is maintained pursuant to this clause.

(ix) In the administration of the provisions of chapter 81 of title 5, United States Code, and the Longshore and Harbor Workers' Compensation Act (33 U.S.C. 901 et seq.), the Secretary of Labor may require by regulation that any person filing a notice of injury or a claim for benefits under such provisions provide as part of such notice or claim such person's social security account number, subject to the requirements of this clause. No officer or employee of the Department of Labor shall have access to any such number for any purpose other than the establishment of a system of records necessary for the effective administration of such provisions. The Secretary of Labor shall restrict, to the satisfaction of the Commissioner of Social Security, access to social security account numbers obtained pursuant to this clause to officers and employees of the United States whose duties or responsibilities require access for the administration or enforcement of such provisions. The Secretary of Labor shall provide such other safeguards as the Commissioner of Social Security determines to be necessary or appropriate to protect the confidentiality of the social security account numbers.

(D)(i) It is the policy of the United States that—

(I) any State (or any political subdivision of a State) and any authorized blood donation facility may utilize the social security account numbers issued by the Commissioner of Social Security for the purpose of identifying blood donors, and

(II) any State (or political subdivision of a State) may require any individual who donates blood within such State (or political subdivision) to furnish to such State (or political subdivision), to any agency thereof having related administrative responsibility, or to any authorized blood donation facility the social security account number (or numbers, if the donor has more than one such number) issued to the donor by the Commissioner of Social Security.

(ii) If and to the extent that any provision of Federal law enacted before the date of the enactment of this subparagraph[105] is inconsistent with the policy set forth in clause , such provision shall, on and after such date, be null, void, and of no effect.

(iii) For purposes of this subparagraph—

(I) the term "authorized blood donation facility" means an entity described in section 1141(h)(1)(B), and

(II) the term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Commonwealth of the Northern Marianas, and the Trust Territory of the Pacific Islands.

(E)(i) It is the policy of the United States that—

(I) any State (or any political subdivision of a State) may utilize the social security account numbers issued by the Commissioner of Social Security for the additional purposes described in clause (ii) if such numbers have been collected and are otherwise utilized by such State (or political subdivision) in accordance with applicable law, and

(II) any district court of the United States may use, for such additional purposes, any such social security account numbers which have been so collected and are so utilized by any State.

(ii) The additional purposes described in this clause are the following:

(I) Identifying duplicate names of individuals on master lists used for jury selection purposes.

(II) Identifying on such master lists those individuals who are ineligible to serve on a jury by reason of their conviction of a felony.

(iii) To the extent that any provision of Federal law enacted before the date of the enactment of this subparagraph[106] is inconsistent with the policy set forth

[105] This subparagraph was enacted November 10, 1988.
[106] August 15, 1994 [P.L. 103–296, §304; 108 Stat. 1520].

in clause , such provision shall, on and after that date, be null, void, and of no effect.

(iv) For purposes of this subparagraph, the term "State" has the meaning such term has in subparagraph (D).

(F) The Commissioner of Social Security shall require, as a condition for receipt of benefits under this title, that an individual furnish satisfactory proof of a social security account number assigned to such individual by the Commissioner of Social Security or, in the case of an individual to whom no such number has been assigned, that such individual make proper application for assignment of such a number.

(G) The Commissioner of Social Security shall issue a social security card to each individual at the time of the issuance of a social security account number to such individual. The social security card shall be made of banknote paper, and (to the maximum extent practicable) shall be a card which cannot be counterfeited.

(H) The Commissioner of Social Security shall share with the Secretary of the Treasury the information obtained by the Commissioner pursuant to the second sentence of subparagraph (B)(ii) and to subparagraph (C)(ii) for the purpose of administering those sections of the Internal Revenue Code of 1986 which grant tax benefits based on support or residence of children.

(3) The Commissioner's record shall be evidence for the purpose of proceedings before the Commissioner of Social Security or any court of the amounts of wages paid to, and self-employment income derived by, an individual and of the periods in which such wages were paid and such income was derived. The absence of an entry in such records as to wages alleged to have been paid to, or as to self-employment income alleged to have been derived by, an individual in any period shall be evidence that no such alleged wages were paid to, or that no such alleged income was derived by, such individual during such period.

(4) Prior to the expiration of the time limitation following any year the Commissioner of Social Security may, if it is brought to the Commissioner's attention that any entry of wages or self-employment income in the Commissioner's records for such year is erroneous or that any item of wages or self-employment income for such year has been omitted from such records, correct such entry or include such omitted item in his records, as the case may be. After the expiration of the time limitation following any year—

(A) the Commissioner's records (with changes, if any, made pursuant to paragraph (5)) of the amounts of wages paid to, and self-employment income derived by, an individual during any period in such year shall be conclusive for the purposes of this title;

(B) the absence of an entry in the Commissioner's records as to the wages alleged to have been paid by an employer to an individual during any period in such year shall be presumptive evidence for the purposes of this title

that no such alleged wages were paid to such individual in such period; and

(C) the absence of an entry in the Commissioner's records as to the self-employment income alleged to have been derived by an individual in such year shall be conclusive for the purposes of this title that no such alleged self-employment income was derived by such individual in such year unless it is shown that he filed a tax return of his self-employment income for such year before the expiration of the time limitation following such year, in which case the Commissioner of Social Security shall include in the Commissioner's records the self-employment income of such individual for such year.

(5) After the expiration of the time limitation following any year in which wages were paid or alleged to have been paid to, or self-employment income was derived or alleged to have been derived by, an individual, the Commissioner of Social Security may change or delete any entry with respect to wages or self-employment income in the Commissioner's records of such year for such individual or include in the Commissioner's records of such year for such individual any omitted item of wages or self-employment income but only—

(A) if an application for monthly benefits or for a lump-sum death payment was filed within the time limitation following such year; except that no such change, deletion, or inclusion may be made pursuant to this subparagraph after a final decision upon the application for monthly benefits or lump-sum death payment;

(B) if within the time limitation following such year an individual or his survivor makes a request for a change or deletion, or for an inclusion of an omitted item, and alleges in writing that the Commissioner's records of the wages paid to, or the self-employment income derived by, such individual in such year are in one or more respects erroneous; except that no such change, deletion, or inclusion may be made pursuant to this subparagraph after a final decision upon such request. Written notice of the Commissioner's decision on any such request shall be given to the individual who made the request;

(C) to correct errors apparent on the face of such records;

(D) to transfer items to records of the Railroad Retirement Board if such items were credited under this title when they should have been credited under the Railroad Retirement Act of 1937 or 1974, or to enter items transferred by the Railroad Retirement Board which have been credited under the Railroad Retirement Act of 1937 or 1974 when they should have been credited under this title;

(E) to delete or reduce the amount of any entry which is erroneous as a result of fraud;

(F) to conform the Commissioner's records to—

(i) tax returns or portions thereof (including information returns and other written statements) filed with the Commissioner of Internal Revenue under title VIII of the Social Security Act, under subchapter E of chapter 1 or subchapter A of chapter 9 of the In-

ternal Revenue Code of 1939[107], under chapter 2 or 21 of the Internal Revenue Code of 1954 or the Internal Revenue Code of 1986[108], or under regulations made under authority of such title, subchapter, or chapter;

(ii) wage reports filed by a State pursuant to an agreement under section 218 or regulations of the Commissioner of Social Security thereunder; or

(iii) assessments of amounts due under an agreement pursuant to section 218 (as in effect prior to December 31, 1986), if such assessments are made within the period specified in subsection (q) of such section (as so in effect), or allowances of credits or refunds of overpayments by a State under an agreement pursuant to such section;

except that no amount of self-employment income of an individual for any taxable year (if such return or statement was filed after the expiration of the time limitation following the taxable year) shall be included in the Commissioner's records pursuant to this subparagraph;

(G) to correct errors made in the allocation, to individuals or periods, of wages or self-employment income entered in the records of the Commissioner of Social Security;

(H) to include wages paid during any period in such year to an individual by an employer;

(I) to enter items which constitute remuneration for employment under subsection (o), such entries to be in accordance with certified reports of records made by the Railroad Retirement Board pursuant to section 5(k)(3) of the Railroad Retirement Act of 1937 or section 7(b)(7) of the Railroad Retirement Act of 1974[109]; or

(J) to include self-employment income for any taxable year, up to, but not in excess of, the amount of wages deleted by the Commissioner of Social Security as payments erroneously included in such records as wages paid to such individual, if such income (or net earnings from self-employment), not already included in such records as self-employment income, is included in a return or statement (referred to in subparagraph (F)) filed before the expiration of the time limitation following the taxable year in which such deletion of wages is made.

(6) Written notice of any deletion or reduction under paragraph (4) or (5) shall be given to the individual whose record is involved or to his survivor, except that (A) in the case of a deletion or reduction with respect to any entry of wages such notice shall be given to such individual only if he has previously been notified by the Commissioner of Social Security of the amount of his wages for the period involved, and (B) such notice shall be given to such survivor only if he or the individual whose record is involved has previously been notified by the Commissioner of Social Security of the amount of such individual's wages and self-employment income for the period involved.

[107] P.L. 76–1.
[108] P.L. 83–591.
[109] See Vol. II, P.L. 75–162, §7(b)(7).

(7) Upon request in writing (within such period, after any change or refusal of a request for a change of the Commissioner's records pursuant to this subsection, as the Commissioner of Social Security may prescribe), opportunity for hearing with respect to such change or refusal shall be afforded to any individual or his survivor. If a hearing is held pursuant to this paragraph the Commissioner of Social Security shall make findings of fact and a decision based upon the evidence adduced at such hearing and shall include any omitted items, or change or delete any entry, in the Commissioner's records as may be required by such findings and decision.

(8) A translation into English by a third party of a statement made in a foreign language by an applicant for or beneficiary of monthly insurance benefits under this title shall not be regarded as reliable for any purpose under this title unless the third party, under penalty or perjury—

(A) certifies that the translation is accurate; and

(B) discloses the nature and scope of the relationship between the third party and the applicant or recipient, as the case may be.

(9) Decisions of the Commissioner of Social Security under this subsection shall be reviewable by commencing a civil action in the United States district court as provided in subsection (g).

(d) For the purpose of any hearing, investigation, or other proceeding authorized or directed under this title, or relative to any other matter within the Commissioner's jurisdiction hereunder, the Commissioner of Social Security shall have power to issue subpoenas requiring the attendance and testimony of witnesses and the production of any evidence that relates to any matter under investigation or in question before the Commissioner of Social Security. Such attendance of witnesses and production of evidence at the designated place of such hearing, investigation, or other proceeding may be required from any place in the United States or in any Territory or possession thereof. Subpoenas of the Commissioner of Social Security shall be served by anyone authorized by the Commissioner (1) by delivering a copy thereof to the individual named therein, or (2) by registered mail or by certified mail addressed to such individual at his last dwelling place or principal place of business. A verified return by the individual so serving the subpena setting forth the manner of service, or, in the case of service by registered mail or by certified mail, the return post-office receipt therefor signed by the individual so served, shall be proof of service. Witnesses so subpoenaed shall be paid the same fees and mileage as are paid witnesses in the district courts of the United States.

(e) In case of contumacy by, or refusal to obey a subpena duly served upon, any person, any district court of the United States for the judicial district in which said person charged with contumacy or refusal to obey is found or resides or transacts business, upon application by the Commissioner of Social Security, shall have jurisdiction to issue an order requiring such person to appear and give testimony, or to appear and produce evidence, or both; any failure to obey such order of the court may be punished by said court as contempt thereof.

(f) [Repealed.[110]]

(g) Any individual, after any final decision of the Commissioner of Social Security made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Commissioner of Social Security may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides, or has his principal place of business, or, if he does not reside or have his principal place of business within any such judicial district, in the United States District Court for the District of Columbia. As part of the Commissioner's answer the Commissioner of Social Security shall file a certified copy of the transcript of the record including the evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Commissioner of Social Security, with or without remanding the cause for a rehearing. The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive, and where a claim has been denied by the Commissioner of Social Security or a decision is rendered under subsection (b) hereof which is adverse to an individual who was a party to the hearing before the Commissioner of Social Security, because of failure of the claimant or such individual to submit proof in conformity with any regulation prescribed under subsection (a) hereof, the court shall review only the question of conformity with such regulations and the validity of such regulations. The court may, on motion of the Commissioner of Social Security made for good cause shown before the Commissioner files the Commissioner's answer, remand the case to the Commissioner of Social Security for further action by the Commissioner of Social Security, and it may at any time order additional evidence to be taken before the Commissioner of Social Security, but only upon a showing that there is new evidence which is material and that there is good cause for the failure to incorporate such evidence into the record in a prior proceeding; and the Commissioner of Social Security shall, after the case is remanded, and after hearing such additional evidence if so ordered, modify or affirm the Commissioner's findings of fact or the Commissioner's decision, or both, and shall file with the court any such additional and modified findings of fact and decision and, in any case in which the Commissioner has not made a decision fully favorable to the individual, a transcript[111] of the additional record and testimony upon which the Commissioner's action in modifying or affirming was based. Such additional or modified findings of fact and decision shall be reviewable only to the extent provided for review of the original findings of fact and decision. The judgment of the court shall be final except that it shall be subject to review in the same manner as a judgment in other civil actions. Any action instituted in accordance with this subsection shall survive notwithstanding any

[110] P.L. 91–452, §236; 84 Stat. 930.

[111] P.L. 108-203, §411(a), struck out "and a transcript" and substituted "and, in any case in which the Commissioner has not made a decision fully favorable to the individual, a transcript", applicable with respect to final determinations issued (upon remand) on or after March 2, 2004.

change in the person occupying the office of Commissioner of Social Security or any vacancy in such office.

(h) The findings and decision of the Commissioner of Social Security after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Commissioner of Social Security shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Commissioner of Social Security or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28, United States Code [112], to recover on any claim arising under this title.

(i) Upon final decision of the Commissioner of Social Security, or upon final judgment of any court of competent jurisdiction, that any person is entitled to any payment or payments under this title, the Commissioner of Social Security shall certify to the Managing Trustee the name and address of the person so entitled to receive such payment or payments, the amount of such payment or payments, and the time at which such payment or payments should be made, and the Managing Trustee, through the Fiscal Service of the Department of the Treasury, and prior to any action thereon by the General Accounting Office [113], shall make payment in accordance with the certification of the Commissioner of Social Security (except that in the case of (A) an individual who will have completed ten years of service (or five or more years of service, all of which accrues after December 31, 1995) creditable under the Railroad Retirement Act of 1937 or the Railroad Retirement Act of 1974 [114], (B) the wife or husband of such an individual, (C) any survivor of such an individual if such survivor is entitled, or could upon application become entitled, to an annuity under section 2 of the Railroad Retirement Act of 1974, and (D) any other person entitled to benefits under section 202 of this Act on the basis of the wages and self-employment income of such an individual (except a survivor of such an individual where such individual did not have a current connection with the railroad industry, as defined in the Railroad Retirement Act of 1974, at the time of his death), such certification shall be made to the Railroad Retirement Board which shall provide for such payment or payments to such person on behalf of the Managing Trustee in accordance with the provisions of the Railroad Retirement Act of 1974): *Provided,* That where a review of the Commissioner's decision is or may be sought under subsection (g) the Commissioner of Social Security may withhold certification of payment pending such review. The Managing Trustee shall not be held personally liable for any payment or payments made in accordance with a certification by the Commissioner of Social Security.

Representative Payees

(j)(1)(A) If the Commissioner of Social Security determines that the interest of any individual under this title would be served thereby, certification of payment of such individual's benefit under this title may be made, regardless of the legal competency or in-

[112] See Vol. II, Title 28.

[113] P.L. 108–271, §8(b), provided that any reference to the General Accounting Office in any law, rule, regulation, certificate, directive, instruction, or other official paper in force on July 7, 2004, shall be considered to refer and apply to the Government Accountability Office.

[114] P.L. 75–162 [as amended by P.L. 93–445].

competency of the individual, either for direct payment to the individual, or for his or her use and benefit, to another individual, or an organization, with respect to whom the requirements of paragraph (2) have been met (hereinafter in this subsection referred to as the individual's "representative payee"). If the Commissioner of Social Security or a court of competent jurisdiction determines that a representative payee has misused any individual's benefit paid to such representative payee pursuant to this subsection or section 807 or 1631(a)(2), the Commissioner of Social Security shall promptly revoke certification for payment of benefits to such representative payee pursuant to this subsection and certify payment to an alternative representative payee or, if the interest of the individual under this title would be served thereby, to the individual.

(B) In the case of an individual entitled to benefits based on disability, the payment of such benefits shall be made to a representative payee if the Commissioner of Social Security determines that such payment would serve the interest of the individual because the individual also has an alcoholism or drug addiction condition (as determined by the Commissioner) and the individual is incapable of managing such benefits.

(2) [115](A) Any certification made under paragraph (1) for payment of benefits to an individual's representative payee shall be made on the basis of—

(i) an investigation by the Commissioner of Social Security of the person to serve as representative payee, which shall be conducted in advance of such certification and shall, to the extent practicable, include a face-to-face interview with such person, and

(ii) adequate evidence that such certification is in the interest of such individual (as determined by the Commissioner of Social Security in regulations).

(B)(i) As part of the investigation referred to in subparagraph (A), the Commissioner of Social Security shall—

(I) require the person being investigated to submit documented proof of the identity of such person, unless information establishing such identity has been submitted with an application for benefits under this title, title VIII, or title XVI,

(II) verify such person's social security account number (or employer identification number),

(III) determine whether such person has been convicted of a violation of section 208, 811, or 1632, and

(IV) determine whether certification of payment of benefits to such person has been revoked pursuant to this subsection or, the designation of such person as a representative payee has been revoked pursuant to section 807(a), payment of benefits to such person has been terminated pursuant to section 1631(a)(2)(A)(iii) by reason of misuse of funds paid as benefits under this title or title XVI.

[115] P.L. 108-203, §102(a)(1)(A) and §103(a), amend (j)(2)(B) and (C) in several places. These amendments shall take effect on April 1, 2005. P.L. 108-203, §105(a)(2), further amends (j)(2)(C)(v).

(ii) The Commissioner of Social Security shall establish and maintain a centralized file, which shall be updated periodically and which shall be in a form which renders it readily retrievable by each servicing office of the Social Security Administration. Such file shall consist of—

(I) a list of the names and social security account numbers (or employer identification numbers) of all persons with respect to whom certification of payment of benefits has been revoked on or after January 1, 1991, pursuant to this subsection, whose designation as a representative payee has been revoked pursuant to section 807(a), or with respect to whom payment of benefits has been terminated on or after such date pursuant to section 1631(a)(2)(A)(iii), by reason of misuse of funds paid as benefits under this title, title VIII, or title XVI, and

(II) a list of the names and social security account numbers (or employer identification numbers) of all persons who have been convicted of a violation of section 208, 811, or 1632.

(C)(i) Benefits of an individual may not be certified for payment to any other person pursuant to this subsection if—

(I) such person has previously been convicted as described in subparagraph (B)(III),

(II) except as provided in clause (ii), certification of payment of benefits to such person under this subsection has previously been revoked as described in subparagraph (B)(IV),, [116] the designation of such person as a representative payee has been revoked pursuant to section 807(a), or payment of benefits to such person pursuant to section 1631(a)(2)(A)(ii) has previously been terminated as described in section 1631(a)(2)(B)(ii)(IV), or

(III) except as provided in clause (iii), such person is a creditor of such individual who provides such individual with goods or services for consideration.

(ii) The Commissioner of Social Security shall prescribe regulations under which the Commissioner of Social Security may grant exemptions to any person from the provisions of clause (II) on a case-by-case basis if such exemption is in the best interest of the individual whose benefits would be paid to such person pursuant to this subsection.

(iii) Clause (III) shall not apply with respect to any person who is a creditor referred to therein if such creditor is—

(I) a relative of such individual if such relative resides in the same household as such individual,

[116] As in original.

(II) a legal guardian or legal representative of such individual,

(III) a facility that is licensed or certified as a care facility under the law of a State or a political subdivision of a State,

(IV) a person who is an administrator, owner, or employee of a facility referred to in subclause (III) if such individual resides in such facility, and the certification of payment to such facility or such person is made only after good faith efforts have been made by the local servicing office of the Social Security Administration to locate an alternative representative payee to whom such certification of payment would serve the best interests of such individual, or

(V) an individual who is determined by the Commissioner of Social Security, on the basis of written findings and under procedures which the Commissioner of Social Security shall prescribe by regulation, to be acceptable to serve as a representative payee.

(iv) The procedures referred to in clause (iii)(V) shall require the individual who will serve as representative payee to establish, to the satisfaction of the Commissioner of Social Security, that—

(I) such individual poses no risk to the beneficiary,

(II) the financial relationship of such individual to the beneficiary poses no substantial conflict of interest, and

(III) no other more suitable representative payee can be found.

(v) In the case of an individual described in paragraph (1)(B), when selecting such individual's representative payee, preference shall be given to—

(I) a community-based nonprofit social service agency licensed or bonded by the State,

(II) a Federal, State, or local government agency whose mission is to carry out income maintenance, social service, or health care-related activities,

(III) a State or local government agency with fiduciary responsibilities, or

(IV) a designee of an agency (other than of a Federal agency) referred to in the preceding subclauses of this clause, if the Commissioner of Social Security deems it appropriate,

unless the Commissioner of Social Security determines that selection of a family member would be appropriate.

(D)(i) Subject to clause (ii), if the Commissioner of Social Security makes a determination described in the first sentence of paragraph (1) with respect to any individual's benefit and determines that direct payment of the benefit to the individual would cause substantial harm to the individual, the Commissioner of Social Security may defer (in

the case of initial entitlement) or suspend (in the case of existing entitlement) direct payment of such benefit to the individual, until such time as the selection of a representative payee is made pursuant to this subsection.

(ii)(I) Except as provided in subclause (II), any deferral or suspension of direct payment of a benefit pursuant to clause shall be for a period of not more than 1 month.

(II) Subclause shall not apply in any case in which the individual is, as of the date of the Commissioner's determination, legally incompetent, under the age of 15 years, or described in paragraph (1)(B).

(iii) Payment pursuant to this subsection of any benefits which are deferred or suspended pending the selection of a representative payee shall be made to the individual or the representative payee as a single sum or over such period of time as the Commissioner of Social Security determines is in the best interest of the individual entitled to such benefits.

(E)(i) Any individual who is dissatisfied with a determination by the Commissioner of Social Security to certify payment of such individual's benefit to a representative payee under paragraph (1) or with the designation of a particular person to serve as representative payee shall be entitled to a hearing by the Commissioner of Social Security to the same extent as is provided in subsection (b), and to judicial review of the Commissioner's final decision as is provided in subsection (g).

(ii) In advance of the certification of payment of an individual's benefit to a representative payee under paragraph (1), the Commissioner of Social Security shall provide written notice of the Commissioner's initial determination to certify such payment. Such notice shall be provided to such individual, except that, if such individual—

(I) is under the age of 15,

(II) is an unemancipated minor under the age of 18, or

(III) is legally incompetent,

then such notice shall be provided solely to the legal guardian or legal representative of such individual.

(iii) Any notice described in clause (ii) shall be clearly written in language that is easily understandable to the reader, shall identify the person to be designated as such individual's representative payee, and shall explain to the reader the right under clause of such individual or of such individual's legal guardian or legal representative—

(I) to appeal a determination that a representative payee is necessary for such individual,

(II) to appeal the designation of a particular person to serve as the representative payee of such individual, and

(III) to review the evidence upon which such designation is based and submit additional evidence.

(3)(A) In any case where payment under this title is made to a person other than the individual entitled to such payment, the Commissioner of Social Security shall establish a system of accountability monitoring whereby such person shall report not less often than annually with respect to the use of such payments. The Commissioner of Social Security shall establish and implement statistically valid procedures for reviewing such reports in order to identify instances in which such persons are not properly using such payments.

(B) Subparagraph (A) shall not apply in any case where the other person to whom such payment is made is a State institution. In such cases, the Commissioner of Social Security shall establish a system of accountability monitoring for institutions in each State.

(C) Subparagraph (A) shall not apply in any case where the individual entitled to such payment is a resident of a Federal institution and the other person to whom such payment is made is the institution.

(D) Notwithstanding subparagraphs (A), (B), and (C), the Commissioner of Social Security may require a report at any time from any person receiving payments on behalf of another, if the Commissioner of Social Security has reason to believe that the person receiving such payments is misusing such payments.

(E)[117] In any case in which the person described in subparagraph (A) or (D) receiving payments on behalf of another fails to submit a report required by the Commissioner of Social Security under subparagraph (A) or (D), the Commissioner may, after furnishing notice to such person and the individual entitled to such payment, require that such person appear in person at a field office of the Social Security Administration serving the area in which the individual resides in order to receive such payments.

(F)[118] The Commissioner of Social Security shall maintain a centralized file, which shall be updated periodically and which shall be in a form which will be readily retrievable by each servicing office of the Social Security Administration, of—

(i) the address and the social security account number (or employer identification number) of each representative payee who is receiving benefit payments pursuant to this subsection, section 807, or section 1631(a)(2), and

(ii) the address and social security account number of each individual for whom each representative payee is reported to be providing services as representative payee pursuant to this subsection, section 807, or section 1631(a)(2).

[117] P.L. 108-203, §106 (a)(2), added this subparagraph (E), effective September 2004.
[118] P.L. 108-203, §106(a)(1), redesignated the former subparagraph (E) as subparagraph (F).

(G)[119] Each servicing office of the Administration shall maintain a list, which shall be updated periodically, of public agencies and community-based nonprofit social service agencies[120] which are qualified to serve as representative payees pursuant to this subsection or 807 or section 1631(a)(2) and which are located in the area served by such servicing office.

(4)(A)(i) Except as provided in the next sentence, a[121] qualified organization may collect from an individual a monthly fee for expenses (including overhead) incurred by such organization in providing services performed as such individual's representative payee pursuant to this subsection if such fee does not exceed the lesser of—

(I) 10 percent of the monthly benefit involved, or

(II) $25.00 per month ($50.00 per month in any case in which the individual is described in paragraph(1)(B).

A qualified organization may not collect a fee from an individual for any month with respect to which the Commissioner of Social Security or a court of competent jurisdiction has determined that the organization misused all or part of the individual's benefit, and any amount so collected by the qualified organization for such month shall be treated as a misused part of the individual's benefit for purposes of paragraphs (5) and (6). The Commissioner[122] shall adjust annually (after 1995) each dollar amount set forth in subclause (II) under procedures providing for adjustments in the same manner and to the same extent as adjustments are provided for under the procedures used to adjust benefit amounts under section 215(2)(A), except that any amount so adjusted that is not a multiple of $1.00 shall be rounded to the nearest multiple of $1.00.

(ii) In the case of an individual who is no longer currently entitled to monthly insurance benefits under this title but to whom all past-due benefits have not been paid, for purposes of clause (i), any amount of such past-due benefits payable in any month shall be treated as a monthly benefit referred to in clause (i)(I).

Any agreement providing for a fee in excess of the amount permitted under this subparagraph shall be void and shall be treated as misuse by such organization of such individual's benefits.

(B) For purposes of this paragraph, the term "qualified organization" means any State or local government agency whose mission is to carry out income maintenance, social service, or health care-related activities, any State or local government agency with fiduciary responsibilities, or any community-based nonprofit social service agency which is bonded or licensed in each State in which it serves as a

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[119] P.L. 108-203, §106(a)(1), redesignated the former subparagraph (F) as subparagraph (G).

[120] P.L. 108-203, §102(a)(1)(B), strikes out "community-based nonprofit social service agencies" and substitutes "certified community-based nonprofit social service agencies (as defined in paragraph (9)*)," to take effect on April 1, 2005.

*P.L. 108-203, §105(a)(2), struck out "paragraph (9)" and substituted "paragraph (10)".

[121] P.L. 108-203, §104(a)(1), struck out "A" and substituted "Except as provided in the next sentence, a".

[122] P.L. 108-203, §104(a)(2), struck out "The Secretary" and substituted the sentence "A qualified organization ... for purposes of paragraphs (5) and (6)." and "The Commissioner", applicable to any month involving benefit misuse by a representative payee in any case with respect to which the Commissioner of Social Security or a court of competent jurisdiction makes the determination of misuse after September 2004.

representative payee[123], if such agency, in accordance with any applicable regulations of the Commissioner of Social Security—

(i) regularly provides services as the representative payee, pursuant to this subsection or 807 or section 1631(a)(2), concurrently to 5 or more individuals,

(ii) demonstrates to the satisfaction of the Commissioner of Social Security that such agency is not otherwise a creditor of any such individual.

The Commissioner of Social Security shall prescribe regulations under which the Commissioner of Social Security may grant an exception from clause (ii) for any individual on a case-by-case basis if such exception is in the best interests of such individual.

(C) Any qualified organization which knowingly charges or collects, directly or indirectly, any fee in excess of the maximum fee prescribed under subparagraph (A) or makes any agreement, directly or indirectly, to charge or collect any fee in excess of such maximum fee, shall be fined in accordance with title 18, United States Code, or imprisoned not more than 6 months, or both.

(5) In cases where the negligent failure of the Commissioner of Social Security to investigate or monitor a representative payee results in misuse of benefits by the representative payee, the Commissioner of Social Security shall certify for payment to the beneficiary or the beneficiary's alternative representative payee an amount equal to such misused benefits. In any case in which a representative payee that—

(A) is not an individual (regardless of whether it is a "qualified organization" within the meaning of paragraph (4)(B)); or

(B) is an individual who, for any month during a period when misuse occurs, serves 15 or more individuals who are beneficiaries under this title, title VIII, title XVI, or any combination of such titles;

misuses all or part of an individual's benefit paid to such representative payee, the Commissioner of Social Security shall certify for payment to the beneficiary or the beneficiary's alternative representative payee an amount equal to the amount of such benefit so misused. The provisions of this paragraph are subject to the limitations of paragraph (7)(B).[124] The Commissioner of Social Security shall make a good faith effort to obtain restitution from the terminated representative payee.

(6)[125](A) In addition to such other reviews of representative payees as the Commissioner of Social Security may otherwise conduct, the Commissioner shall provide for the periodic onsite review of any person or agency located in the United States

[123] P.L. 108-203, §102(a)(1)(C), strikes out "any community-based nonprofit social service agency which is bonded or licensed in each State in which it serves as a representative payee" and substitutes "any certified community-based nonprofit social service agency (as defined in paragraph (9))*, to take effect on April 1, 2005.

*P.L. 108-203, §105(a)(2), strikes out "paragraph (9)" and substitutes paragraph (10)".

[124] P.L. 108-203, §101(a)(1), added "In any case in which a representative payee that—", subparagraphs (A) and (B) through "such benefit so misused." and the sentence "The provisions of this paragraph are subject to the limitations of paragraph (7)(B).", applicable to any case of benefit misuse by a representative payee with respect to which the Commissioner of Social Security makes the determination of misuse on or after January 1, 1995.

[125] P.L. 108-203, §102(b)(1), amended paragraph (6) in its entirety, effective March 2, 2004. For paragraph (6) as it formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L. 108-203.

that receives the benefits payable under this title (alone or in combination with benefits payable under title VIII or title XVI) to another individual pursuant to the appointment of such person or agency as a representative payee under this subsection, section 807, or section 1631(a)(2) in any case in which—

(i) the representative payee is a person who serves in that capacity with respect to 15 or more such individuals;

(ii) the representative payee is a certified community-based nonprofit social service agency (as defined in paragraph (10)[126] of this subsection or section 1631(a)(2)(I)); or

(iii) the representative payee is an agency (other than an agency described in clause (ii)) that serves in that capacity with respect to 50 or more such individuals.

(B) Within 120 days after the end of each fiscal year, the Commissioner shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report on the results of periodic onsite reviews conducted during the fiscal year pursuant to subparagraph (A) and of any other reviews of representative payees conducted during such fiscal year in connection with benefits under this title. Each such report shall describe in detail all problems identified in such reviews and any corrective action taken or planned to be taken to correct such problems, and shall include—

(i) the number of such reviews;

(ii) the results of such reviews;

(iii) the number of cases in which the representative payee was changed and why;

(iv) the number of cases involving the exercise of expedited, targeted oversight of the representative payee by the Commissioner conducted upon receipt of an allegation of misuse of funds, failure to pay a vendor, or a similar irregularity;

(v) the number of cases discovered in which there was a misuse of funds;

(vi) how any such cases of misuse of funds were dealt with by the Commissioner;

(vii) the final disposition of such cases of misuse of funds, including any criminal penalties imposed; and

(viii) such other information as the Commissioner deems appropriate.

(7)[127](A) If the Commissioner of Social Security or a court of competent jurisdiction determines that a representative payee that is not a Federal, State, or local government agency has misused all or part of an individual's benefit that was paid to such representative payee under this subsection, the representative payee shall be liable for the amount misused, and such amount (to the extent not repaid by the representative payee) shall be treated as an overpayment of benefits under this title

[126] P.L. 108-203, §105(a)(3), struck out "paragraph (9)" and substituted "paragraph (10)".

[127] P.L 108-203, §105(a)(4), added a new paragraph (7), applicable to benefit misuse by a representative payee in any case with respect to which the Commissioner of Social Security or a court of competent jurisdiction makes the determination of misuse after September 2004.

to the representative payee for all purposes of this Act and related laws pertaining to the recovery of such overpayments. Subject to subparagraph (B), upon recovering all or any part of such amount, the Commissioner shall certify an amount equal to the recovered amount for payment to such individual or such individual's alternative representative payee.

(B) The total of the amount certified for payment to such individual or such individual's alternative representative payee under subparagraph (A) and the amount certified for payment under paragraph (5) may not exceed the total benefit amount misused by the representative payee with respect to such individual.

(8)[128] For purposes of this subsection, the term "benefit based on disability" of an individual means a disability insurance benefit of such individual under section 223 or a child's, widow's, or widower's insurance benefit of such individual under section 202 based on such individual's disability.

(9)[129] For purposes of this subsection, misuse of benefits by a representative payee occurs in any case in which the representative payee receives payment under this title for the use and benefit of another person and converts such payment, or any part thereof, to a use other than for the use and benefit of such other person. The Commissioner of Social Security may prescribe by regulation the meaning of the term "use and benefit" for purposes of this paragraph.

(10)[130] For purposes of this subsection, the term 'certified community-based nonprofit social service agency' means a community-based nonprofit social service agency which is in compliance with requirements, under regulations which shall be prescribed by the Commissioner, for annual certification to the Commissioner that it is bonded in accordance with requirements specified by the Commissioner and that it is licensed in each State in which it serves as a representative payee (if licensing is available in the State) in accordance with requirements specified by the Commissioner. Any such annual certification shall include a copy of any independent audit on the agency which may have been performed since the previous certification.

(k) Any payment made after December 31, 1939, under conditions set forth in subsection (j), any payment made before January 1, 1940, to, or on behalf of, a legally incompetent individual, and any payment made after December 31, 1939, to a legally incompetent individual without knowledge by the Commissioner of Social Security of incompetency prior to certification of payment, if otherwise valid under this title, shall be a complete settlement and satisfaction of any claim, right, or interest in and to such payment.

(l) The Commissioner of Social Security is authorized to delegate to any member, officer, or employee of the Social Security Administration designated by him any of the powers conferred upon him by this section, and is authorized to be represented by his own at-

[128] P.L. 108-203, §105(a)(1), redesignated the former paragraph (7) as paragraph (8).

[129] P.L. 108-203, §101(a)(2), added paragraph (8), applicable to any case of benefit misuse by a representative payee with respect to which the Commissioner of Social Security makes the determination of misuse on or after January 1, 1995; §105(a)(1), redesignated this paragraph (8) as paragraph (9).

[130] P.L 108-203, §102(a)(1)(D), added this paragraph as paragraph (9), to be effective April 1, 2005; §105(a)(1), redesigned this paragraph as paragraph (10).

torneys in any court in any case or proceeding arising under the provisions of subsection (e).

(m) [Repealed.[131]]

(n) The Commissioner of Social Security may, in the Commissioner's discretion, certify to the Managing Trustee any two or more individuals of the same family for joint payment of the total benefits payable to such individuals for any month, and if one of such individuals dies before a check representing such joint payment is negotiated, payment of the amount of such unnegotiated check to the surviving individual or individuals may be authorized in accordance with regulations of the Secretary of the Treasury; except that appropriate adjustment or recovery shall be made under section 204(a) with respect to so much of the amount of such check as exceeds the amount to which such surviving individual or individuals are entitled under this title for such month.

Crediting of Compensation Under the Railroad Retirement Act

(o) If there is no person who would be entitled, upon application therefor, to an annuity under section 2 of the Railroad Retirement Act of 1974[132], or to a lump–sum payment under section 6(b) of such Act, with respect to the death of an employee (as defined in such Act), then, notwithstanding section 210(a)(9)[133] of this Act, compensation (as defined in such Railroad Retirement Act, but excluding compensation attributable as having been paid during any month on account of military service creditable under section 3 of such Act if wages are deemed to have been paid to such employee during such month under subsection (a) or (e) of section 217 of this Act) of such employee shall constitute remuneration for employment for purposes of determining (A) entitlement to and the amount of any lump–sum death payment under this title on the basis of such employee's wages and self–employment income and (B) entitlement to and the amount of any monthly benefit under this title, for the month in which such employee died or for any month thereafter, on the basis of such wages and self–employment income. For such purposes, compensation (as so defined) paid in a calendar year before 1978 shall, in the absence of evidence to the contrary, be presumed to have been paid in equal proportions with respect to all months in the year in which the employee rendered services for such compensation.

Special Rules in Case of Federal Service

(p)(1) With respect to service included as employment under section 210 which is performed in the employ of the United States or in the employ of any instrumentality which is wholly owned by the United States, including service, performed as a member of a uniformed service, to which the provisions of subsection (l)(1) of such section are applicable, and including service, performed as a volunteer or volunteer leader within the meaning of the Peace Corps Act[134], to which the provisions of section 210(o) are applicable, the Commissioner of Social Security shall not make determinations as to the amounts of remuneration for such service, or the periods in

[131] P.L. 81–734, §101(b)(2); 64 Stat. 488. See, instead, §202(j)(2).
[132] See Vol. II, P.L. 75–162 [as amended by P.L. 93–445].
[133] P.L. 83–761, §101(a)(5), redesignated §210(a)(9) as §201(a)(10).
[134] See Vol. II, P.L. 87–293.

which or for which such remuneration was paid, but shall accept the determinations with respect thereto of the head of the appropriate Federal agency or instrumentality, and of such agents as such head may designate, as evidenced by returns filed in accordance with the provisions of section 3122 of the Internal Revenue Code of 1954[135] and certifications made pursuant to this subsection. Such determinations shall be final and conclusive. Nothing in this paragraph shall be construed to affect the Commissioner's authority to determine under sections 209 and 210 whether any such service constitutes employment, the periods of such employment, and whether remuneration paid for any such service constitutes wages.

(2) The head of any such agency or instrumentality is authorized and directed, upon written request of the Commissioner of Social Security, to make certification to the Commissioner with respect to any matter determinable for the Commissioner of Social Security by such head or his agents under this subsection, which the Commissioner of Social Security finds necessary in administering this title.

(3) The provisions of paragraphs (1) and (2) shall be applicable in the case of service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Army and Air Force Exchange Service, Army and Air Force Motion Picture Service, Navy Exchanges, Marine Corps Exchanges, or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of Defense, at installations of the Department of Defense for the comfort, pleasure, contentment, and mental and physical improvement of personnel of such Department; and for purposes of paragraphs (1) and (2) the Secretary of Defense shall be deemed to be the head of such instrumentality. The provisions of paragraphs (1) and (2) shall be applicable also in the case of service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Coast Guard Exchanges or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of Transportation, at installations of the Coast Guard for the comfort, pleasure, contentment, and mental and physical improvement of personnel of the Coast Guard; and for purposes of paragraphs (1) and (2) the Secretary of Transportation shall be deemed to be the head of such instrumentality.

Expedited Benefit Payments

(q)(1) The Commissioner of Social Security shall establish and put into effect procedures under which expedited payment of monthly insurance benefits under this title will, subject to paragraph (4) of this subsection, be made as set forth in paragraphs (2) and (3) of this subsection.

(2) In any case in which—

(A) an individual makes an allegation that a monthly benefit under this title was due him in a particular month but was not paid to him, and

(B) such individual submits a written request for the payment of such benefit—

[135] P.L. 83–591 (this volume).

(i) in the case of an individual who received a regular monthly benefit in the month preceding the month with respect to which such allegation is made, not less than 30 days after the 15th day of the month with respect to which such allegation is made (and in the event that such request is submitted prior to the expiration of such 30-day period, it shall be deemed to have been submitted upon the expiration of such period), and

(ii) in any other case, not less than 90 days after the later of (I) the date on which such benefit is alleged to have been due, or (II) the date on which such individual furnished the last information requested by the Commissioner of Social Security (and such written request will be deemed to be filed on the day on which it was filed, or the ninetieth day after the first day on which the Commissioner of Social Security has evidence that such allegation is true, whichever is later),

the Commissioner of Social Security shall, if he finds that benefits are due, certify such benefits for payment, and payment shall be made within 15 days immediately following the date on which the written request is deemed to have been filed.

(3) In any case in which the Commissioner of Social Security determines that there is evidence, although additional evidence might be required for a final decision, that an allegation described in paragraph (2)(A) is true, he may make a preliminary certification of such benefit for payment even though the 30-day or 90-day periods described in paragraph (2)(B)(i) and (B)(ii) have not elapsed.

(4) Any payment made pursuant to a certification under paragraph (3) of this subsection shall not be considered an incorrect payment for purposes of determining the liability of the certifying or disbursing officer.

(5) For purposes of this subsection, benefits payable under section 228 shall be treated as monthly insurance benefits payable under this title. However, this subsection shall not apply with respect to any benefit for which a check has been negotiated, or with respect to any benefit alleged to be due under either section 223, or section 202 to a wife, husband, or child of an individual entitled to or applying for benefits under section 223, or to a child who has attained age 18 and is under a disability, or to a widow or widower on the basis of being under a disability.

Use of Death Certificates to Correct Program Information

(r)(1) The Commissioner of Social Security shall undertake to establish a program under which—

(A) States (or political subdivisions thereof) voluntarily contract with the Commissioner of Social Security to furnish the Commissioner of Social Security periodically with information (in a form established by the Commissioner of Social Security in consultation with the States) concerning individuals with respect to whom death certificates (or equivalent documents maintained by the States or subdivisions) have been officially filed with them; and

(B) there will be (i) a comparison of such information on such individuals with information on such individuals in the records being used in the administration of this Act, (ii) validation of the results of such comparisons, and (iii) corrections in such records to accurately reflect the status of such individuals.

(2) Each State (or political subdivision thereof) which furnishes the Commissioner of Social Security with information on records of deaths in the State or subdivision under this subsection may be paid by the Commissioner of Social Security from amounts available for administration of this Act the reasonable costs (established by the Commissioner of Social Security in consultations with the States) for transcribing and transmitting such information to the Commissioner of Social Security.

(3) In the case of individuals with respect to whom federally funded benefits are provided by (or through) a Federal or State agency other than under this Act, the Commissioner of Social Security shall to the extent feasible provide such information through a cooperative arrangement with such agency, for ensuring proper payment of those benefits with respect to such individuals if—

(A) under such arrangement the agency provides reimbursement to the Commissioner of Social Security for the reasonable cost of carrying out such arrangement, and

(B) such arrangement does not conflict with the duties of the Commissioner of Social Security under paragraph (1).

(4) The Commissioner of Social Security may enter into similar agreements with States to provide information for their use in programs wholly funded by the States if the requirements of subparagraphs (A) and (B) of paragraph (3) are met.

(5) The Commissioner of Social Security may use or provide for the use of such records as may be corrected under this section, subject to such safeguards as the Commissioner of Social Security determines are necessary or appropriate to protect the information from unauthorized use or disclosure, for statistical and research activities conducted by Federal and State agencies.

(6) Information furnished to the Commissioner of Social Security under this subsection may not be used for any purpose other than the purpose described in this subsection and is exempt from disclosure under section 552 of title 5, United States Code, and from the requirements of section 552a of such title [136].

(7) The Commissioner of Social Security shall include information on the status of the program established under this section and impediments to the effective implementation of the program in the 1984 report required under section 704 of this Act.

Notice Requirements

(s) The Commissioner of Social Security shall take such actions as are necessary to ensure that any notice to one or more individ-

[136] See Vol. II, Title 5.

uals issued pursuant to this title by the Commissioner of Social Security or by a State agency—

(1) is written in simple and clear language, and

(2) includes the address and telephone number of the local office of the Social Security Administration which serves the recipient.

In the case of any such notice which is not generated by a local servicing office, the requirements of paragraph (2) shall be treated as satisfied if such notice includes the address of the local office of the Social Security Administration which services the recipient of the notice and a telephone number through which such office can be reached.

Same-Day Personal Interviews at Field Offices In Cases Where Time Is of The Essence

(t) In any case in which an individual visits a field office of the Social Security Administration and represents during the visit to an officer or employee of the Social Security Administration in the office that the individual's visit is occasioned by—

(1) the receipt of a notice from the Social Security Administration indicating a time limit for response by the individual, or

(2) the theft, loss, or nonreceipt of a benefit payment under this title,

the Commissioner of Social Security shall ensure that the individual is granted a face-to-face interview at the office with an officer or employee of the Social Security Administration before the close of business on the day of the visit.

(u)(1)(A) The Commissioner of Social Security shall immediately redetermine the entitlement of individuals to monthly insurance benefits under this title if there is reason to believe that fraud or similar fault was involved in the application of the individual for such benefits, unless a United States attorney, or equivalent State prosecutor, with jurisdiction over potential or actual related criminal cases, certifies, in writing, that there is a substantial risk that such action by the Commissioner of Social Security with regard to beneficiaries in a particular investigation would jeopardize the criminal prosecution of a person involved in a suspected fraud.

(B) When redetermining the entitlement, or making an initial determination of entitlement, of an individual under this title, the Commissioner of Social Security shall disregard any evidence if there is reason to believe that fraud or similar fault was involved in the providing of such evidence.

(2) For purposes of paragraph (1), similar fault is involved with respect to a determination if—

(A) an incorrect or incomplete statement that is material to the determination is knowingly made; or

(B) information that is material to the determination is knowingly concealed.

(3) If, after redetermining pursuant to this subsection the entitlement of an individual to monthly insurance benefits, the Commissioner of Social Security determines that there is insufficient evidence to support such entitlement, the Commissioner of Social Security may terminate such entitlement and may

treat benefits paid on the basis of such insufficient evidence as overpayments.

REPRESENTATION OF CLAIMANTS [137]

SEC. 206. [42 U.S.C. 406] (a)(1) The Commissioner of Social Security may prescribe rules and regulations governing the recognition of agents or other persons, other than attorneys as hereinafter provided, representing claimants before the Commissioner of Social Security, and may require of such agents or other persons, before being recognized as representatives of claimants that they shall show that they are of good character and in good repute, possessed of the necessary qualifications to enable them to render such claimants valuable service, and otherwise competent to advise and assist such claimants in the presentation of their cases. An attorney in good standing who is admitted to practice before the highest court of the State, Territory, District, or insular possession of his residence or before the Supreme Court of the United States or the inferior Federal courts, shall be entitled to represent claimants before the Commissioner of Social Security. Notwithstanding the preceding sentences, the Commissioner, after due notice and opportunity for hearing, (A) may refuse to recognize as a representative, and may disqualify a representative already recognized, any attorney who has been disbarred or suspended from any court or bar to which he or she was previously admitted to practice or who has been disqualified from participating in or appearing before any Federal program or agency, and (B) may refuse to recognize, and may disqualify, as a non-attorney representative any attorney who has been disbarred or suspended from any court or bar to which he or she was previously admitted to practice. A representative who has been disqualified or suspended pursuant to this section from appearing before the Social Security Administration as a result of collecting or receiving a fee in excess of the amount authorized shall be barred from appearing before the Social Security Administration as a representative until full restitution is made to the claimant and, thereafter, may be considered for reinstatement only under such rules as the Commissioner may prescribe. [138] The Commissioner of Social Security may, after due notice and opportunity for hearing, suspend or prohibit from further practice before the Commissioner any such person, agent, or attorney who refuses to comply with the Commissioner's rules and regulations or who violates any provision of this section for which a penalty is prescribed. The Commissioner of Social Security may, by rule and regulation, prescribe the maximum fees which may be charged for services performed in connection with any claim before the Commissioner of Social Security under this title, and any agreement in violation of such rules and regulations shall be void. Except as provided in paragraph (2)(A), whenever the Commissioner of Social Security, in any claim before the Commissioner for benefits under this title, makes a determination favorable to the claimant, the Commissioner shall, if the claimant was represented by an attorney in connection with such claim, fix (in accordance with the regu-

[137] See Vol. II, P.L. 108–203, §303, with respect to a nationwide demonstration project providing for extension of fee withholding procedures to non-attorney representatives; and §304, with respect to a GAO study regarding the fee payment process for claimant representatives.

[138] P.L. 108-203, §205, added the two sentences preceding the footnote indicator, starting with "Notwithstanding..." through "...the Commissioner may prescribe.", effective March 2, 2004.

lations prescribed pursuant to the preceding sentence) a reasonable fee to compensate such attorney for the services performed by him in connection with such claim.

(2)(A) In the case of a claim of entitlement to past-due benefits under this title, if—

(i) an agreement between the claimant and another person regarding any fee to be recovered by such person to compensate such person for services with respect to the claim is presented in writing to the Commissioner of Social Security prior to the time of the Commissioner's determination regarding the claim,

(ii) the fee specified in the agreement does not exceed the lesser of—

(I) 25 percent of the total amount of such past-due benefits (as determined before any applicable reduction under section 1127(a)), or

(II) $4,000, and

(iii) the determination is favorable to the claimant,

then the Commissioner of Social Security shall approve that agreement at the time of the favorable determination, and (subject to paragraph (3)) the fee specified in the agreement shall be the maximum fee. The Commissioner of Social Security may from time to time increase the dollar amount under clause (ii)(II) to the extent that the rate of increase in such amount, as determined over the period since January 1, 1991, does not at any time exceed the rate of increase in primary insurance amounts under section 215(i) since such date. The Commissioner of Social Security shall publish any such increased amount in the Federal Register.

(B) For purposes of this subsection, the term "past-due benefits" excludes any benefits with respect to which payment has been continued pursuant to subsection (g) or (h) of section 223.

(C) In any case involving—

(i) an agreement described in subparagraph (A) with any person relating to both a claim of entitlement to past-due benefits under this title and a claim of entitlement to past-due benefits under title XVI, and

(ii) a favorable determination made by the Commissioner of Social Security with respect to both such claims,

the Commissioner of Social Security may approve such agreement only if the total fee or fees specified in such agreement does not exceed, in the aggregate, the dollar amount in effect under subparagraph (A)(ii)(II).

(D) In the case of a claim with respect to which the Commissioner of Social Security has approved an agreement pursuant to subparagraph (A), the Commissioner of Social Security shall provide the claimant and the person representing the claimant a written notice of—

(i) the dollar amount of the past-due benefits (as determined before any applicable reduction under section 1127(a)) and the dollar amount of the past-due benefits payable to the claimant,

(ii) the dollar amount of the maximum fee which may be charged or recovered as determined under this paragraph, and

(iii) a description of the procedures for review under paragraph (3).

(3)(A) The Commissioner of Social Security shall provide by regulation for review of the amount which would otherwise be the maximum fee as determined under paragraph (2) if, within 15 days after receipt of the notice provided pursuant to paragraph (2)(D)—

(i) the claimant, or the administrative law judge or other adjudicator who made the favorable determination, submits a written request to the Commissioner of Social Security to reduce the maximum fee, or

(ii) the person representing the claimant submits a written request to the Commissioner of Social Security to increase the maximum fee.

Any such review shall be conducted after providing the claimant, the person representing the claimant, and the adjudicator with reasonable notice of such request and an opportunity to submit written information in favor of or in opposition to such request. The adjudicator may request the Commissioner of Social Security to reduce the maximum fee only on the basis of evidence of the failure of the person representing the claimant to represent adequately the claimant's interest or on the basis of evidence that the fee is clearly excessive for services rendered.

(B)(i) In the case of a request for review under subparagraph (A) by the claimant or by the person representing the claimant, such review shall be conducted by the administrative law judge who made the favorable determination or, if the Commissioner of Social Security determines that such administrative law judge is unavailable or if the determination was not made by an administrative law judge, such review shall be conducted by another person designated by the Commissioner of Social Security for such purpose.

(ii) In the case of a request by the adjudicator for review under subparagraph (A), the review shall be conducted by the Commissioner of Social Security or by an administrative law judge or other person (other than such adjudicator) who is designated by the Commissioner of Social Security.

(C) Upon completion of the review, the administrative law judge or other person conducting the review shall affirm or modify the amount which would otherwise be the maximum fee. Any such amount so affirmed or modified shall be considered the amount of the maximum fee which may be recovered under paragraph (2). The decision of the administrative law judge or other person conducting the review shall not be subject to further review.

(4) Subject to subsection (d), if the claimant is determined to be entitled to past-due benefits under this title and the person representing the claimant is an attorney, the Commissioner of Social Security shall, notwithstanding section 205(i), certify for payment out of such past-due benefits (as determined before any applicable reduction under section 1127(a)) to such attorney an amount equal to so much of the maximum fee as does not exceed 25 percent of such past-due benefits (as determined before any applicable reduction under section 1127(a)).

(5) Any person who shall, with intent to defraud, in any manner willfully and knowingly deceive, mislead, or threaten any claimant or prospective claimant or beneficiary under this title by word, circular, letter or advertisement, or who shall knowingly charge or collect directly or indirectly any fee in excess of the maximum fee, or make any agreement directly or indirectly to charge or collect any fee in excess of the maximum fee, prescribed by the Commissioner of Social Security shall be deemed guilty of a misdemeanor and, upon conviction thereof, shall for each offense be punished by a fine not exceeding $500 or by imprisonment not exceeding one year, or both. The Commissioner of Social Security shall maintain in the electronic information retrieval system used by the Social Security Administration a current record, with respect to any claimant before the Commissioner of Social Security, of the identity of any person representing such claimant in accordance with this subsection.

(b)(1)(A) Whenever a court renders a judgment favorable to a claimant under this title who was represented before the court by an attorney, the court may determine and allow as part of its judgment a reasonable fee for such representation, not in excess of 25 percent of the total of the past-due benefits to which the claimant is entitled by reason of such judgment, and the Commissioner of Social Security may, notwithstanding the provisions of section 205(i), but subject to subsection (d) of this section, certify the amount of such fee for payment to such attorney out of, and not in addition to, the amount of such past-due benefits. In case of any such judgment, no other fee may be payable or certified for payment for such representation except as provided in this paragraph.

(B) For purposes of this paragraph—

(i) the term "past-due benefits" excludes any benefits with respect to which payment has been continued pursuant to subsection (g) or (h) of section 223, and

(ii) amounts of past-due benefits shall be determined before any applicable reduction under section 1127(a).

(2) Any attorney who charges, demands, receives, or collects for services rendered in connection with proceedings before a court to which paragraph (1) is applicable any amount in excess of that allowed by the court thereunder shall be guilty of a misdemeanor and upon conviction thereof shall be subject to a fine of not more than $500, or imprisonment for not more than one year, or both.[139]

(c) The Commissioner of Social Security shall notify each claimant in writing, together with the notice to such claimant of an adverse determination, of the options for obtaining attorneys to represent individuals in presenting their cases before the Commissioner of Social Security. Such notification shall also advise the claimant of the availability to qualifying claimants of legal services organizations which provide legal services free of charge.

(d) ASSESSMENT ON ATTORNEYS.—

(1) IN GENERAL.—Whenever a fee for services is required to be certified for payment to an attorney from a claimant's past–due benefits pursuant to subsection (a)(4) or (b)(1), the Com-

[139] See Vol. II, P.L. 96–481, with respect to an award of attorney fees and other expenses.

missioner shall impose on the attorney an assessment calculated in accordance with paragraph (2).

(2) AMOUNT.—

(A) The amount of an assessment under paragraph (1) shall be equal to the product obtained by multiplying the amount of the representative's fee that would be required to be so certified by subsection (a)(4) or (b)(1) before the application of this subsection, by the percentage specified in subparagraph (B), except that the maximum amount of the assessment may not exceed the greater of $75 or the adjusted amount as provided pursuant to the following two sentences[140]. In the case of any calendar year beginning after the amendments made by section 301 of the Social Security Protection Act of 2003 take effect, the dollar amount specified in the preceding sentence (including a previously adjusted amount) shall be adjusted annually under the procedures used to adjust benefit amounts under section 215(i)(2)(A)(ii), except such adjustment shall be based on the higher of $75 or the previously adjusted amount that would have been in effect for December of the preceding year, but for the rounding of such amount pursuant to the following sentence. Any amount so adjusted that is not a multiple of $1 shall be rounded to the next lowest multiple of $1, but in no case less than $75.[141]

(B) The percentage specified in this subparagraph is—

(i) for calendar years before 2001, 6.3 percent, and

(ii) for calendar years after 2000, such percentage rate as the Commissioner determines is necessary in order to achieve full recovery of the costs of determining and certifying fees to attorneys from the past–due benefits of claimants, but not in excess of 6.3 percent.

(3) COLLECTION.—The Commissioner may collect the assessment imposed on an attorney under paragraph (1) by offset from the amount of the fee otherwise required by subsection (a)(4) or (b)(1) to be certified for payment to the attorney from a claimant's past–due benefits.

(4) PROHIBITION ON CLAIMANT REIMBURSEMENT.—An attorney subject to an assessment under paragraph (1) may not, directly or indirectly, request or otherwise obtain reimbursement for such assessment from the claimant whose claim gave rise to the assessment.

(5) DISPOSITION OF ASSESSMENTS.—Assessments on attorneys collected under this subsection shall be credited to the Federal Old–Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, as appropriate.

(6) AUTHORIZATION OF APPROPRIATIONS.—The assessments authorized under this section shall be collected and available for obligation only to the extent and in the amount provided in advance in appropriations Acts. Amounts so appropriated

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[140] P.L. 108-203, §301(a)(1), inserted ", except that the maximum amount of the assessment may not exceed the greater of $75 or the adjusted amount as provided pursuant to the following two sentences", applicable with respect to fees for representation of claimants which are first required to be certified or paid under section 206 on or after September 1, 2004.

[141] P.L. 108-203, §301(a)(2), added these two sentences beginning with "In the case of" through "$75.", applicable with respect to fees for representation of claimants which are first required to be certified or paid under section 206 on or after September 1, 2004.

are authorized to remain available until expended, for administrative expenses in carrying out this title and related laws.

ASSIGNMENT [142]

SEC. 207. [42 U.S.C. 407] (a) The right of any person to any future payment under this title shall not be transferable or assignable, at law or in equity, and none of the moneys paid or payable or rights existing under this title shall be subject to execution, levy, attachment, garnishment, or other legal process, or to the operation of any bankruptcy or insolvency law.

(b) No other provision of law, enacted before, on, or after the date of the enactment of this section [143], may be construed to limit, supersede, or otherwise modify the provisions of this section except to the extent that it does so by express reference to this section.

(c) Nothing in this section shall be construed to prohibit withholding taxes from any benefit under this title, if such withholding is done pursuant to a request made in accordance with section 3402(p)(1) of the Internal Revenue Code of 1986 by the person entitled to such benefit or such person's representative payee.

PENALTIES [144]

SEC. 208. [42 U.S.C. 408] (a) Whoever—

(1) for the purpose of causing an increase in any payment authorized to be made under this title, or for the purpose of causing any payment to be made where no payment is authorized under this title, shall make or cause to be made any false statement or representation (including any false statement or representation in connection with any matter arising under subchapter E of chapter 1, or subchapter A or E of chapter 9 of the Internal Revenue Code of 1939 [145], or chapter 2 or 21 or subtitle F of the Internal Revenue Code of 1954 [146]) as to—

(A) whether wages were paid or received for employment (as said terms are defined in this title and the Internal Revenue Code), or the amount of wages or the period during which paid or the person to whom paid; or

(B) whether net earnings from self-employment (as such term is defined in this title and in the Internal Revenue Code) were derived, or as to the amount of such net earnings or the period during which or the person by whom derived; or

(C) whether a person entitled to benefits under this title had earnings in or for a particular period (as determined under section 203(f) of this title for purposes of deductions from benefits), or as to the amount thereof; or

(2) makes or causes to be made any false statement or representation of a material fact in any application for any payment or for a disability determination under this title; or

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[142] See Vol. II, P.L. 83–59, §§86, 861, and 871, with respect to income subject to taxes.

[143] This section was enacted August 10, 1939, [P.L. 76–379, §207].
This subsection was enacted April 20, 1983, [P.L. 98–21, §335(a)(2)].

[144] See Vol. II, 18 U.S.C. 1028 and 1738, with respect to penalties relating to use of identification documents.

[145] P.L. 76–1.

[146] See P.L. 83–591, chapter 2 (this volume).

(3) at any time makes or causes to be made any false statement or representation of a material fact for use in determining rights to payment under this title; or

(4) having knowledge of the occurrence of any event affecting (1) his initial or continued right to any payment under this title, or (2) the initial or continued right to any payment of any other individual in whose behalf he has applied for or is receiving such payment, conceals or fails to disclose such event with an intent fraudulently to secure payment either in a greater amount than is due or when no payment is authorized; or

(5) having made application to receive payment under this title for the use and benefit of another and having received such a payment, knowingly and willfully converts such a payment, or any part thereof, to a use other than for the use and benefit of such other person; or

(6) willfully, knowingly, and with intent to deceive the Commissioner of Social Security as to his true identity (or the true identity of any other person) furnishes or causes to be furnished false information to the Commissioner of Social Security with respect to any information required by the Commissioner of Social Security in connection with the establishment and maintenance of the records provided for in section 205(c)(2); or

(7) for the purpose of causing an increase in any payment authorized under this title (or any other program financed in whole or in part from Federal funds), or for the purpose of causing a payment under this title (or any such other program) to be made when no payment is authorized thereunder, or for the purpose of obtaining (for himself or any other person) any payment or any other benefit to which he (or such other person) is not entitled, or for the purpose of obtaining anything of value from any person, or for any other purpose—

(A) willfully, knowingly, and with intent to deceive, uses a social security account number, assigned by the Commissioner of Social Security (in the exercise of the Commissioner's authority under section 205(c)(2) to establish and maintain records) on the basis of false information furnished to the Commissioner of Social Security by him or by any other person; or

(B) with intent to deceive, falsely represents a number to be the social security account number assigned by the Commissioner of Social Security to him or to another person, when in fact such number is not the social security account number assigned by the Commissioner of Social Security to him or to such other person; or

(C) knowingly alters a social security card issued by the Commissioner of Social Security, buys or sells a card that is, or purports to be, a card so issued, counterfeits a social security card, or possesses a social security card or counterfeit social security card with intent to sell or alter it; or

(8) discloses, uses, or compels the disclosure of the social security number of any person in violation of the laws of the United States;

shall be guilty of a felony and upon conviction thereof shall be fined under title 18, United States Code, or imprisoned for not more than five years, or both.

(b)[147] (1) Any Federal court, when sentencing a defendant convicted of an offense under subsection (a), may order, in addition to or in lieu of any other penalty authorized by law, that the defendant make restitution to the victims of such offense specified in paragraph (4).

(2) Sections 3612, 3663, and 3664 of title 18, United States Code, shall apply with respect to the issuance and enforcement of orders of restitution to victims of such offense under this subsection.

(3) If the court does not order restitution, or orders only partial restitution, under this subsection, the court shall state on the record the reasons therefor.

(4) For purposes of paragraphs (1) and (2), the victims of an offense under subsection (a) are the following:

(A) Any individual who suffers a financial loss as a result of the defendant's violation of subsection (a).

(B) The Commissioner of Social Security, to the extent that the defendant's violation of subsection (a) results in—

(i) the Commissioner of Social Security making a benefit payment that should not have been made; or

(ii) an individual suffering a financial loss due to the defendant's violation of subsection (a) in his or her capacity as the individual's representative payee appointed pursuant to section 205(j).

(5)(A) Except as provided in subparagraph (B), funds paid to the Commissioner of Social Security as restitution pursuant to a court order shall be deposited in the Federal Old-Age and Survivors Insurance Trust Fund, or the Federal Disability Insurance Trust Fund, as appropriate.

(B) In the case of funds paid to the Commissioner of Social Security pursuant to paragraph (4)(B)(ii), the Commissioner of Social Security shall certify for payment to the individual described in such paragraph an amount equal to the lesser of the amount of the funds so paid or the individual's outstanding financial loss, except that such amount may be reduced by the amount of any overpayments of benefits owed under this title, title VIII, or title XVI by the individual.

(c)[148] Any person or other entity who is convicted of a violation of any of the provisions of this section, if such violation is committed by such person or entity in his role as, or in applying to become, a certified payee under section 205(j) on behalf of another individual (other than such person's spouse), upon his second or any subsequent such conviction shall, in lieu of the penalty set forth in the preceding provisions of this section, be guilty of a felony and shall be fined under title 18, United States Code, or imprisoned for not more than five years, or both.[149]

(d)[150] Any individual or entity convicted of a felony under this section or under section 1632(b) may not be certified as a payee

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[147] P.L. 108-203, §209(a)(2), added subsection (b), applicable with respect to violations occurring on or after March 2, 2004.

[148] P.L. 108-203, §209(a)(1), redesignated the former subsection (b) as subsection (c).

[149] P.L. 108-203, §209(a)(3), struck out "In the case of any violation described in the preceding sentence, including a first such violation, if the court determines that such violation includes a willful misuse of funds by such person or entity, the court may also require that full or partial restitution of such funds be made to the individual for whom such person or entity was the certified payee.", applicable with respect to violations occurring on or after March 2, 2004.

[150] P.L. 108-203, §209(a)(1), redesignated the former subsection (c) as subsection (d).

under section 205(j). For the purpose of subsection (a)(7), the terms "social security number" and "social security account number" mean such numbers as are assigned by the Commissioner of Social Security under section 205(c)(2) whether or not, in actual use, such numbers are called social security numbers.

(e)[151] (1) Except as provided in paragraph (2), an alien—

(A) whose status is adjusted to that of lawful temporary resident under section 210 or 245A of the Immigration and Nationality Act or under section 902 of the Foreign Relations Authorization Act, Fiscal Years 1988 and 1989,

(B) whose status is adjusted to that of permanent resident—

(i) under section 202 of the Immigration Reform and Control Act of 1986, or

(ii) pursuant to section 249 of the Immigration and Nationality Act, or

(C) who is granted special immigrant status under section 101(a)(27)(I) of the Immigration and Nationality Act,

shall not be subject to prosecution for any alleged conduct described in paragraph (6) or (7) of subsection (a) if such conduct is alleged to have occurred prior to 60 days after the date of the enactment of the Omnibus Budget Reconciliation Act of 1990.

(2) Paragraph (1) shall not apply with respect to conduct (described in subsection (a)(7)(C)) consisting of—

(A) selling a card that is, or purports to be, a social security card issued by the Commissioner of Social Security,

(B) possessing a social security card with intent to sell it, or

(C) counterfeiting a social security card with intent to sell it.

(3) Paragraph (1) shall not apply with respect to any criminal conduct involving both the conduct described in subsection (a)(7) to which paragraph (1) applies and any other criminal conduct if such other conduct would be criminal conduct if the conduct described in subsection (a)(7) were not committed.

DEFINITION OF WAGES

SEC. 209. [42 U.S.C. 409] (a) For the purposes of this title, the term "wages" means remuneration paid prior to 1951 which was wages for the purposes of this title under the law applicable to the payment of such remuneration, and remuneration paid after 1950 for employment, including the cash value of all remuneration (including benefits) paid in any medium other than cash; except that, in the case of remuneration paid after 1950, such term shall not include—

(1)(A) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $3,600 with respect to employment has been paid to an individual during any calendar year prior to 1955, is paid to such individual during such calendar year;

(B) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $4,200 with respect to

[151] P.L. 108-203, §209(a)(1), redesignated the former subsection (d) as subsection (e).

employment has been paid to an individual during any calendar year after 1954 and prior to 1959, is paid to such individual during such calendar year;

(C) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $4,800 with respect to employment has been paid to an individual during any calendar year after 1958 and prior to 1966, is paid to such individual during such calendar year;

(D) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $6,600 with respect to employment has been paid to an individual during any calendar year after 1965 and prior to 1968, is paid to such individual during such calendar year;

(E) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $7,800 with respect to employment has been paid to an individual during any calendar year after 1967 and prior to 1972, is paid to such individual during such calendar year;

(F) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $9,000 with respect to employment has been paid to an individual during any calendar year after 1971 and prior to 1973, is paid to such individual during any such calendar year;

(G) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $10,800 with respect to employment has been paid to an individual during any calendar year after 1972 and prior to 1974, is paid to such individual during such calendar year;

(H) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $13,200 with respect to employment has been paid to an individual during any calendar year after 1973 and prior to 1975, is paid to such individual during such calendar year;

(I) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to the contribution and benefit base (determined under section 230) with respect to employment has been paid to an individual during any calendar year after 1974 with respect to which such contribution and benefit base is effective, is paid to such individual during such calendar year;

(2) The amount of any payment (including any amount paid by an employer for insurance or annuities, or into a fund, to provide for any such payment) made to, or on behalf of, an employee or any of his dependents under a plan or system established by an employer which makes provision for his employees generally (or for his employees generally and their dependents) or for a class or classes of his employees (or for a class or classes of his employees and their dependents), on account of (A) sickness or accident disability (but, in the case of payments

made to an employee or any of his dependents, this clause shall exclude from the term "wages" only payments which are received under a workmen's compensation law), or [152] (B) medical or hospitalization expenses in connection with sickness or accident disability, or (C) death, except that this subsection does not apply to a payment for group-term life insurance to the extent that such payment is includible in the gross income of the employee under the Internal Revenue Code of 1986;

(3) Any payment on account of sickness or accident disability, or medical or hospitalization expenses in connection with sickness or accident disability, made by an employer to, or on behalf of, an employee after the expiration of six calendar months following the last calendar month in which the employee worked for such employer;

(4) Any payment made to, or on behalf of, an employee or his beneficiary (A) from or to a trust exempt from tax under section 165(a) of the Internal Revenue Code of 1939 [153] at the time of such payment or, in the case of a payment after 1954, under sections 401 and 501(a) of the Internal Revenue Code of 1954 or the Internal Revenue Code of 1986 [154], unless such payment is made to an employee of the trust as remuneration for services rendered as such employee and not as a beneficiary of the trust, or (B) under or to an annuity plan which, at the time of such payment, meets the requirements of section 165(a)(3), (4), (5), and (6) of the Internal Revenue Code of 1939 or, in the case of a payment after 1954 and prior to 1963, the requirements of section 401(a)(3), (4), (5), and (6) of the Internal Revenue Code of 1954, or (C) under or to an annuity plan which, at the time of any such payment after 1962, is a plan described in section 403(a) of the Internal Revenue Code of 1986 [155], or (D) under or to a bond purchase plan which, at the time of any such payment after 1962, is a qualified bond purchase plan described in section 405(a) of the Internal Revenue Code of 1954 (as in effect before the enactment of the Tax Reform Act of 1984), or (E) under or to an annuity contract described in section 403(b) of the Internal Revenue Code of 1986 [156], other than a payment for the purchase of such contract which is made by reason of a salary reduction agreement (whether evidenced by a written instrument or otherwise), or (F) under or to an exempt governmental deferred compensation plan (as defined in section 3121(v)(3) of such Code [157]), or (G) to supplement pension benefits under a plan or trust described in any of the foregoing provisions of this subsection to take into account some portion or all of the increase in the cost of living (as determined by the Secretary of Labor) since retirement but only if such supplemental payments are under a plan which is treated as a welfare plan under section 3(2)(B)(ii) of the Employee Retirement Income Security Act of 1974 [158] , or (H) under a simplified employee pension (as defined in section 408(k)(1) of such

[152] See Vol. II, P.L. 97–123, §3(e), with respect to treatment of payments under a State temporary disability law.
[153] P.L. 76–1.
[154] See Vol. II, P.L. 83–591, §§401 and 501(a).
[155] See Vol. II, P.L. 83–591, §403(a).
[156] See Vol. II, P.L. 83–591, §403(b).
[157] See P.L. 83–591, §3121(v) (this volume).
[158] See Vol. II, P.L. 93–406.

Code), other than any contributions described in section 408(k)(6) of such Code, (I) under a cafeteria plan (within the meaning of section 125 of the Internal Revenue Code of 1986) if such payment would not be treated as wages without regard to such plan and it is reasonable to believe that (if section 125 applied for purposes of this section) section 125 would not treat any wages as constructively received; or (J) under an arrangement to which section 408(p) of such Code applies, other than any elective contributions under paragraph (2)(A)(i) thereof; or (K) under a plan described in section 457(e)(11)(A)(ii) of the Internal Revenue Code of 1986 and maintained by an eligible employer (as defined in section 457(e)(1) of such Code);

(5) The payment by an employer (without deduction from the remuneration of the employee)—

(A) of the tax imposed upon an employee under section 3101 of the Internal Revenue Code of 1986 [159], or

(B) of any payment required from an employee under a State unemployment compensation law,

with respect to remuneration paid to an employee for domestic service in a private home of the employer or for agricultural labor;

(6)(A) Remuneration paid in any medium other than cash to an employee for service not in the course of the employer's trade or business or for domestic service in a private home of the employer;

(B) Cash remuneration paid by an employer in any calendar year to an employee for domestic service in a private home of the employer (including domestic service on a farm operated for profit [160]), if the cash remuneration paid in such year by the employer to the employee for such service is less than the applicable dollar threshold (as defined in section 3121(x) of the Internal Revenue Code of 1986) for such year;

(C) Cash remuneration paid by an employer in any calendar year to an employee for service not in the course of the employer's trade or business, if the cash remuneration paid in such year by the employer to the employee for such service is less than $100. As used in this paragraph, the term "service not in the course of the employer's trade or business" does not include domestic service in a private home of the employer and does not include service described in section 210(f)(5);

(7)(A) Remuneration paid in any medium other than cash for agricultural labor;

(B) Cash remuneration paid by an employer in any calendar year to an employee for agricultural labor unless—

(i) the cash remuneration paid in such year by the employer to the employee for such labor is $150 or more, or

(ii) the employer's expenditures for agricultural labor in such year equal or exceed $2,500,

except that clause (ii) shall not apply in determining whether remuneration paid to an employee constitutes "wages" under

[159] See P.L. 83–591, §3101 (this volume).

[160] P.L. 108-203, §423(b), struck out "described in section 210(f)(5)" and substituted "on a farm operated for profit", effective March 2, 2004.

this section if such employee (I) is employed as a hand harvest laborer and is paid on a piece rate basis in an operation which has been, and is customarily and generally recognized as having been, paid on a piece rate basis in the region of employment, (II) commutes daily from his permanent residence to the farm on which he is so employed, and (III) has been employed in agriculture less than 13 weeks during the preceding calendar year;

(8) Remuneration paid by an employer in any year to an employee for service described in section 210(j)(3)(C) (relating to home workers), if the cash remuneration paid in such year by the employer to the employee for such service is less than $100;

(9) Remuneration paid to or on behalf of an employee if (and to the extent that) at the time of the payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 217 of the Internal Revenue Code of 1986 (determined without regard to section 274(n) of such Code [161]);

(10)(A) Tips paid in any medium other than cash;

(B) Cash tips received by an employee in any calendar month in the course of his employment by an employer unless the amount of such cash tips is $20 or more;

(11) Any payment or series of payments by an employer to an employee or any of his dependents which is paid—

(A) upon or after the termination of an employee's employment relationship because of (A) death, or (B) retirement for disability, and

(B) under a plan established by the employer which makes provision for his employees generally or a class or classes of his employees (or for such employees or class or classes of employees and their dependents),

other than any such payment or series of payments which would have been paid if the employee's employment relationship had not been so terminated;

(12) Any payment made by an employer to a survivor or the estate of a former employee after the calendar year in which such employee died;

(13) Any payment made by an employer to an employee, if at the time such payment is made such employee is entitled to disability insurance benefits under section 223(a) and such entitlement commenced prior to the calendar year in which such payment is made, and if such employee did not perform any services for such employer during the period for which such payment is made;

(14)(A) Remuneration paid by an organization exempt from income tax under section 501 of the Internal Revenue Code of 1986 [162] in any calendar year to an employee for service rendered in the employ of such organization, if the remuneration paid in such year by the organization to the employee for such service is less than $100;

(B) Any contribution, payment, or service, provided by an employer which may be excluded from the gross income

[161] See Vol. II, P.L. 83–591, §§217 and 274(n).
[162] See Vol. II, P.L. 83–591, §501.

of an employee, his spouse, or his dependents, under the provisions of section 120 of the Internal Revenue Code of 1986[163] (relating to amounts received under qualified group legal services plans);

(15) Any payment made, or benefit furnished, to or for the benefit of an employee if at the time of such payment or such furnishing it is reasonable to believe that the employee will be able to exclude such payment or benefit from income under section 127 or 129 of the Internal Revenue Code of 1986[164];

(16) The value of any meals or lodging furnished by or on behalf of the employer if at the time of such furnishing it is reasonable to believe that the employee will be able to exclude such items from income under section 119 of the Internal Revenue Code of 1986[165] ;

(17) Any benefit provided to or on behalf of an employee if at the time such benefit is provided it is reasonable to believe that the employee will be able to exclude such benefit from income under section 74(c), 108(f)(4),[166] 117, or 132 of the Internal Revenue Code of 1986[167];[168]

(18) Remuneration consisting of income excluded from taxation under section 7873 of the Internal Revenue Code of 1986 (relating to income derived by Indians from exercise of fishing rights); or[169]

(19)[170] Remuneration on account of—

(A) a transfer of a share of stock to any individual pursuant to an exercise of an incentive stock option (as defined in section 422(b) of the Internal Revenue Code of 1986) or under an employee stock purchase plan (as defined in section 423(b) of such Code), or

(B) any disposition by the individual of such stock.

(b) Nothing in the regulations prescribed for purposes of chapter 24 of the Internal Revenue Code of 1986[171] (relating to income tax withholding) which provides an exclusion from "wages" as used in such chapter shall be construed to require a similar exclusion from "wages" in the regulations prescribed for purposes of this title.

(c) For purposes of this title, in the case of domestic service described in subsection (a)(6)(B), any payment of cash remuneration for such service which is more or less than a whole-dollar amount shall, under such conditions and to such extent as may be prescribed by regulations made under this title, be computed to the nearest dollar. For the purpose of the computation to the nearest dollar, the payment of a fractional part of a dollar shall be disregarded unless it amounts to one-half dollar or more, in which case it shall be increased to $1. The amount of any payment of cash remuneration so computed to the nearest dollar shall, in lieu of the amount actually paid, be deemed to constitute the amount of cash remuneration for purposes of subsection (a)(6)(B).

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[163] See Vol. II, P.L. 83–591, §120.
[164] See Vol. II, P.L. 83–591, §§127 and 129.
[165] See Vol. II, P.L. 83–591, §119.
[166] P.L. 108–357, §320(b)(5), inserted 108(f)(4), applicable to amounts received by an individual in taxable years beginning after December 31, 2003.
[167] See Vol. II, P.L. 83–591, §§74(c), 117 and 132.
[168] P.L. 108–357, §251(a)(1)(B), struck out "or".
[169] P.L. 108–357, §251(a)(1)(B), struck out the period and substituted "; or".
[170] P.L. 108–357, §251(a)(1)(B), added paragraph (19), applicable to stock acquired pursuant to options exercised after October 22, 2004.
[171] See P.L. 83–591 (this volume).

(d) For purposes of this title, in the case of an individual performing service, as a member of a uniformed service, to which the provisions of section 210(l)(1) are applicable, the term "wages" shall, subject to the provisions of subsection (a)(1) of this section, include as such individual's remuneration for such service only (1) his basic pay as described in chapter 3 and section 1009 of title 37, United States Code [172], in the case of an individual performing service to which subparagraph (A) of such section 210(l)(1) applies, or (2) his compensation for such service as determined under section 206(a) of title 37, United States Code, in the case of an individual performing service to which subparagraph (B) of such section 210(l)(1) applies.

(e) For purposes of this title, in the case of an individual performing service, as a volunteer or volunteer leader within the meaning of the Peace Corps Act [173], to which the provisions of section 210(o) are applicable, (1) the term "wages" shall, subject to the provisions of subsection (a) of this section, include as such individual's remuneration for such service only amounts certified as payable pursuant to section 5(c) or 6(1) of the Peace Corps Act, and (2) any such amount shall be deemed to have been paid to such individual at the time the service, with respect to which it is paid, is performed.

(f) For purposes of this title, tips received by an employee in the course of his employment shall be considered remuneration for employment. Such remuneration shall be deemed to be paid at the time a written statement including such tips is furnished to the employer pursuant to section 6053(a) of the Internal Revenue Code of 1986 [174] or (if no statement including such tips is so furnished) at the time received.

(g) For purposes of this title, in any case where an individual is a member of a religious order (as defined in section 3121(r)(2) of the Internal Revenue Code of 1986 [175]) performing service in the exercise of duties required by such order, and an election of coverage under section 3121(r) of such Code is in effect with respect to such order or with respect to the autonomous subdivision thereof to which such member belongs, the term "wages" shall, subject to the provisions of subsection (a) of this section, include as such individual's remuneration for such service the fair market value of any board, lodging, clothing, and other perquisites furnished to such member by such order or subdivision thereof or by any other person or organization pursuant to an agreement with such order or subdivision, except that the amount included as such individual's remuneration under this paragraph shall not be less than $100 a month.

(h) For purposes of this title, in the case of an individual performing service under the provisions of section 294 of title 28, United States Code [176] (relating to assignment of retired justices and judges to active duty), the term "wages" shall not include any payment under section 371(b) of such title 28 which is received during the period of such service.

(i) Nothing in any of the foregoing provisions of this section (other than subsection (a)) shall exclude from the term "wages"—

[172] See Vol. II, Title 37.
[173] See Vol. II, P.L. 87–293.
[174] See Vol. II, P.L. 83–591, §6053(a).
[175] See P.L. 83–591 (this volume).
[176] See Vol. II, Title 28.

(1) Any employer contribution under a qualified cash or deferred arrangement (as defined in section 401(k) of the Internal Revenue Code of 1954[177]) to the extent not included in gross income by reason of section 402(a)(8) of such Code, or

(2) Any amount which is treated as an employer contribution under section 414(h)(2) of such Code where the pickup referred to in such section is pursuant to a salary reduction agreement (whether evidenced by a written instrument or otherwise).

(j) Any amount deferred under a nonqualified deferred compensation plan (within the meaning of section 3121(v)(2)(C) of the Internal Revenue Code of 1986[178]) shall be taken into account for purposes of this title as of the later of when the services are performed, or when there is no substantial risk of forfeiture of the rights to such amount. Any amount taken into account as wages by reason of the preceding sentence (and the income attributable thereto) shall not thereafter be treated as wages for purposes of this title.

(k)(1) For purposes of sections 203(f)(8)(B)(ii), 213(d)(2)(B), 215(a)(1)(B)(ii), 215(a)(1)(C)(ii), 215(a)(1)(D), 215(b)(3)(A)(ii), 215(i)(1)(E), 215(i)(2)(C)(ii), 224(f)(2)(B), and 230(b)(2) as in effect immediately prior to the enactment of the Social Security Amendments of 1977), the term "national average wage index" for any particular calendar year means, subject to regulations of the Commissioner of Social Security under paragraph (2), the average of the total wages for such particular calendar year.

(2) The Commissioner of Social Security shall prescribe regulations under which the national average wage index for any calendar year shall be computed—

(A) on the basis of amounts reported to the Secretary of the Treasury or his delegate for such year,

(B) by disregarding the limitation on wages specified in subsection (1)(1),

(C) with respect to calendar years after 1990, by incorporating deferred compensation amounts and factoring in for such years the rate of change from year to year in such amounts, in a manner consistent with the requirements of section 10208 of the Omnibus Budget Reconciliation Act of 1989, and

(D) with respect to calendar years before 1978, in a manner consistent with the manner in which the average of the total wages for each such calendar years was determined as provided by applicable law as in effect for such years.

(3) For purposes of this subsection, the term "deferred compensation amount" means—

(A) any amount excluded from gross income under chapter 1 of the Internal Revenue Code of 1986 by reason of section 402(a)(8)[179] , 402(h)(1)(B), or 457(a) of such Code or by reason of a salary reduction agreement under section 403(b) of such Code,

(B) any amount with respect to which a deduction is allowable under chapter 1 of such Code by reason of a contribution to a plan described in section 501(c)(18) of such Code,[180] and

[177] See Vol. II, P.L. 83-591, §401(k)

[178] See P.L. 83–591, §3121(v) (this volume).

[179] As in original. Reference should be to §402(e)(3). (P.L. 102–318, §521(a) amended §402(a) through (c).)

[180] See Vol. II, P.L. 83–591.

(C) to the extent provided in regulations of the Commissioner of Social Security, deferred compensation provided under any arrangement, agreement, or plan referred to in subsection (i) or (j).

DEFINITION OF EMPLOYMENT

SEC. 210. [42 U.S.C. 410] For the purposes of this title—

Employment

(a) The term "employment" means any service performed after 1936 and prior to 1951 which was employment for the purposes of this title under the law applicable to the period in which such service was performed, and any service, of whatever nature, performed after 1950 (A) by an employee for the person employing him, irrespective of the citizenship or residence of either, (i) within the United States, or (ii) on or in connection with an American vessel or American aircraft under a contract of service which is entered into within the United States or during the performance of which and while the employee is employed on the vessel or aircraft it touches at a port in the United States, if the employee is employed on and in connection with such vessel or aircraft when outside the United States, or (B) outside the United States by a citizen or resident of the United States as an employee (i) of an American employer (as defined in subsection (e) of this section), or (ii) of a foreign affiliate (as defined in section 3121(l)(6) of the Internal Revenue Code of 1986[181]) of an American employer during any period for which there is in effect an agreement, entered into pursuant to section 3121(l) of such Code, with respect to such affiliate, or (C) if it is service, regardless of where or by whom performed, which is designated as employment or recognized as equivalent to employment under an agreement entered into under section 233; except that, in the case of service performed after 1950, such term shall not include—

(1) Service performed by foreign agricultural workers lawfully admitted to the United States from the Bahamas, Jamaica, and the other British West Indies, or from any other foreign country or possession thereof, on a temporary basis to perform agricultural labor;

(2) Domestic service performed in a local college club, or local chapter of a college fraternity or sorority, by a student who is enrolled and is regularly attending classes at a school, college, or university;

(3)(A) Service performed by a child under the age of 18 in the employ of his father or mother;

(B) Service not in the course of the employer's trade or business, or domestic service in a private home of the employer, performed by an individual under the age of 21 in the employ of his father or mother, or performed by an individual in the employ of his spouse or son or daughter; except that the provisions of this subparagraph shall not be applicable to such domestic service performed by an individual in the employ of his son or daughter if—

[181] See P.L. 83–591, §3121 (this volume).

(i) the employer is a surviving spouse or a divorced individual and has not remarried, or has a spouse living in the home who has a mental or physical condition which results in such spouse's being incapable of caring for a son, daughter, stepson, or stepdaughter (referred to in clause (ii)) for at least 4 continuous weeks in the calendar quarter in which the service is rendered, and

(ii) a son, daughter, stepson, or stepdaughter of such employer is living in the home, and

(iii) the son, daughter, stepson, or stepdaughter (referred to in clause (ii)) has not attained age 18 or has a mental or physical condition which requires the personal care and supervision of an adult for at least 4 continuous weeks in the calendar quarter in which the service is rendered;

(4) Service performed by an individual on or in connection with a vessel not an American vessel, or on or in connection with an aircraft not an American aircraft, if (A) the individual is employed on and in connection with such vessel or aircraft when outside the United States and (B)(i) such individual is not a citizen of the United States or (ii) the employer is not an American employer;

(5) Service performed in the employ of the United States or any instrumentality of the United States, if such service—

(A) would be excluded from the term "employment" for purposes of this title if the provisions of paragraphs (5) and (6) of this subsection as in effect in January 1983 had remained in effect, and

(B) is performed by an individual who—

(i) has been continuously performing service described in subparagraph (A) since December 31, 1983, and for purposes of this clause—

(I) if an individual performing service described in subparagraph (A) returns to the performance of such service after being separated therefrom for a period of less than 366 consecutive days, regardless of whether the period began before, on, or after December 31, 1983, then such service shall be considered continuous,

(II) if an individual performing service described in subparagraph (A) returns to the performance of such service after being detailed or transferred to an international organization as described under section 3343 of subchapter III of chapter 33 of title 5, United States Code, or under section 3581 of chapter 35 of such title, then the service performed for that organization shall be considered service described in subparagraph (A),

(III) if an individual performing service described in subparagraph (A) is reemployed or reinstated after being separated from such service for the purpose of accepting employment with the American Institute of Taiwan as provided under section 3310 of chapter 48 of title 22, United

States Code [182], then the service performed for that Institute shall be considered service described in subparagraph (A),

(IV) if an individual performing service described in subparagraph (A) returns to the performance of such service after performing service as a member of a uniformed service (including, for purposes of this clause, service in the National Guard and temporary service in the Coast Guard Reserve) and after exercising restoration or reemployment rights as provided under chapter 43 of title 38, United States Code [183], then the service so performed as a member of a uniformed service shall be considered service described in subparagraph (A), and

(V) if an individual performing service described in subparagraph (A) returns to the performance of such service after employment (by a tribal organization) to which section 104(e)(2) of the Indian Self-Determination Act [184] applies, then the service performed for that tribal organization shall be considered service described in subparagraph (A); or

(ii) is receiving an annuity from the Civil Service Retirement and Disability Fund, or benefits (for service as an employee) under another retirement system established by a law of the United States for employees of the Federal Government (other than for members of the uniformed services);

except that this paragraph shall not apply with respect to any such service performed on or after any date on which such individual performs—

(C) service performed as the President or Vice President of the United States,

(D) service performed—

(i) in a position placed in the Executive Schedule under sections 5312 through 5317 of title 5, United States Code,

(ii) as a noncareer appointee in the Senior Executive Service or a noncareer member of the Senior Foreign Service, or

(iii) in a position to which the individual is appointed by the President (or his designee) or the Vice President under section 105(a)(1), 106(a)(1), or 107(a)(1) or (b)(1) of title 3, United States Code [185], if the maximum rate of basic pay for such position is at or above the rate for level V of the Executive Schedule,

(E) service performed as the Chief Justice of the United States, an Associate Justice of the Supreme Court, a judge of a United States court of appeals, a judge of a United States district court (including the district court of a terri-

[182] See Vol. II, Title 22.
[183] See Vol. II, Title 38.
[184] See Vol. II, P.L. 93–638, §104(e)(2).
[185] See Vol. II, Title 3.

tory), a judge of the United States Claims Court[186], a judge of the United States Court of International Trade, a judge of the United States Tax Court, a United States magistrate, or a referee in bankruptcy or United States bankruptcy judge,

(F) service performed as a Member, Delegate, or Resident Commissioner of or to the Congress,

(G)[187] any other service in the legislative branch of the Federal Government if such service—

(i) is performed by an individual who was not subject to subchapter III of chapter 83 of title 5, United States Code, or to another retirement system established by a law of the United States for employees of the Federal Government (other than for members of the uniformed services), on December 31, 1983, or

(ii) is performed by an individual who has, at any time after December 31, 1983, received a lump-sum payment under section 8342(a) of title 5, United States Code, or under the corresponding provision of the law establishing the other retirement system described in clause (i), or

(iii) is performed by an individual after such individual has otherwise ceased to be subject to subchapter III of chapter 83 of title 5, United States Code (without having an application pending for coverage under such subchapter), while performing service in the legislative branch (determined without regard to the provisions of subparagraph (B) relating to continuity of employment), for any period of time after December 31, 1983,

and for purposes of this subparagraph (G) an individual is subject to such subchapter III or to any such other retirement system at any time only if (a) such individual's pay is subject to deductions, contributions, or similar payments (concurrent with the service being performed at that time) under section 8334(a) of such title 5 or the corresponding provision of the law establishing such other system, or (in a case to which section 8332(k)(1) of such title applies) such individual is making payments of amounts equivalent to such deductions, contributions, or similar payments while on leave without pay, or (b) such individual is receiving an annuity from the Civil Service Retirement and Disability Fund, or is receiving benefits (for service as an employee) under another retirement system established by a law of the United States for employees of the Federal Government (other than for members of the uniformed services), or

(H) service performed by an individual—

(i) on or after the effective date of an election by such individual, under section 301 of the Federal Em-

[186] P.L. 102-572, §902(b)(1), provided that "the United States Claims Court" shall be deemed to refer to "the United States Court of Federal Claims", effective October 29, 1992.

[187] See Vol. II, P.L 98–369, §2601(c), with respect to the applicability of subchapter III, chapter 83, of Title 5, United States Code, to service performed after December 31, 1983; and §2601(e)(1), with respect to employees of certain nonprofit organizations who are considered to be performing services in the employ of an instrumentality of the United States.

ployees' Retirement System Act of 1986[188] , section 307 of the Central Intelligence Agency Retirement Act (50 U.S.C. 2157)[189], or the Federal Employees' Retirement System Open Enrollment Act of 1997 to become subject to the Federal Employees' Retirement System provided in chapter 84 of title 5, United States Code, or

(ii) on or after the effective date of an election by such individual, under regulations issued under section 860 of the Foreign Service Act of 1980[190], to become subject to the Foreign Service Pension System provided in subchapter II of chapter 8 of title I of such Act;

(6) Service performed in the employ of the United States or any instrumentality of the United States if such service is performed—

(A) in a penal institution of the United States by an inmate thereof;

(B) by any individual as an employee included under section 5351(2) of title 5, United States Code (relating to certain interns, student nurses, and other student employees of hospitals of the Federal Government), other than as a medical or dental intern or a medical or dental resident in training; or

(C) by any individual as an employee serving on a temporary basis in case of fire, storm, earthquake, flood, or other similar emergency;

(7) Service performed in the employ of a State, or any political subdivision thereof, or any instrumentality of any one or more of the foregoing which is wholly owned thereby, except that this paragraph shall not apply in the case of—

(A) service included under an agreement under section 218,

(B) service which, under subsection (k), constitutes covered transportation service,

(C) service in the employ of the Government of Guam or the Government of American Samoa or any political subdivision thereof, or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, performed by an officer or employee thereof (including a member of the legislature of any such Government or political subdivision), and, for purposes of this title—

(i) any person whose service as such an officer or employee is not covered by a retirement system established by a law of the United States shall not, with respect to such service, be regarded as an officer or employee of the United States or any agency or instrumentality thereof, and

(ii) the remuneration for service described in clause (i) (including fees paid to a public official) shall be deemed to have been paid by the Government of Guam or the Government of American Samoa or by a political subdivision thereof or an instrumentality of any

[188] See Vol. II, P.L. 99–335.
[189] See Vol. II, Title 50.
[190] See Vol. II, P.L. 96–465.

one or more of the foregoing which is wholly owned thereby, whichever is appropriate,

(D) service performed in the employ of the District of Columbia or any instrumentality which is wholly owned thereby, if such service is not covered by a retirement system established by a law of the United States (other than the Federal Employees Retirement System provided in chapter 84 of title 5, United States Code); except that the provisions of this subparagraph shall not be applicable to service performed—

(i) in a hospital or penal institution by a patient or inmate thereof;

(ii) by any individual as an employee included under section 5351(2) of title 5, United States Code (relating to certain interns, student nurses, and other student employees of hospitals of the District of Columbia Government), other than as a medical or dental intern or as a medical or dental resident in training;

(iii) by any individual as an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or other similar emergency; or

(iv) by a member of a board, committee, or council of the District of Columbia, paid on a per diem, meeting, or other fee basis,

(E) service performed in the employ of the Government of Guam (or any instrumentality which is wholly owned by such Government) by an employee properly classified as a temporary or intermittent employee, if such service is not covered by a retirement system established by a law of Guam; except that (i) the provisions of this subparagraph shall not be applicable to services performed by an elected official or a member of the legislature or in a hospital or penal institution by a patient or inmate thereof, and (ii) for purposes of this subparagraph, clauses (i) and (ii) of subparagraph (C) shall apply, or

(F) service in the employ of a State (other than the District of Columbia, Guam, or American Samoa), of any political subdivision thereof, or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, by an individual who is not a member of a retirement system of such State, political subdivision, or instrumentality, except that the provisions of this subparagraph shall not be applicable to service performed—

(i) by an individual who is employed to relieve such individual from unemployment;

(ii) in a hospital, home, or other institution by a patient or inmate thereof;

(iii) by any individual as an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or other similar emergency;

(iv) by an election official or election worker if the remuneration paid in a calendar year for such service is less than $1,000 with respect to service performed during any calendar year commencing on or after January 1, 1995, ending on or before December 31, 1999, and the adjusted amount determined under section

218(c)(8)(B) for any calendar year commencing on or after January 1, 2000, with respect to service performed during such calendar year; or

(v) by an employee in a position compensated solely on a fee basis which is treated pursuant to section 211(c)(2)(E) as a trade or business for purposes of inclusion of such fees in net earnings from self employment;

for purposes of this subparagraph, except as provided in regulations prescribed by the Secretary of the Treasury, the term "retirement system" has the meaning given such term by section 218(b)(4).

(8)(A) Service performed by a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry or by a member of a religious order in the exercise of duties required by such order, except that this subparagraph shall not apply to service performed by a member of such an order in the exercise of such duties, if an election of coverage under section 3121(r) of the Internal Revenue Code of 1986[191] is in effect with respect to such order, or with respect to the autonomous subdivision thereof to which such member belongs;

(B) Service performed in the employ of a church or qualified church-controlled organization if such church or organization has in effect an election under section 3121(w) of the Internal Revenue Code of 1986[192], other than service in an unrelated trade or business (within the meaning of section 513(a) of such Code);

(9) Service performed by an individual as an employee or employee representative as defined in section 3231 of the Internal Revenue Code of 1986[193];

(10) Service performed in the employ of—

(A) a school, college, or university, or

(B) an organization described in section 509(a)(3) of the Internal Revenue Code of 1986[194] if the organization is organized, and at all times thereafter is operated, exclusively for the benefit of, to perform the functions of, or to carry out the purposes of a school, college, or university and is operated, supervised, or controlled by or in connection with such school, college, or university, unless it is a school, college, or university of a State or a political subdivision thereof and the services in its employ performed by a student referred to in section 218(c)(5) are covered under the agreement between the Commissioner of Social Security and such State entered into pursuant to section 218;

if such service is performed by a student who is enrolled and regularly attending classes at such school, college, or university;

(11) Service performed in the employ of a foreign government (including service as a consular or other officer or employee or a Nonduplication representative);

(12) Service performed in the employ of an instrumentality wholly owned by a foreign government—

[191] See P.L. 83–591, §3121(r) (this volume).
[192] See P.L. 83–591, §3121(w) (this volume).
[193] See P.L. 83–591, §3231 (this volume).
[194] See Vol. II, P.L. 83–591, §509(a)(3).

(A) If the service is of a character similar to that performed in foreign countries by employees of the United States Government or of an instrumentality thereof; and

(B) If the Secretary of State shall certify to the Secretary of the Treasury that the foreign government, with respect to whose instrumentality and employees thereof exemption is claimed, grants an equivalent exemption with respect to similar service performed in the foreign country by employees of the United States Government and of instrumentalities thereof;

(13) Service performed as a student nurse in the employ of a hospital or a nurses' training school by an individual who is enrolled and is regularly attending classes in a nurses' training school chartered or approved pursuant to State law;

(14)(A) Service performed by an individual under the age of eighteen in the delivery or distribution of newspapers or shopping news, not including delivery or distribution to any point for subsequent delivery or distribution;

(B) Service performed by an individual in, and at the time of, the sale of newspapers or magazines to ultimate consumers, under an arrangement under which the newspapers or magazines are to be sold by him at a fixed price, his compensation being based on the retention of the excess of such price over the amount at which the newspapers or magazines are charged to him, whether or not he is guaranteed a minimum amount of compensation for such service, or is entitled to be credited with the unsold newspapers or magazines turned back;

(15) Service performed in the employ of an international organization entitled to enjoy privileges, exemptions, and immunities as an international organization under the International Organizations Immunities Act [195] (59 Stat. 669), except service which constitutes "employment" under subsection (r);

(16) Service performed by an individual under an arrangement with the owner or tenant of land pursuant to which—

(A) such individual undertakes to produce agricultural or horticultural commodities (including livestock, bees, poultry, and fur-bearing animals and wildlife) on such land,

(B) the agricultural or horticultural commodities produced by such individual, or the proceeds therefrom, are to be divided between such individual and such owner or tenant, and

(C) the amount of such individual's share depends on the amount of the agricultural or horticultural commodities produced;

(17) Service in the employ of any organization which is performed (A) in any year during any part of which such organization is registered, or there is in effect a final order of the Subversive Activities Control Board requiring such organization to register, under the Internal Security Act of 1950 [196], as amended, as a Communist-action organization, a Communist-front or-

[195] See Vol. II, P.L. 79–291.
[196] See P.L. 81–831.

ganization, or a Communist-infiltrated organization, and (B) after June 30, 1956;

(18) Service performed in Guam by a resident of the Republic of the Philippines while in Guam on a temporary basis as a nonimmigrant alien admitted to Guam pursuant to section 101(a)(15)(H)(ii) of the Immigration and Nationality Act[197] (8 U.S.C. 1101(a)(15)(H)(ii));

(19) Service which is performed by a nonresident alien individual for the period he is temporarily present in the United States as a nonimmigrant under subparagraph (F), (J), (M), or (Q) of section 101(a)(15) of the Immigration and Nationality Act, as amended, and which is performed to carry out the purpose specified in subparagraph (F), (J), (M), or (Q) as the case may be;

(20) Service (other than service described in paragraph (3)(A)) performed by an individual on a boat engaged in catching fish or other forms of aquatic animal life under an arrangement with the owner or operator of such boat pursuant to which—

(A) such individual does not receive any additional compensation other than as provided in subparagraph (B) and other than case remuneration—

(i) which does not exceed $100 per trip;

(ii) which is contingent on a minimum catch; and

(iii) which is paid solely for additional duties (such as mate, engineer, or cook) for which additional cash remuneration is traditional in the industry,

(B) such individual receives a share of the boat's (or the boats' in the case of a fishing operation involving more than one boat) catch of fish or other forms of aquatic animal life or a share of the proceeds from the sale of such catch, and

(C) the amount of such individual's share depends on the amount of the boat's (or boats' in the case of a fishing operation involving more than one boat) catch of fish or other forms of aquatic animal life,

but only if the operating crew of such boat (or each boat from which the individual receives a share in the case of a fishing operation involving more than one boat) is normally made up of fewer than 10 individuals; or

(21) Domestic service in a private home of the employer which—

(A) is performed in any year by an individual under the age of 18 during any portion of such year; and

(B) is not the principal occupation of such employee.

For purposes of paragraph (20), the operating crew of a boat shall be treated as normally made up of fewer than 10 individuals if the average size of the operating crew on trips made during the preceding 4 calendar quarters consisted of fewer than 10 individuals.

Included and Excluded Service

(b) If the services performed during one-half or more of any pay period by an employee for the person employing him constitute em-

[197] See Vol. II, P.L. 82–414.

ployment, all the services of such employee for such period shall be deemed to be employment; but if the services performed during more than one-half of any such pay period by an employee for the person employing him do not constitute employment, then none of the services of such employee for such period shall be deemed to be employment. As used in this subsection, the term "pay period" means a period (of not more than thirty-one consecutive days) for which a payment of remuneration is ordinarily made to the employee by the person employing him. This subsection shall not be applicable with respect to services performed in a pay period by an employee for the person employing him, where any of such service is excepted by paragraph (9) of subsection (a).

American Vessel

(c) The term "American vessel" means any vessel documented or numbered under the laws of the United States; and includes any vessel which is neither documented or numbered under the laws of the United States nor documented under the laws of any foreign country, if its crew is employed solely by one or more citizens or residents of the United States or corporations organized under the laws of the United States or of any State.

American Aircraft

(d) The term "American aircraft" means an aircraft registered under the laws of the United States.

American Employer

(e) The term "American employer" means an employer which is (1) the United States or any instrumentality thereof, (2) a State or any political subdivision thereof, or any instrumentality of any one or more of the foregoing, (3) an individual who is a resident of the United States, (4) a partnership, if two-thirds or more of the partners are residents of the United States, (5) a trust, if all of the trustees are residents of the United States, or (6) a corporation organized under the laws of the United States or of any State.

Agricultural Labor

(f) The term "agricultural labor" includes all service performed—

(1) On a farm, in the employ of any person, in connection with cultivating the soil, or in connection with raising or harvesting any agricultural or horticultural commodity, including the raising, shearing, feeding, caring for, training, and management of livestock, bees, poultry, and fur-bearing animals and wildlife.

(2) In the employ of the owner or tenant or other operator of a farm, in connection with the operation, management, conservation, improvement, or maintenance of such farm and its tools and equipment, or in salvaging timber or clearing land of brush and other debris left by a hurricane, if the major part of such service is performed on a farm.

(3) In connection with the production or harvesting of any commodity defined as an agricultural commodity in section

15(g) of the Agricultural Marketing Act[198], as amended, or in connection with the ginning of cotton, or in connection with the operation or maintenance of ditches, canals, reservoirs, or waterways, not owned or operated for profit, used exclusively for supplying and storing water for farming purposes.

(4)(A) In the employ of the operator of a farm in handling, planting, drying, packing, packaging, processing, freezing, grading, storing, or delivering to storage or to market or to a carrier for transportation to market, in its unmanufactured state, any agricultural or horticultural commodity; but only if such operator produced more than one-half of the commodity with respect to which such service is performed.

(B) In the employ of a group of operators of farms (other than a cooperative organization) in the performance of service described in subparagraph (A), but only if such operators produced all of the commodity with respect to which such service is performed. For the purposes of this subparagraph, any unincorporated group of operators shall be deemed a cooperative organization if the number of operators comprising such group is more than twenty at any time during the calendar year in which such service is performed.

(5) On a farm operated for profit if such service is not in the course of the employer's trade or business[199].

The provisions of subparagraphs (A) and (B) of paragraph (4) shall not be deemed to be applicable with respect to service performed in connection with commercial canning or commercial freezing or in connection with any agricultural or horticultural commodity after its delivery to a terminal market for distribution for consumption.

Farm

(g) The term "farm" includes stock, dairy, poultry, fruit, fur-bearing animal, and truck farms, plantations, ranches, nurseries, ranges, greenhouses or other similar structures used primarily for the raising of agricultural or horticultural commodities, and orchards.

State

(h) The term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

United States

(i) The term "United States" when used in a geographical sense means the States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

Employee

(j) The term "employee" means—

(1) any officer of a corporation; or

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[198] See Vol. II, P.L. 71–10.

[199] P.L. 108-203, §423(c), struck out "or is domestic service in a private home of the employer", effective March 2, 2004.

(2) any individual who, under the usual common law rules applicable in determining the employer-employee relationship, has the status of an employee; or

(3) any individual (other than an individual who is an employee under paragraph (1) or (2) of this subsection) who performs services for remuneration for any person—

(A) as an agent-driver or commission-driver engaged in distributing meat products, vegetable products, fruit products, bakery products, beverages (other than milk), or laundry or dry-cleaning services, for his principal;

(B) as a full-time life insurance salesman;

(C) as a home worker performing work, according to specifications furnished by the person for whom the services are performed, on materials or goods furnished by such person which are required to be returned to such person or a person designated by him; or

(D) as a traveling or city salesman, other than as an agent-driver or commission-driver, engaged upon a full-time basis in the solicitation on behalf of, and the transmission to, his principal (except for side-line sales activities on behalf of some other person) of orders from wholesalers, retailers, contractors, or operators of hotels, restaurants, or other similar establishments for merchandise for resale or supplies for use in their business operations;

if the contract of service contemplates that substantially all of such services are to be performed personally by such individual; except that an individual shall not be included in the term "employee" under the provisions of this paragraph if such individual has a substantial investment in facilities used in connection with the performance of such services (other than in facilities for transportation), or if the services are in the nature of a single transaction not part of a continuing relationship with the person for whom the services are performed.

Covered Transportation Service

(k)(1) Except as provided in paragraph (2), all service performed in the employ of a State or political subdivision in connection with its operation of a public transportation system shall constitute covered transportation service if any part of the transportation system was acquired from private ownership after 1936 and prior to 1951.

(2) Service performed in the employ of a State or political subdivision in connection with the operation of its public transportation system shall not constitute covered transportation service if—

(A) any part of the transportation system was acquired from private ownership after 1936 and prior to 1951, and substantially all service in connection with the operation of the transportation system is, on December 31, 1950, covered under a general retirement system providing benefits which, by reason of a provision of the State constitution dealing specifically with retirement systems of the State or political subdivisions thereof, cannot be diminished or impaired; or

(B) no part of the transportation system operated by the State or political subdivision on December 31, 1950, was

acquired from private ownership after 1936 and prior to 1951;

except that if such State or political subdivision makes an acquisition after 1950 from private ownership of any part of its transportation system, then, in the case of any employee who—

(C) became an employee of such State or political subdivision in connection with and at the time of its acquisition after 1950 of such part, and

(D) prior to such acquisition rendered service in employment in connection with the operation of such part of the transportation system acquired by the State or political subdivision,

the service of such employee in connection with the operation of the transportation system shall constitute covered transportation service, commencing with the first day of the third calendar quarter following the calendar quarter in which the acquisition of such part took place, unless on such first day such service of such employee is covered by a general retirement system which does not, with respect to such employee, contain special provisions applicable only to employees described in subparagraph (C).

(3) All service performed in the employ of a State or political subdivision thereof in connection with its operation of a public transportation system shall constitute covered transportation service if the transportation system was not operated by the State or political subdivision prior to 1951 and, at the time of its first acquisition (after 1950) from private ownership of any part of its transportation system, the State or political subdivision did not have a general retirement system covering substantially all service performed in connection with the operation of the transportation system.

(4) For the purposes of this subsection—

(A) The term "general retirement system" means any pension, annuity, retirement, or similar fund or system established by a State or by a political subdivision thereof for employees of the State, political subdivision, or both; but such term shall not include such a fund or system which covers only service performed in positions connected with the operation of its public transportation system.

(B) A transportation system or a part thereof shall be considered to have been acquired by a State or political subdivision from private ownership if prior to the acquisition service performed by employees in connection with the operation of the system or part thereof acquired constituted employment under this title, and some of such employees became employees of the State or political subdivision in connection with and at the time of such acquisition.

(C) The term "political subdivision" includes an instrumentality of (i) a State, (ii) one or more political subdivisions of a State, or (iii) a State and one or more of its political subdivisions.

Service in the Uniformed Services

(l)(1) Except as provided in paragraph (4), the term "employment" shall, notwithstanding the provisions of subsection (a) of this section, include—

(A) service performed after December 1956 by an individual as a member of a uniformed service on active duty, but such term shall not include any such service which is performed while on leave without pay, and

(B) service performed after December 1987 by an individual as a member of a uniformed service on inactive duty training.

(2) The term "active duty" means "active duty" as described in paragraph (21) of section 101 of title 38, United States Code [200], except that it shall also include "active duty for training" as described in paragraph (22) of such section.

(3) The term "inactive duty training" means "inactive duty training" as described in paragraph (23) of such section 101.

(4)(A) Paragraph (1) of this subsection shall not apply in the case of any service, performed by an individual as a member of a uniformed service, which is creditable under section 3(i) of the Railroad Retirement Act of 1974 [201]. The Railroad Retirement Board shall notify the Commissioner of Social Security, with respect to all such service which is so creditable.

(B) In any case where benefits under this title are already payable on the basis of such individual's wages and self-employment income at the time such notification (with respect to such individual) is received by the Commissioner of Social Security, the Commissioner of Social Security shall certify no further benefits for payment under this title on the basis of such individual's wages and self-employment income, or shall recompute the amount of any further benefits payable on the basis of such wages and self-employment income, as may be required as a consequence of subparagraph (A) of this paragraph. No payment of a benefit to any person on the basis of such individual's wages and self-employment income, certified by the Commissioner of Social Security prior to the end of the month in which the Commissioner receives such notification from the Railroad Retirement Board, shall be deemed by reason of this subparagraph to have been an erroneous payment or a payment to which such person was not entitled. The Commissioner of Social Security shall, as soon as possible after the receipt of such notification from the Railroad Retirement Board, advise such Board whether or not any such benefit will be reduced or terminated by reason of subparagraph (A), and if any such benefit will be so reduced or terminated, specify the first month with respect to which such reduction or termination will be effective.

Member of a Uniformed Service

(m) The term "member of a uniformed service" means any person appointed, enlisted, or inducted in a component of the Army, Navy, Air Force, Marine Corps, or Coast Guard (including a reserve component as defined in section 101(27) of title 38, United States Code [202]), or in one of those services without specification of compo-

[200] See Vol. II, title 38 and see P.L. 95–202, §401, with respect to the Women's Air Forces Service Pilots.

[201] See Vol. II, P.L. 75–162 [as amended by P.L. 93–445].

[202] See Vol. II, Title 38.

nent, or as a commissioned officer of the Coast and Geodetic Survey, the National Oceanic and Atmospheric Administration Corps, or the Regular or Reserve Corps of the Public Health Service, and any person serving in the Army or Air Force under call or conscription. The term includes—

(1) a retired member of any of those services;

(2) a member of the Fleet Reserve or Fleet Marine Corps Reserve;

(3) a cadet at the United States Military Academy, a midshipman at the United States Naval Academy, and a cadet at the United States Coast Guard Academy or United States Air Force Academy;

(4) a member of the Reserve Officers' Training Corps, the Naval Reserve Officers' Training Corps, or the Air Force Reserve Officers' Training Corps, when ordered to annual training duty for fourteen days or more, and while performing authorized travel to and from that duty; and

(5) any person while en route to or from, or at, a place for final acceptance or for entry upon active duty in the military, naval, or air service—

(A) who has been provisionally accepted for such duty; or

(B) who, under the Military Selective Service Act[203], has been selected for active military, naval, or air service;

and has been ordered or directed to proceed to such place.

The term does not include a temporary member of the Coast Guard Reserve.

Crew Leader

(n) The term "crew leader" means an individual who furnishes individuals to perform agricultural labor for another person, if such individual pays (either on his own behalf or on behalf of such person) the individuals so furnished by him for the agricultural labor performed by them and if such individual has not entered into a written agreement with such person whereby such individual has been designated as an employee of such person; and such individuals furnished by the crew leader to perform agricultural labor for another person shall be deemed to be the employees of such crew leader. A crew leader shall, with respect to services performed in furnishing individuals to perform agricultural labor for another person and service performed as a member of the crew, be deemed not to be an employee of such other person.

Peace Corps Volunteer Service

(o) The term "employment" shall, notwithstanding the provisions of subsection (a), include service performed by an individual as a volunteer or volunteer leader within the meaning of the Peace Corps Act[204].

Medicare Qualified Government Employment

(p)(1) For purposes of sections 226 and 226A, the term "medicare qualified government employment" means any service which would

[203] P.L. 80–759.
[204] See Vol. II, P.L. 87–293.

constitute "employment" as defined in subsection (a) of this section but for the application of the provisions of—

(A) subsection (a)(5), or

(B) subsection (a)(7), except as provided in paragraphs (2) and (3).

(2) Service shall not be treated as employment by reason of paragraph (1)(B) if the service is performed—

(A) by an individual who is employed by a State or political subdivision thereof to relieve him from unemployment,

(B) in a hospital, home, or other institution by a patient or inmate thereof as an employee of a State or political subdivision thereof or of the District of Columbia,

(C) by an individual, as an employee of a State or political subdivision thereof or of the District of Columbia, serving on a temporary basis in case of fire, storm, snow, earthquake, flood or other similar emergency,

(D) by any individual as an employee included under section 5351(2) of title 5, United States Code[205] (relating to certain interns, student nurses, and other student employees of hospitals of the District of Columbia Government), other than as a medical or dental intern or a medical or dental resident in training, or

(E) by an election official or election worker if the remuneration paid in a calendar year for such service is less than $1,000 with respect to service performed during any calendar year commencing on or after January 1, 1995, ending on or before December 31, 1999, and the adjusted amount determined under section 218(c)(8)(B) for any calendar year commencing on or after January 1, 2000, with respect to service performed during such calendar year.

As used in this paragraph, the terms "State" and "political subdivision" have the meanings given those terms in section 218(b).

(3) Service performed for an employer shall not be treated as employment by reason of paragraph (1)(B) if—

(A) such service would be excluded from the term "employment" for purposes of this section if paragraph (1)(B) did not apply;

(B) such service is performed by an individual—

(i) who was performing substantial and regular service for remuneration for that employer before April 1, 1986,

(ii) who is a bona fide employee of that employer on March 31, 1986, and

(iii) whose employment relationship with that employer was not entered into for purposes of meeting the requirements of this subparagraph; and

(C) the employment relationship with that employer has not been terminated after March 31, 1986.

(4) For purposes of paragraph (3), under regulations (consistent with regulations established under section 3121(u)(2)(D) of the Internal Revenue Code of 1954[206])—

[205] See Vol. II, Title 5.

[206] See P.L. 83–591, §3121 (this volume).

(A) all agencies and instrumentalities of a State (as defined in section 218(b)) or of the District of Columbia shall be treated as a single employer, and

(B) all agencies and instrumentalities of a political subdivision of a State (as so defined) shall be treated as a single employer and shall not be treated as described in subparagraph (A).

Treatment of Real Estate Agents and Direct Sellers

(q) Notwithstanding any other provision of this title, the rules of section 3508 of the Internal Revenue Code of 1986[207] shall apply for purposes of this title.

Service in the Employ of International Organizations by Certain Transferred Federal Employees

(r)(1) For purposes of this title, service performed in the employ of an international organization by an individual pursuant to a transfer of such individual to such international organization pursuant to section 3582 of title 5, United States Code, shall constitute "employment" if—

(A) immediately before such transfer, such individual performed service with a Federal agency which constituted "employment" as defined in subsection (a), and

(B) such individual would be entitled, upon separation from such international organization and proper application, to reemployment with such Federal agency under such section 3582.

(2) For purposes of this subsection:

(A) The term "Federal agency" means an agency, as defined in section 3581(1) of title 5, United States Code.

(B) The term "international organization" has the meaning provided such term by section 3581(3) of title 5, United States Code.[208]

SELF-EMPLOYMENT

SEC. 211. [42 U.S.C. 411] For the purposes of this title—

Net Earnings From Self-Employment

(a) The term "net earnings from self-employment" means the gross income, as computed under subtitle A of the Internal Revenue Code of 1986, derived by an individual from any trade or business carried on by such individual, less the deductions allowed under such subtitle which are attributable to such trade or business, plus his distributive share (whether or not distributed) of the ordinary net income or loss, as computed under section 702(a)(8) of such Code, from any trade or business carried on by a partnership of which he is a member; except that in computing such gross income and deductions and such distributive share of partnership ordinary net income or loss—

(1) There shall be excluded rentals from real estate and from personal property leased with the real estate (including such

[207] P.L. 83–591, §3508 (this volume).
[208] See Vol. II, Title 5, §§3581 and 3582.

rentals paid in crop shares), together with the deductions attributable thereto, unless such rentals are received in the course of a trade or business as a real estate dealer; except that the preceding provisions of this paragraph shall not apply to any income derived by the owner or tenant of land if (A) such income is derived under an arrangement, between the owner or tenant and another individual, which provides that such other individual shall produce agricultural or horticultural commodities (including livestock, bees, poultry, and fur-bearing animals and wildlife) on such land, and that there shall be material participation by the owner or tenant (as determined without regard to any activities of an agent of such owner or tenant) in the production or the management of the production of such agricultural or horticultural commodities, and (B) there is material participation by the owner or tenant (as determined without regard to any activities of an agent of such owner or tenant) with respect to any such agricultural or horticultural commodity;

(2) There shall be excluded dividends on any share of stock, and interest on any bond, debenture, note, or certificate, or other evidence of indebtedness, issued with interest coupons or in registered form by any corporation (including one issued by a government or political subdivision thereof), unless such dividends and interest are received in the course of a trade or business as a dealer in stocks or securities;

(3) There shall be excluded any gain or loss (A) which is considered under subtitle A of the Internal Revenue Code of 1986 as gain or loss from the sale or exchange of a capital asset, (B) from the cutting of timber, or the disposal of timber, coal, or iron ore, if section 631 of the Internal Revenue Code of 1954 applies to such gain or loss, or (C) from the sale, exchange, involuntary conversion, or other disposition of property if such property is neither (i) stock in trade or other property of a kind which would properly be includible in inventory if on hand at the close of the taxable year, nor (ii) property held primarily for sale to customers in the ordinary course of the trade or business;

(4) The deduction for net operating losses provided in section 172 of the Internal Revenue Code of 1986[209] shall not be allowed;

(5)(A) If any of the income derived from a trade or business (other than a trade or business carried on by a partnership) is community income under community property laws applicable to such income, the gross income and deductions attributable to such trade or business shall be treated as the gross income and deductions of the spouse carrying on such trade or business or, if such trade or business is jointly operated, treated as the gross income and deductions of each spouse on the basis of their respective distributive share of the gross income and deductions;[210]

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[209] See Vol. II, P.L. 83–591, §172.

[210] P.L. 108-203, §425(c), struck out "all of the gross income and deductions attributable to such trade or business shall be treated as the gross income and deductions of the husband unless the wife exercises substantially all of the management and control of such trade or business, in which case all of such gross income and deductions shall be treated as the gross income and deductions of the wife;" and substituted "the gross income and deductions attributable to such trade or business shall be treated as the gross income and deductions of the spouse carry-

(B) If any portion of a partner's distributive share of the ordinary net income or loss from a trade or business carried on by a partnership is community income or loss under the community property laws applicable to such share, all of such distributive share shall be included in computing the net earnings from self-employment of such partner, and no part of such share shall be taken into account in computing the net earnings from self-employment of the spouse of such partner;

(6) A resident of the Commonwealth of Puerto Rico shall compute his net earnings from self-employment in the same manner as a citizen of the United States but without regard to the provisions of section 933 of the Internal Revenue Code of 1986[211];

(7) An individual who is a duly ordained, commissioned, or licensed minister of a church or a member of a religious order shall compute his net earnings from self-employment derived from the performance of service described in subsection (c)(4) without regard to section 107 (relating to rental value of parsonages), section 119 (relating to meals and lodging furnished for the convenience of the employer), and section 911 (relating to earned income from sources without the United States) of the Internal Revenue Code of 1986, but shall not include in any such net earnings from self-employment the rental value of any parsonage or any parsonage allowance (whether or not excluded under section 107 of the Internal Revenue Code of 1986) provided after the individual retires, or any other retirement benefit received by such individual from a church plan (as defined in section 414(e) of such Code) after the individual retires[212];

(8) The exclusion from gross income provided by section 931 of the Internal Revenue Code of 1986 shall not apply;

(9) There shall be excluded amounts received by a partner pursuant to a written plan of the partnership, which meets such requirements as are prescribed by the Secretary of the Treasury or his delegate, and which provides for payments on account of retirement, on a periodic basis, to partners generally or to a class or classes of partners, such payments to continue at least until such partner's death, if—

(A) such partner rendered no services with respect to any trade or business carried on by such partnership (or its successors) during the taxable year of such partnership (or its successors), ending within or with his taxable year, in which such amounts were received, and

(B) no obligation exists (as of the close of the partnership's taxable year referred to in subparagraph (A)) from the other partners to such partner except with respect to retirement payments under such plan, and

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ing on such trade or business or, if such trade or business is jointly operated, treated as the gross income and deductions of each spouse on the basis of their respective distributive share of the gross income and deductions;", effective March 2, 2004.

[211] See Vol. II, P.L. 83–591, §933.

[212] P.L. 108-203, §422(a), inserted ", but shall not include in any such net earnings from self-employment the rental value of any parsonage or any parsonage allowance (whether or not excluded under section 107 of the Internal Revenue Code of 1986) provided after the individual retires, or any other retirement benefit received by such individual from a church plan (as defined in section 414(e) of such Code) after the individual retires", applicable to the years beginning before, on, or after December 31, 1994.

(C) such partner's share, if any, of the capital of the partnership has been paid to him in full before the close of the partnership's taxable year referred to in subparagraph (A);

(10) The exclusion from gross income provided by section 911(a)(1) of the Internal Revenue Code of 1954[213] shall not apply;

(11) In lieu of the deduction provided by section 164(f) of the Internal Revenue Code of 1986[214] (relating to deduction for one-half of self-employment taxes), there shall be allowed a deduction equal to the product of—

(A) the taxpayer's net earnings from self-employment for the taxable year (determined without regard to this paragraph), and

(B) one-half of the sum of the rates imposed by subsections (a) and (b) of section 1401 of such Code[215] for such year;

(12) There shall be excluded the distributive share of any item of income or loss of a limited partner, as such, other than guaranteed payments described in section 707(c) of the Internal Revenue Code of 1986[216] to that partner for services actually rendered to or on behalf of the partnership to the extent that those payments are established to be in the nature of remuneration for those services;

(13) In the case of church employee income, the special rules of subsection (i)(1) shall apply;

(14) There shall be excluded income excluded from taxation under section 7873 of the Internal Revenue Code of 1986[217] (relating to income derived by Indians from exercise of fishing rights); and

(15) The deduction under section 162(l)[218] (relating to health insurance costs of self-employed individuals) shall not be allowed.

If the taxable year of a partner is different from that of the partnership, the distributive share which he is required to include in computing his net earnings from self-employment shall be based upon the ordinary net income or loss of the partnership for any taxable year of the partnership (even though beginning prior to 1951) ending within or with his taxable year. In the case of any trade or business which is carried on by an individual or by a partnership and in which, if such trade or business were carried on exclusively by employees, the major portion of the services would constitute agricultural labor as defined in section 210(f)—

(i) in the case of an individual, if the gross income derived by him from such trade or business is not more than $2,400, the net earnings from self-employment derived by him from such trade or business may, at his option, be deemed to be 66 ⅔ percent of such gross income; or

(ii) in the case of an individual, if the gross income derived by him from such trade or business is more than

[213] See Vol. II, P.L. 83–591, §911.
[214] See Vol. II, P.L. 83–591, §164(f).
[215] See P.L. 83–591, §1401 (this volume).
[216] See Vol. II, P.L. 83–591, §707(c).
[217] See Vol. II, P.L. 83–591, §7873.
[218] P.L. 108–203, §424(a), struck out "section 162(m) and substituted "section 162(l)". See Vol. II, P.L. 83–591, §162(l).

$2,400 and the net earnings from self-employment derived by him from such trade or business (computed under this subsection without regard to this sentence) are less than $1,600, the net earnings from self-employment derived by him from such trade or business may, at his option, be deemed to be $1,600; and

(iii) in the case of a member of a partnership, if his distributive share of the gross income of the partnership derived from such trade or business (after such gross income has been reduced by the sum of all payments to which section 707(c) of the Internal Revenue Code of 1986[219] applies) is not more than $2,400, his distributive share of income described in section 702(a)(8) of such Code derived from such trade or business may, at his option, be deemed to be an amount equal to 66 ⅔ percent of his distributive share of such gross income (after such gross income has been so reduced); or

(iv) in the case of a member of a partnership, if his distributive share of the gross income of the partnership derived from such trade or business (after such gross income has been reduced by the sum of all payments to which section 707(c) of the Internal Revenue Code of 1986 applies) is more than $2,400 and his distributive share (whether or not distributed) of income described in section 702(a)(8) of such Code derived from such trade or business (computed under this subsection without regard to this sentence) is less than $1,600, his distributive share of income described in such section 702(a)(8) derived from such trade or business may, at his option, be deemed to be $1,600.

For purposes of the preceding sentence, gross income means—

(v) in the case of any such trade or business in which the income is computed under a cash receipts and disbursements method, the gross receipts from such trade or business reduced by the cost or other basis of property which was purchased and sold in carrying on such trade or business, adjusted (after such reduction) in accordance with the provisions of paragraphs (1) through (6) and paragraph (8) of this subsection; and

(vi) in the case of any such trade or business in which the income is computed under an accrual method, the gross income from such trade or business, adjusted in accordance with the provisions of paragraphs (1) through (6) and paragraph (8) of this subsection;

and, for purposes of such sentence, if an individual (including a member of a partnership) derives gross income from more than one such trade or business, such gross income (including his distributive share of the gross income of any partnership derived from any such trade or business) shall be deemed to have been derived from one trade or business.

The preceding sentence and clauses (i) through (iv) of the second preceding sentence shall also apply in the case of any trade or business (other than a trade or business specified in such second preceding sentence) which is carried on by an individual who is self-employed on a regular basis as defined in subsection (g), or by a

[219] See Vol. II, P.L. 83–591, §707(c).

partnership of which an individual is a member on a regular basis as defined in subsection (g), but only if such individual's net earnings from self-employment in the taxable year as determined without regard to this sentence are less than $1,600 and less than 66 ⅔ percent of the sum (in such taxable year) of such individual's gross income derived from all trades or businesses carried on by him and his distributive share of the income or loss from all trades or businesses carried on by all the partnerships of which he is a member; except that this sentence shall not apply to more than 5 taxable years in the case of any individual, and in no case in which an individual elects to determine the amount of his net earnings from self-employment for a taxable year under the provisions of the two preceding sentences with respect to a trade or business to which the second preceding sentence applies and with respect to a trade or business to which this sentence applies shall such net earnings for such year exceed $1,600.

Self-Employment Income (b) The term "self-employment income" means the net earnings from self-employment derived by an individual (other than a nonresident alien individual, except as provided by an agreement under section 233) during any taxable year beginning after 1950; except that such term shall not include—

(1) That part of the net earnings from self-employment which is in excess of—

(A) For any taxable year ending prior to 1955, (i) $3,600, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(B) For any taxable year ending after 1954 and prior to 1959, (i) $4,200, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(C) For any taxable year ending after 1958 and prior to 1966, (i) $4,800, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(D) For any taxable year ending after 1965 and prior to 1968, (i) $6,600, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(E) For any taxable year ending after 1967 and beginning prior to 1972, (i) $7,800, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(F) For any taxable year beginning after 1971 and prior to 1973, (i) $9,000, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(G) For any taxable year beginning after 1972 and prior to 1974, (i) $10,800, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(H) For any taxable year beginning after 1973 and prior to 1975, (i) $13,200, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(I) For any taxable year beginning in any calendar year after 1974, (i) an amount equal to the contribution and benefit base (as determined under section 230) which is effective for such calendar year, minus (ii) the amount of the wages paid to such individual during such taxable year; or

(2) The net earnings from self-employment, if such net earnings for the taxable year are less than $400.

An individual who is not a citizen of the United States but who is a resident of the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa shall not, for the purposes of this subsection, be considered to be a nonresident alien individual. In the case of church employee income, the special rules of subsection (i)(2) shall apply for purposes of paragraph (2).

Trade or Business

(c) The term "trade or business", when used with reference to self-employment income or net earnings from self-employment, shall have the same meaning as when used in section 162 of the Internal Revenue Code of 1986[220], except that such term shall not include—

(1) The performance of the functions of a public office, other than the functions of a public office of a State or a political subdivision thereof with respect to fees received in any period in which the functions are performed in a position compensated solely on a fee basis and in which such functions are not covered under an agreement entered into by such State and the Commissioner of Social Security pursuant to section 218;

(2) The performance of service by an individual as an employee, other than—

(A) service described in section 210(a)(14)(B) performed by an individual who has attained the age of eighteen,

(B) service described in section 210(a)(16),

(C) service described in section 210(a)(11), (12), or (15) performed in the United States by a citizen of the United States, except service which constitutes "employment" under section 210(r),

(D) service described in paragraph (4) of this subsection,

(E) service performed by an individual as an employee of a State or a political subdivision thereof in a position compensated solely on a fee basis with respect to fees received in any period in which such service is not covered under an agreement entered into by such State and the Commissioner of Social Security pursuant to section 218,

(F) service described in section 210(a)(20), and

(G) service described in section 210(a)(8)(B);

(3) The performance of service by an individual as an employee or employee representative as defined in section 3231 of the Internal Revenue Code of 1986[221];

(4) The performance of service by a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry or by a member of a religious order in the exercise of duties required by such order;

(5) The performance of service by an individual in the exercise of his profession as a Christian Science practitioner; or

[220] See Vol. II, P.L. 83–591, §162.
[221] See P.L. 83–591, §3231 (this volume).

(6) The performance of service by an individual during the period for which an exemption under section 1402(g) of the Internal Revenue Code of 1986[222] is effective with respect to him.

The provisions of paragraph (4) or (5) shall not apply to service (other than service performed by a member of a religious order who has taken a vow of poverty as a member of such order) performed by an individual unless an exemption under section 1402(e) of the Internal Revenue Code of 1986 is effective with respect to him.

Partnership and Partner

(d) The term "partnership" and the term "partner" shall have the same meaning as when used in subchapter K of chapter 1 of the Internal Revenue Code of 1986.

Taxable Year

(e) The term "taxable year" shall have the same meaning as when used in subtitle A of the Internal Revenue Code of 1986; and the taxable year of any individual shall be a calendar year unless he has a different taxable year for the purposes of subtitle A of such Code, in which case his taxable year for the purposes of this title shall be the same as his taxable year under such subtitle A.

Partner's Taxable Year Ending as Result of Death

(f) In computing a partner's net earnings from self-employment for his taxable year which ends as a result of his death (but only if such taxable year ends within, and not with, the taxable year of the partnership), there shall be included so much of the deceased partner's distributive share of the partnership's ordinary income or loss for the partnership taxable year as is not attributable to an interest in the partnership during any period beginning on or after the first day of the first calendar month following the month in which such partner died. For purposes of this subsection—

(1) in determining the portion of the distributive share which is attributable to any period specified in the preceding sentence, the ordinary income or loss of the partnership shall be treated as having been realized or sustained ratably over the partnership taxable year; and

(2) the term "deceased partner's distributive share" includes the share of his estate or of any other person succeeding, by reason of his death, to rights with respect to his partnership interest.

Regular Basis

(g) An individual shall be deemed to be self-employed on a regular basis in a taxable year, or to be a member of a partnership on a regular basis in such year, if he had net earnings from self-employment, as defined in the first sentence of subsection (a), of not less than $400 in at least two of the three consecutive taxable years immediately preceding such taxable year from trades or businesses carried on by such individual or such partnership.

(h)(1) In determining the net earnings from self-employment of any options dealer or commodities dealer—

[222] See P.L. 83–591, §1402 (this volume).

(A) notwithstanding subsection (a)(3)(A), there shall not be excluded any gain or loss (in the normal course of the taxpayer's activity of dealing in or trading section 1256 contracts) from section 1256 contracts or property related to such contracts, and

(B) the deduction provided by section 1202 of the Internal Revenue Code of 1986 shall not apply.

(2) For purposes of this subsection—

(A) The term "options dealer" has the meaning given such term by section 1256(g)(8) of such Code[223].

(B) The term "commodities dealer" means a person who is actively engaged in trading section 1256 contracts and is registered with a domestic board of trade which is designated as a contract market by the Commodities Futures Trading Commission.

(C) The term "section 1256 contracts" has the meaning given to such term by section 1256(b) of such Code.

(i)(1) In applying subsection (a)—

(A) church employee income shall not be reduced by any deduction;

(B) church employee income and deductions attributable to such income shall not be taken into account in determining the amount of other net earnings from self-employment.

(2)(A) Subsection (b)(2) shall be applied separately—

(i) to church employee income, and

(ii) to other net earnings from self-employment.

(B) In applying subsection (b)(2) to church employee income, "$100" shall be substituted for "$400".

(3) Paragraph (1) shall not apply to any amount allowable as a deduction under subsection (a)(11), and paragraph (1) shall be applied before determining the amount so allowable.

(4) For purposes of this section, the term "church employee income" means gross income for services which are described in section 210(a)(8)(B) (and are not described in section 210(a)(8)(A)).

Codification of Treatment of Certain Termination Payments Received by Former Insurance Salesmen

(j) Nothing in subsection (a) shall be construed as including in the net earnings from self-employment of an individual any amount received during the taxable year from an insurance company on account of services performed by such individual as an insurance salesman for such company if—

(1) such amount is received after termination of such individual's agreement to perform such services for such company,

(2) such individual performs no services for such company after such termination and before the close of such taxable year,

(3) such individual enters into a covenant not to compete against such company which applies to at least the 1-year period beginning on the date of such termination, and

(4) the amount of such payment—

[223] See Vol. II, P.L. 83–591, §1256.

(A) depends primarily on policies sold by or credited to the account of such individual during the last year of such agreement or the extent to which such policies remain in force for some period after such termination, or both, and

(B) does not depend to any extent on length of service or overall earnings from services performed for such company (without regard to whether eligibility for payment depends on length of service).

CREDITING OF SELF–EMPLOYMENT INCOME TO CALENDAR YEARS

SEC. 212. [42 U.S.C. 412] (a) For the purposes of determining average monthly wage and quarters of coverage the amount of self–employment income derived during any taxable year which begins before 1978 shall—

(1) in the case of a taxable year which is a calendar year, be credited equally to each quarter of such calendar year; and

(2) in the case of any other taxable year, be credited equally to the calendar quarter in which such taxable year ends and to each of the next three or fewer preceding quarters any part of which is in such taxable year.

(b) For the purposes of determining average indexed monthly earnings, average monthly wage, and quarters of coverage the amount of self-employment income derived during any taxable year which begins after 1977 shall—

(1) in the case of a taxable year which is a calendar year or which begins with or during a calendar year and ends with or during such year, be credited to such calendar year; and

(2) in the case of any other taxable year, be allocated proportionately to the two calendar years, portions of which are included within such taxable year, on the basis of the number of months in each such calendar year which are included completely within the taxable year.

For purposes of clause (2), the calendar month in which a taxable year ends shall be treated as included completely within that taxable year.

QUARTER AND QUARTER OF COVERAGE

Definitions

SEC. 213. [42 U.S.C. 413] (a) For the purposes of this title—

(1) The term "quarter", and the term "calendar quarter", mean a period of three calendar months ending on March 31, June 30, September 30, or December 31.

(2)(A) The term "quarter of coverage" means—

(i) for calendar years before 1978, and subject to the provisions of subparagraph (B), a quarter in which an individual has been paid $50 or more in wages (except wages for agricultural labor paid after 1954) or for which he has been credited (as determined under section 212) with $100 or more of self-employment income; and

(ii) for calendar years after 1977, and subject to the provisions of subparagraph (B), each portion of the total of the wages paid and the self-employment income credited (pursuant to section 212) to an individ-

ual in a calendar year which equals the amount required for a quarter of coverage in that calendar year (as determined under subsection (d)), with such quarter of coverage being assigned to a specific calendar quarter in such calendar year only if necessary in the case of any individual who has attained age 62 or died or is under a disability and the requirements for insured status in subsection (a) or (b) of section 214, the requirements for entitlement to a computation or recomputation of his primary insurance amount, or the requirements of paragraph (3) of section 216(i) would not otherwise be met.

(B) Notwithstanding the provisions of subparagraph (A)—

(i) no quarter after the quarter in which an individual dies shall be a quarter of coverage, and no quarter any part of which is included in a period of disability (other than the initial quarter and the last quarter of such period) shall be a quarter of coverage;

(ii) if the wages paid to an individual in any calendar year equal $3,000 in the case of a calendar year before 1951, or $3,600 in the case of a calendar year after 1950 and before 1955, or $4,200 in the case of a calendar year after 1954 and before 1959, or $4,800 in the case of a calendar year after 1958 and before 1966, or $6,600 in the case of a calendar year after 1965 and before 1968, or $7,800 in the case of a calendar year after 1967 and before 1972, or $9,000 in the case of the calendar year 1972, or $10,800 in the case of the calendar year 1973, or $13,200 in the case of the calendar year 1974, or an amount equal to the contribution and benefit base (as determined under section 230) in the case of any calendar year after 1974 and before 1978 with respect to which such contribution and benefit base is effective, each quarter of such year shall (subject to clauses (i) and (v)) be a quarter of coverage;

(iii) if an individual has self-employment income for a taxable year, and if the sum of such income and the wages paid to him during such year equals $3,600 in the case of a taxable year beginning after 1950 and ending before 1955, or $4,200 in the case of a taxable year ending after 1954 and before 1959, or $4,800 in the case of a taxable year ending after 1958 and before 1966, or $6,600 in the case of a taxable year ending after 1965 and before 1968, or $7,800 in the case of a taxable year ending after 1967 and before 1972, or $9,000 in the case of a taxable year beginning after 1971 and before 1973, or $10,800 in the case of a taxable year beginning after 1972 and before 1974, or $13,200 in the case of a taxable year beginning after 1973 and before 1975, or an amount equal to the contribution and benefit base (as determined under section 230) which is effective for the calendar year in the case of any taxable year beginning in any calendar year after 1974 and before 1978, each quarter any

part of which falls in such year shall (subject to clauses (i) and (v)) be a quarter of coverage;

(iv) if an individual is paid wages for agricultural labor in a calendar year after 1954 and before 1978, then, subject to clauses (i) and (v), (I) the last quarter of such year which can be but is not otherwise a quarter of coverage shall be a quarter of coverage if such wages equal or exceed $100 but are less than $200; (II) the last two quarters of such year which can be but are not otherwise quarters of coverage shall be quarters of coverage if such wages equal or exceed $200 but are less than $300; (III) the last three quarters of such year which can be but are not otherwise quarters of coverage shall be quarters of coverage if such wages equal or exceed $300 but are less than $400; and (IV) each quarter of such year which is not otherwise a quarter of coverage shall be a quarter of coverage if such wages are $400 or more;

(v) no quarter shall be counted as a quarter of coverage prior to the beginning of such quarter;

(vi) not more than one quarter of coverage may be credited to a calendar quarter; and

(vii) no more than four quarters of coverage may be credited to any calendar year after 1977.

If in the case of an individual who has attained age 62 or died or is under a disability and who has been paid wages for agricultural labor in a calendar year after 1954 and before 1978, the requirements for insured status in subsection (a) or (b) of section 214, the requirements for entitlement to a computation or recomputation of his primary insurance amount, or the requirements of paragraph (3) of section 216(i) are not met after assignment of quarters of coverage to quarters in such year as provided in clause (iv) of the preceding sentence, but would be met if such quarters of coverage were assigned to different quarters in such year, then such quarters of coverage shall instead be assigned, for purposes only of determining compliance with such requirements, to such different quarters. If, in the case of an individual who did not die prior to January 1, 1955, and who attained age 62 (if a woman) or age 65 (if a man) or died before July 1, 1957, the requirements for insured status in section 214(a)(3) are not met because of his having too few quarters of coverage but would be met if his quarters of coverage in the first calendar year in which he had any covered employment had been determined on the basis of the period during which wages were earned rather than on the basis of the period during which wages were paid (any such wages paid that are reallocated on an earned basis shall not be used in determining quarters of coverage for subsequent calendar years), then upon application filed by the individual or his survivors and satisfactory proof of his record of wages earned being furnished by such individual or his survivors, the quarters of coverage in such calendar year may be determined on the basis of the periods during which wages were earned.

Crediting of Wages Paid in 1937

(b) With respect to wages paid to an individual in the six-month periods commencing either January 1, 1937, or July 1, 1937; (A) if wages of not less than $100 were paid in any such period, one-half of the total amount thereof shall be deemed to have been paid in each of the calendar quarters in such period; and (B) if wages of less than $100 were paid in any such period, the total amount thereof shall be deemed to have been paid in the latter quarter of such period, except that if in any such period, the individual attained age sixty-five, all of the wages paid in such period shall be deemed to have been paid before such age was attained.

Alternative Method for Determining Quarters of Coverage With Respect to Wages in the Period from 1937 to 1950

(c) For purposes of sections 214(a) and 215(d), an individual shall be deemed to have one quarter of coverage for each $400 of his total wages prior to 1951 (as defined in section 215(d)(1)(C)), except where such individual is not a fully insured individual on the basis of the number of quarters of coverage so derived plus the number of quarters of coverage derived from the wages and self-employment income credited to such individual for periods after 1950.

Amount Required for a Quarter of Coverage

(d)(1) The amount of wages and self-employment income which an individual must have in order to be credited with a quarter of coverage in any year under subsection (a)(2)(A)(ii) shall be $250 in the calendar year 1978 and the amount determined under paragraph (2) of this subsection for years after 1978.

(2) The Commissioner of Social Security shall, on or before November 1 of 1978 and of every year thereafter, determine and publish in the Federal Register the amount of wages and self-employment income which an individual must have in order to be credited with a quarter of coverage in the succeeding calendar year. The amount required for a quarter of coverage shall be the larger of—

(A) the amount in effect in the calendar year in which the determination under this subsection is made, or

(B) the product of the amount prescribed in paragraph (1) which is required for a quarter of coverage in 1978 and the ratio of the national average wage index (as defined in section 209(k)(1)) for the calendar year before the year in which the determination under this paragraph is made to the national average wage index (as so defined) for 1976,

with such product, if not a multiple of $10, being rounded to the next higher multiple of $10 where such amount is a multiple of $5 but not of $10 and to the nearest multiple of $10 in any other case.

INSURED STATUS FOR PURPOSES OF OLD-AGE AND SURVIVORS INSURANCE BENEFITS

SEC. 214. [42 U.S.C. 414] For the purposes of this title—

Fully Insured Individual

(a) The term "fully insured individual" means any individual who had not less than—

(1) one quarter of coverage (whenever acquired) for each calendar year elapsing after 1950 (or, if later, the year in which he attained age 21) and before the year in which he died or (if earlier) the year in which he attained age 62, except that in no case shall an individual be a fully insured individual unless he has at least 6 quarters of coverage; or

(2) 40 quarters of coverage; or

(3) in the case of an individual who died before 1951, 6 quarters of coverage;

not counting as an elapsed year for purposes of paragraph (1) any year any part of which was included in a period of disability (as defined in section 216(i)), and who satisfies the criterion specified in subsection (c)[224].

Currently Insured Individual (b) The term "currently insured individual" means any individual who had not less than six quarters of coverage during the thirteen-quarter period ending with (1) the quarter in which he died, (2) the quarter in which he became entitled to old-age insurance benefits, (3) the quarter in which he became entitled to primary insurance benefits under this title as in effect prior to the enactment of this section[225], or (4) in the case of any individual entitled to disability insurance benefits, the quarter in which he most recently became entitled to disability insurance benefits, not counting as part of such thirteen-quarter period any quarter any part of which was included in a period of disability unless such quarter was a quarter of coverage, and who satisfies the criterion specified in subsection (c)[226].

(c)[227] For purposes of subsections (a) and (b), the criterion specified in this subsection is that the individual, if not a United States citizen or national—

(1) has been assigned a social security account number that was, at the time of assignment, or at any later time, consistent with the requirements of subclause (I) or (III) of section 205(c)(2)(B)(i); or

(2) at the time any such quarters of coverage are earned—

(A) is described in subparagraph (B) or (D) of section 101(a)(15) of the Immigration and Nationality Act,

(B) is lawfully admitted temporarily to the United States for business (in the case of an individual described in such subparagraph (B)) or the performance as a crewman (in

[224] P.L. 108–203, §211(a)(1), inserted ", and who satisfies the criterion specified in subsection (c)", applicable to benefit applications based on social security account numbers issued on or after January 1, 2004.

[225] August 28, 1950 [P.L. 81–734, §104(a); 64 Stat. 477, 505].

[226] P.L. 108–203, §211(a)(2), inserted ", and who satisfies the criterion specified in subsection (c)", applicable to benefit applications based on social security account numbers issued on or after January 1, 2004.

[227] P.L. 108–203, §211(a)(3), added subsection (c), applicable to benefit applications based on social security account numbers issued on or after January 1, 2004.

the case of an individual described in such subparagraph (D)), and

(C) the business engaged in or service as a crewman performed is within the scope of the terms of such individual's admission to the United States.

COMPUTATION OF PRIMARY INSURANCE AMOUNT

SEC. 215. [42 U.S.C. 415] For the purposes of this title—

Primary Insurance Amount

(a)(1)(A) The primary insurance amount of an individual shall (except as otherwise provided in this section) be equal to the sum of—

(i) 90 percent of the individual's average indexed monthly earnings (determined under subsection (b)) to the extent that such earnings do not exceed the amount established for purposes of this clause by subparagraph (B),

(ii) 32 percent of the individual's average indexed monthly earnings to the extent that such earnings exceed the amount established for purposes of clause (i) but do not exceed the amount established for purposes of this clause by subparagraph (B), and

(iii) 15 percent of the individual's average indexed monthly earnings to the extent that such earnings exceed the amount established for purposes of clause (ii),

rounded, if not a multiple of $0.10, to the next lower multiple of $0.10, and thereafter increased as provided in subsection (i).

(B)(i) For individuals who initially become eligible for old-age or disability insurance benefits, or who die (before becoming eligible for such benefits), in the calendar year 1979, the amount established for purposes of clause (i) and (ii) of subparagraph (A) shall be $180 and $1,085, respectively.

(ii) For individuals who initially become eligible for old-age or disability insurance benefits, or who die (before becoming eligible for such benefits), in any calendar year after 1979, each of the amounts so established shall equal the product of the corresponding amount established with respect to the calendar year 1979 under clause (i) of this subparagraph and the quotient obtained by dividing—

(I) the national average wage index (as defined in section 209(k)(1)) for the second calendar year preceding the calendar year for which the determination is made, by

(II) the national average wage index (as so defined) for 1977.

(iii) Each amount established under clause (ii) for any calendar year shall be rounded to the nearest $1, except that any amount so established which is a multiple of $0.50 but not of $1 shall be rounded to the next higher $1.

(C)(i) No primary insurance amount computed under subparagraph (A) may be less than an amount equal to

$11.50 multiplied by the individual's years of coverage in excess of 10, or the increased amount determined for purposes of this clause under subsection (i).

(ii) For purposes of clause (i), the term "years of coverage" with respect to any individual means the number (not exceeding 30) equal to the sum of (I) the number (not exceeding 14 and disregarding any fraction) determined by dividing (a) the total of the wages credited to such individual (including wages deemed to be paid prior to 1951 to such individual under section 217, compensation under the Railroad Retirement Act of 1937 [228] prior to 1951 which is creditable to such individual pursuant to this title, and wages deemed to be paid prior to 1951 to such individual under section 231) for years after 1936 and before 1951 by (b) $900, plus (II) the number equal to the number of years after 1950 each of which is a computation base year (within the meaning of subsection (b)(2)(B)(ii)) and in each of which he is credited with wages (including wages deemed to be paid to such individual under section 217, compensation under the Railroad Retirement Act of 1937 or 1974 [229] which is creditable to such individual pursuant to this title, and wages deemed to be paid to such individual under section 229) and self-employment income of not less than 25 percent (in the case of a year after 1950 and before 1978) of the maximum amount which (pursuant to subsection (e)) may be counted for such year, or 25 percent (in the case of a year after 1977 and before 1991) or 15 percent (in the case of a year after 1990) of the maximum amount which (pursuant to subsection (e)) could be counted for such year if section 230 as in effect immediately prior to the enactment of the Social Security Amendments of 1977 [230] had remained in effect without change (except that, for purposes of subsection (b)(2)(A) of such section 230 as so in effect, the reference therein to the average of the wages of all employees as reported to the Secretary of the Treasury for any calendar year shall be deemed a reference to the national average wage index (within the meaning of section 209(k)(1)) for such calendar year).

(D) In each calendar year the Commissioner of Social Security shall publish in the Federal Register, on or before November 1, the formula for computing benefits under this paragraph and for adjusting wages and self-employment income under subsection (b)(3) in the case of an individual who becomes eligible for an old-age insurance benefit, or (if earlier) becomes eligible for a disability insurance benefit or dies, in the following year, and the national average wage index (as defined in section 209(k)(1)) on which that formula is based.

(2)(A) A year shall not be counted as the year of an individual's death or eligibility for purposes of this subsection or sub-

[228] P.L. 75–162.
[229] P.L. 75–162 [as amended by P.L. 93–445].
[230] December 20, 1977 [P.L. 95–216, 91 Stat. 1509].

section (i) in any case where such individual was entitled to a disability insurance benefit for any of the 12 months immediately preceding the month of such death or eligibility (but there shall be counted instead the year of the individual's eligibility for the disability insurance benefit or benefits to which he was entitled during such 12 months).

(B) In the case of an individual who was entitled to a disability insurance benefit for any of the 12 months before the month in which he became entitled to an old-age insurance benefit, became reentitled to a disability insurance benefit, or died, the primary insurance amount for determining any benefit attributable to that entitlement, reentitlement, or death is the greater of—

(i) the primary insurance amount upon which such disability insurance benefit was based, increased by the amount of each general benefit increase (as defined in subsection (i)(3)), and each increase provided under subsection (i)(2), that would have applied to such primary insurance amount had the individual remained entitled to such disability insurance benefit until the month in which he became so entitled or reentitled or died, or

(ii) the amount computed under paragraph (1)(C).

(C) In the case of an individual who was entitled to a disability insurance benefit for any month, and with respect to whom a primary insurance amount is required to be computed at any time after the close of the period of the individual's disability (whether because of such individual's subsequent entitlement to old-age insurance benefits or to a disability insurance benefit based upon a subsequent period of disability, or because of such individual's death), the primary insurance amount so computed may in no case be less than the primary insurance amount with respect to which such former disability insurance benefit was most recently determined.

(3)(A) Paragraph (1) applies only to an individual who was not eligible for an old-age insurance benefit prior to January 1979 and who in that or any succeeding month—

(i) becomes eligible for such a benefit,

(ii) becomes eligible for a disability insurance benefit, or

(iii) dies, and (except for subparagraph (C)(i) thereof) it applies to every such individual except to the extent otherwise provided by paragraph (4).

(B) For purposes of this title, an individual is deemed to be eligible—

(i) for old-age insurance benefits, for months beginning with the month in which he attains age 62, or

(ii) for disability insurance benefits, for months beginning with the month in which his period of disability began as provided under section 216(i)(2)(C),

except as provided in paragraph (2)(A) in cases where fewer than 12 months have elapsed since the termination of a prior period of disability.

(4) Paragraph (1) (except for subparagraph (C)(i) thereof) does not apply to the computation or recomputation of a primary insurance amount for—

(A) an individual who was eligible for a disability insurance benefit for a month prior to January 1979 unless, prior to the month in which occurs the event described in clause (i), (ii), or (iii) of paragraph (3)(A), there occurs a period of at least 12 consecutive months for which he was not entitled to a disability insurance benefit, or

(B) an individual who had wages or self-employment income credited for one or more years prior to 1979, and who was not eligible for an old-age or disability insurance benefit, and did not die, prior to January 1979, if in the year for which the computation or recomputation would be made the individual's primary insurance amount would be greater if computed or recomputed—

(i) under section 215(a) as in effect in December 1978, for purposes of old-age insurance benefits in the case of an individual who becomes eligible for such benefits prior to 1984, or

(ii) as provided by section 215(d), in the case of an individual to whom such section applies.

In determining whether an individual's primary insurance amount would be greater if computed or recomputed as provided in subparagraph (B), (I) the table of benefits in effect in December 1978, as modified by paragraph (6), shall be applied without regard to any increases in that table which may become effective (in accordance with subsection (i)(4)) for years after 1978 (subject to clause (iii) of subsection (i)(2)(A)) and (II) such individual's average monthly wage shall be computed as provided by subsection (b)(4).

(5)(A) Subject to subparagraphs (B), (C), (D) and (E), for purposes of computing the primary insurance amount (after December 1978) of an individual to whom paragraph (1) does not apply (other than an individual described in paragraph (4)(B)), this section as in effect in December 1978 shall remain in effect, except that, effective for January 1979, the dollar amount specified in paragraph (3) of subsection (a) shall be increased to $11.50.

(B)(i) Subject to clauses (ii), (iii), and (iv), and notwithstanding any other provision of law, the primary insurance amount of any individual described in subparagraph (C) shall be, in lieu of the primary insurance amount as computed pursuant to any of the provisions referred to in subparagraph (D), the primary insurance amount computed under subsection (a) of section 215 as in effect in December 1978, without regard to subsections (b)(4) and (c) of such section as so in effect.

(ii) The computation of a primary insurance amount under this subparagraph shall be subject to section 104(j)(2) of the Social Security Amendments of 1972 (relating to the number of elapsed years under section 215(b)).

(iii) In computing a primary insurance amount under this subparagraph, the dollar amount specified in paragraph (3) of section 215(a) (as in effect in December 1978) shall be increased to $11.50.

(iv) In the case of an individual to whom section 215(d) applies, the primary insurance amount of such individual shall be the greater of—

(I) the primary insurance amount computed under the preceding clauses of this subparagraph, or

(II) the primary insurance amount computed under section 215(d).

(C) An individual is described in this subparagraph if—

(i) paragraph (1) does not apply to such individual by reason of such individual's eligibility for an old-age or disability insurance benefit, or the individual's death, prior to 1979, and

(ii) such individual's primary insurance amount computed under this section as in effect immediately before the date of the enactment of the Omnibus Budget Reconciliation Act of 1990 would have been computed under the provisions described in subparagraph (D).

(D) The provisions described in this subparagraph are—

(i) the provisions of this subsection as in effect prior to the enactment of the Social Security Amendments of 1965, if such provisions would preclude the use of wages prior to 1951 in the computation of the primary insurance amount,

(ii) the provisions of section 209 as in effect prior to the enactment of the Social Security Act Amendments of 1950, and

(iii) the provisions of section 215(d) as in effect prior to the enactment of the Social Security Amendments of 1977.

(E) For purposes of this paragraph, the table for determining primary insurance amounts and maximum family benefits contained in this section in December 1978 shall be revised as provided by subsection (i) for each year after 1978.

(6)(A) In applying the table of benefits in effect in December 1978 under this section for purposes of the last sentence of paragraph (4), such table, revised as provided by subsection (i), as applicable, shall be extended for average monthly wages of less than $76.00 and primary insurance benefits (as determined under subsection (d)) of less than $16.20.

(B) The Commissioner of Social Security shall determine and promulgate in regulations the methodology for extending the table under subparagraph (A).

(7)(A) In the case of an individual whose primary insurance amount would be computed under paragraph (1) of this subsection, who—

(i) attains age 62 after 1985 (except where he or she became entitled to a disability insurance benefit before 1986 and remained so entitled in any of the 12 months immediately preceding his or her attainment of age 62), or

(ii) would attain age 62 after 1985 and becomes eligible for a disability insurance benefit after 1985,

and who first becomes eligible after 1985 for a monthly periodic payment (including a payment determined under subparagraph (C), but excluding (I) a payment under the Railroad Retirement Act of 1974[231] or 1937[232], (II) a payment by a social security system of a foreign country based on an agreement concluded between the United States and such foreign country pursuant to section 233, and (III) a payment based wholly on service as a member of a uniformed service (as defined in section 210(m)) which is based in whole or in part upon his or her earnings for service which did not constitute "employment" as defined in section 210 for purposes of this title (hereafter in this paragraph and in subsection (d)(3) referred to as "noncovered service"), the primary insurance amount of that individual during his or her concurrent entitlement to such monthly periodic payment and to old-age or disability insurance benefits shall be computed or recomputed under subparagraph (B).

(B)(i) If paragraph (1) of this subsection would apply to such an individual (except for subparagraph (A) of this paragraph), there shall first be computed an amount equal to the individual's primary insurance amount under paragraph (1) of this subsection, except that for purposes of such computation the percentage of the individual's average indexed monthly earnings established by subparagraph (A)(i) of paragraph (1) shall be the percent specified in clause (ii). There shall then be computed (without regard to this paragraph) a second amount, which shall be equal to the individual's primary insurance amount under paragraph (1) of this subsection, except that such second amount shall be reduced by an amount equal to one-half of the portion of the monthly periodic payment which is attributable to noncovered service performed after 1956 (with such attribution being based on the proportionate number of years of such noncovered service) and to which the individual is entitled (or is deemed to be entitled) for the initial month of his or her concurrent entitlement to such monthly periodic payment and old-age or disability insurance benefits. The individual's primary insurance amount shall be the larger of the two amounts computed under this subparagraph (before the application of subsection (i)) and shall be deemed to be computed under paragraph (1) of this subsection for the purpose of applying other provisions of this title.

(ii) For purposes of clause (i), the percent specified in this clause is—

(I) 80.0 percent with respect to individuals who become eligible (as defined in paragraph (3)(B)) for old-age insurance benefits (or became eligible as so defined for disability insurance benefits before attaining age 62) in 1986;

(II) 70.0 percent with respect to individuals who so become eligible in 1987;

(III) 60.0 percent with respect to individuals who so become eligible in 1988;

[231] P.L. 75–162 [as amended by P.L. 93–445].
[232] P.L. 75–162.

(IV) 50.0 percent with respect to individuals who so become eligible in 1989; and

(V) 40.0 percent with respect to individuals who so become eligible in 1990 or thereafter.

(C)(i) Any periodic payment which otherwise meets the requirements of subparagraph (A), but which is paid on other than a monthly basis, shall be allocated on a basis equivalent to a monthly payment (as determined by the Commissioner of Social Security), and such equivalent monthly payment shall constitute a monthly periodic payment for purposes of this paragraph.

(ii) In the case of an individual who has elected to receive a periodic payment that has been reduced so as to provide a survivor's benefit to any other individual, the payment shall be deemed to be increased (for purposes of any computation under this paragraph or subsection (d)(3) by the amount of such reduction.

(iii) For purposes of this paragraph, the term "periodic payment" includes a payment payable in a lump sum if it is a commutation of, or a substitute for, periodic payments.

(D) This paragraph shall not apply in the case of an individual who has 30 years or more of coverage. In the case of an individual who has more than 20 years of coverage but less than 30 years of coverage (as so defined), the percent specified in the applicable subdivision of subparagraph (B)(ii) shall (if such percent is smaller than the applicable percent specified in the following table) be deemed to be the applicable percent specified in the following table:

If the number of such individual's years of coverage (as so defined) is:	**The applicable percent is:**
29	85 percent
28	80 percent
27	75 percent
26	70 percent
25	65 percent
24	60 percent
23	55 percent
22	50 percent
21	45 percent

For purposes of this subparagraph, the term "year of coverage" shall have the meaning provided in paragraph (1)(C)(ii), except that the reference to "15 percent" therein shall be deemed to be a reference to "25 percent".

(E) This paragraph shall not apply in the case of an individual whose eligibility for old-age or disability insurance benefits is based on an agreement concluded pursuant to section 233 or an individual who on January 1, 1984—

(i) is an employee performing service to which social security coverage is extended on that date solely by reason of the amendments made by section 101 of the Social Security Amendments of 1983[233]; or

(ii) is an employee of a nonprofit organization which (on December 31, 1983) did not have in effect a waiver certificate under section 3121(k) of the Internal Revenue Code of 1954[234] and to the employees of which social security coverage is extended on that date solely by reason of the amendments made by section 102 of that Act, unless social security coverage had previously extended to service performed by such individual as an employee of that organization under a waiver certificate which was subsequently (prior to December 31, 1983) terminated.

Average Indexed Monthly Earnings; Average Monthly Wage (b)(1) An individual's average indexed monthly earnings shall be equal to the quotient obtained by dividing—

(A) the total (after adjustment under paragraph (3)) of his wages paid in and self-employment income credited to his benefit computation years (determined under paragraph (2)), by

(B) the number of months in those years.

(2)(A) The number of an individual's benefit computation years equals the number of elapsed years reduced—

(i) in the case of an individual who is entitled to old-age insurance benefits (except as provided in the second sentence of this subparagraph), or who has died, by 5 years, and

(ii) in the case of an individual who is entitled to disability insurance benefits, by the number of years equal to one-fifth of such individual's elapsed years (disregarding any resulting fractional part of a year), but not by more than 5 years.

Clause (ii), once applicable with respect to any individual, shall continue to apply for purposes of determining such individual's primary insurance amount for purposes of any subsequent eligibility for disability or old-age insurance benefits unless prior to the month in which such eligibility begins there occurs a period of at least 12 consecutive months for which he was not entitled to a disability or an old-age insurance benefit. If an individual described in clause (ii) is living with a child (of such individual or his or her spouse) under the age of 3 in any calendar year which is included in such individual's computation base years, but which is not disregarded pursuant to clause (ii) or to subparagraph (B) (in determining such individual's benefit computation years) by reason of the reduction in the number of such individual's elapsed years under clause (ii), the number by which such elapsed years are reduced under this subparagraph pursuant to clause (ii) shall be increased by one (up to a combined total not exceeding 3) for each such calendar year; except that (I) no calendar year shall be disregarded by reason of this sentence (in determining such individ-

[233] P.L. 98–21.

[234] P.L. 83–591; however, §3121(k) was repealed by P.L. 98–21, §102(b)(2).

ual's benefit computation years) unless the individual was living with such child substantially throughout the period in which the child was alive and under the age of 3 in such year and the individual had no earnings as described in section 203(f)(5) in such year, (II) the particular calendar years to be disregarded under this sentence (in determining such benefit computation years) shall be those years (not otherwise disregarded under clause (ii)) which, before the application of section 215(f), meet the conditions of subclause (I), and (III) this sentence shall apply only to the extent that its application would not result in a lower primary insurance amount. The number of an individual's benefit computation years as determined under this subparagraph shall in no case be less than 2.

(B) For purposes of this subsection with respect to any individual—

(i) the term "benefit computation years" means those computation base years, equal in number to the number determined under subparagraph (A), for which the total of such individual's wages and self-employment income, after adjustment under paragraph (3), is the largest;

(ii) the term "computation base years" means the calendar years after 1950 and before—

(I) in the case of an individual entitled to old-age insurance benefits, the year in which occurred (whether by reason of section 202(j)(1) or otherwise) the first month of that entitlement; or

(II) in the case of an individual who has died (without having become entitled to old-age insurance benefits), the year succeeding the year of his death;

except that such term excludes any calendar year entirely included in a period of disability; and

(iii) the term "number of elapsed years" means (except as otherwise provided by section 104(j)(2) of the Social Security Amendments of 1972[235]) the number of calendar years after 1950 (or, if later, the year in which the individual attained age 21) and before the year in which the individual died, or, if it occurred earlier (but after 1960), the year in which he attained age 62; except that such term excludes any calendar year any part of which is included in a period of disability.

(3)(A) Except as provided by subparagraph (B), the wages paid in and self-employment income credited to each of an individual's computation base years for purposes of the selection therefrom of benefit computation years under paragraph (2) shall be deemed to be equal to the product of—

(i) the wages and self-employment income paid in or credited to such year (as determined without regard to this subparagraph), and

(ii) the quotient obtained by dividing—

(I) the national average wage index (as defined in section 209(k)(1)) for the second calendar year

[235] See Vol. II, P.L. 92–603.

preceding the earliest of the year of the individual's death, eligibility for an old-age insurance benefit, or eligibility for a disability insurance benefit (except that the year in which the individual dies, or becomes eligible, shall not be considered as such year if the individual was entitled to disability insurance benefits for any month in the 12-month period immediately preceding such death or eligibility, but there shall be counted instead the year of the individual's eligibility for the disability insurance benefit to which he was entitled in such 12-month period), by

(II) the national average wage index (as so defined) for the computation base year for which the determination is made.

(B) Wages paid in or self-employment income credited to an individual's computation base year which—

(i) occurs after the second calendar year specified in subparagraph (A)(ii)(I), or

(ii) is a year treated under subsection (f)(2)(C) as though it were the last year of the period specified in paragraph (2)(B)(ii),

shall be available for use in determining an individual's benefit computation years, but without applying subparagraph (A) of this paragraph.

(4) For purposes of determining the average monthly wage of an individual whose primary insurance amount is computed (after 1978) under section 215(a) or 215(d) as in effect (except with respect to the table contained therein) in December 1978, by reason of subsection (a)(4)(B), this subsection as in effect in December 1978 shall remain in effect, except that paragraph (2)(C) (as then in effect) shall be deemed to provide that "computation base years" include only calendar years in the period after 1950 (or 1936, if applicable) and prior to the year in which occurred the first month for which the individual was eligible (as defined in subsection (a)(3)(B) as in effect in January 1979) for an old-age or disability insurance benefit, or, if earlier, the year in which he died. Any calendar year all of which is included in a period of disability shall not be included as a computation base year for such purposes.

Application of Prior Provisions in Certain Cases

(c) Subject to the amendments made by section 5117 of the Omnibus Budget Reconciliation Act of 1990, this subsection as in effect in December 1978 shall remain in effect with respect to an individual to whom subsection (a)(1) does not apply by reason of the individual's eligibility for an old-age or disability insurance benefit, or the individual's death, prior to 1979.

Primary Insurance Benefit Under 1939 Act

(d)(1) For purposes of column I of the table appearing in subsection (a), as that subsection was in effect in December 1977, an individual's primary insurance benefit shall be computed as follows:

(A) The individual's average monthly wage shall be determined as provided in subsection (b), as in effect in December 1977 (but without regard to paragraph (4) thereof and subject to section 104(j)(2) of the Social Security Amendments of 1972), except that for purposes of paragraphs (2)(C) and (3) of that subsection (as so in effect) 1936 shall be used instead of 1950.

(B) For purposes of subparagraphs (B) and (C) of subsection (b)(2) (as so in effect)—

(i) the total wages prior to 1951 (as defined in subparagraph (C) of this paragraph) of an individual—

(I) shall, in the case of an individual who attained age 21 prior to 1950, be divided by the number of years (hereinafter in this subparagraph referred to as the "divisor") elapsing after the year in which the individual attained age 20, or 1936 if later, and prior to the earlier of the year of death or 1951, except that such divisor shall not include any calendar year entirely included in a period of disability, and in no case shall the divisor be less than one, and

(II) shall, in the case of an individual who died before 1950 and before attaining age 21, be divided by the number of years (hereinafter in this subparagraph referred to as the "divisor") elapsing after the second year prior to the year of death, or 1936 if later, and prior to the year of death, and in no case shall the divisor be less than one; and

(ii) the total wages prior to 1951 (as defined in subparagraph (C) of this paragraph) of an individual who either attained age 21 after 1949 or died after 1949 before attaining age 21, shall be divided by the number of years (hereinafter in this subparagraph referred to as the "divisor") elapsing after 1949 and prior to 1951.

The quotient so obtained shall be deemed to be the individual's wages credited to each of the years which were used in computing the amount of the divisor, except that—

(iii) if the quotient exceeds $3,000, only $3,000 shall be deemed to be the individual's wages for each of the years which were used in computing the amount of the divisor, and the remainder of the individual's total wages prior to 1951 (I) if less than $3,000, shall be deemed credited to the computation base year (as defined in subsection (b)(2) as in effect in December 1977) immediately preceding the earliest year used in computing the amount of the divisor, of (II) if $3,000 or more, shall be deemed credited, in $3,000 increments, to the computation base year (as so defined) immediately preceding the earliest year used in computing the amount of the divisor and to each of the computation base years (as so defined) consecutively preceding that year, with any remainder less than $3,000 being credited to the computation base year (as so defined) immediately preceding the earliest year to which a full $3,000 increment was credited; and

(iv) no more than $42,000 may be taken into account, for purposes of this subparagraph, as total wages after 1936 and prior to 1951.

(C) For the purposes of subparagraph (B), "total wages prior to 1951" with respect to an individual means the sum of (i) remuneration credited to such individual prior to 1951 on the records of the Commissioner of Social Security, (ii) wages deemed paid prior to 1951 to such individual under section 217, (iii) compensation under the Railroad Retirement Act of 1937[236] prior to 1951 creditable to him pursuant to this title, and (iv) wages deemed paid prior to 1951 to such individual under section 231.

(D) The individual's primary insurance benefit shall be 40 percent of the first $50 of his average monthly wage as computed under this subsection, plus 10 percent of the next $200 of his average monthly wage, increased by 1 percent for each increment year. The number of increment years is the number, not more than 14 nor less than 4, that is equal to the individual's total wages prior to 1951 divided by $1,650 (disregarding any fraction).

(2) The provisions of this subsection shall be applicable only in the case of an individual—

(A) with respect to whom at least one of the quarters elapsing prior to 1951 is a quarter of coverage;

(B) who attained age 22 after 1950 and with respect to whom less than six of the quarters elapsing after 1950 are quarters of coverage, or who attained such age before 1951; and

(C)(i) who becomes entitled to benefits under section 202(a) or 223 or who dies, or

(ii) whose primary insurance amount is required to be recomputed under paragraph (2), (6), or (7) of subsection (f) or under section 231.

(3) In the case of an individual whose primary insurance amount is not computed under paragraph (1) of subsection (a) by reason of paragraph (4)(B)(ii) of that subsection, who—

(A) attains age 62 after 1985 (except where he or she became entitled to a disability insurance benefit before 1986, and remained so entitled in any of the 12 months immediately preceding his or her attainment of age 62), or

(B) would attain age 62 after 1985 and becomes eligible for a disability insurance benefit after 1985,

and who first becomes eligible after 1985 for a monthly periodic payment (including a payment determined under subsection (a)(7)(C), but excluding (I) a payment under the Railroad Retirement Act of 1974[237] or 1937), (II) a payment by a social security system of a foreign country based on an agreement concluded between the United States and such foreign country pursuant to section 233, and (III) a payment based wholly on service as a member of a uniformed service (as defined in section 210(m)) which is based (in whole or in part) upon his or her earnings in noncovered service, the primary insurance amount of such individual during his or her concurrent entitlement to such monthly periodic payment and

[236] P.L. 75–162.
[237] P.L. 75–162 [as amended by P.L. 93–445].

to old-age or disability insurance benefits shall be the primary insurance amount computed or recomputed under this subsection (without regard to this paragraph and before the application of subsection (i)) reduced by an amount equal to the smaller of—

(i) one-half of the primary insurance amount (computed without regard to this paragraph and before the application of subsection (i)), or

(ii) one-half of the portion of the monthly periodic payment (or payment determined under subsection (a)(7)(C)) which is attributable to noncovered service performed after 1956 (with such attribution being based on the proportionate number of years of such noncovered service) and to which that individual is entitled (or is deemed to be entitled) for the initial month of such concurrent entitlement.

This paragraph shall not apply in the case of any individual to whom subsection (a)(7) would not apply by reason of subparagraph (E) or the first sentence of subparagraph (D) thereof.

Certain Wages and Self-Employment Income Not To Be Counted

(e) For the purposes of subsections (b) and (d)—

(1) in computing an individual's average indexed monthly earnings or, in the case of an individual whose primary insurance amount is computed under section 215(a) as in effect prior to January 1979, average monthly wage, there shall not be counted the excess over $3,600 in the case of any calendar year after 1950 and before 1955, the excess over $4,200 in the case of any calendar year after 1954 and before 1959, the excess over $4,800 in the case of any calendar year after 1958 and before 1966, the excess over $6,600 in the case of any calendar year after 1965 and before 1968, the excess over $7,800 in the case of any calendar year after 1967 and before 1972, the excess over $9,000 in the case of any calendar year after 1971 and before 1973, the excess over $10,800 in the case of any calendar year after 1972 and before 1974, the excess over $13,200 in the case of any calendar year after 1973 and before 1975, and the excess over an amount equal to the contribution and benefit base (as determined under section 230) in the case of any calendar year after 1974 with respect to which such contribution and benefit base is effective, (before the application, in the case of average indexed monthly earnings, of subsection (b)(3)(A)) of (A) the wages paid to him in such year, plus (B) the self-employment income credited to such year (as determined under section 212); and

(2) if an individual's average indexed monthly earnings or, in the case of an individual whose primary insurance amount is computed under section 215(a) as in effect prior to January 1979, average monthly wage, computed under subsection (b) or for the purposes of subsection (d) is not a multiple of $1, it shall be reduced to the next lower multiple of $1.

Recomputation of Benefits

(f)(1) After an individual's primary insurance amount has been determined under this section, there shall be no recomputation of such individual's primary insurance amount except as provided in

this subsection or, in the case of a World War II veteran who died prior to July 27, 1954, as provided in section 217(b).

(2)(A)If an individual has wages or self-employment income for a year after 1978 for any part of which he is entitled to old-age or disability insurance benefits, the Commissioner of Social Security shall, at such time or times and within such period as the Commissioner may by regulation prescribe, recompute the individual's primary insurance amount for that year.

(B) For the purpose of applying subparagraph (A) of subsection (a)(1) to the average indexed monthly earnings of an individual to whom that subsection applies and who receives a recomputation under this paragraph, there shall be used, in lieu of the amounts established by subsection (a)(1)(B) for purposes of clauses (i) and (ii) of subsection (a)(1)(A), the amounts so established that were (or, in the case of an individual described in subsection (a)(4)(B), would have been) used in the computation of such individual's primary insurance amount prior to the application of this subsection.

(C) A recomputation of any individual's primary insurance amount under this paragraph shall be made as provided in subsection (a)(1) as though the year with respect to which it is made is the last year of the period specified in subsection (b)(2)(B)(ii); and subsection (b)(3)(A) shall apply with respect to any such recomputation as it applied in the computation of such individual's primary insurance amount prior to the application of this subsection.

(D) A recomputation under this paragraph with respect to any year shall be effective—

(i) in the case of an individual who did not die in that year, for monthly benefits beginning with benefits for January of the following year; or

(ii) in the case of an individual who died in that year, for monthly benefits beginning with benefits for the month in which he died.

(3) [Repealed.[238]]

(4) A recomputation shall be effective under this subsection only if it increases the primary insurance amount by at least $1.

(5) In the case of a man who became entitled to old-age insurance benefits and died before the month in which he attained retirement age (as defined in section 216(l)), the Commissioner of Social Security shall recompute his primary insurance amount as provided in subsection (a) as though he became entitled to old-age insurance benefits in the month in which he died; except that (i) his computation base years referred to in subsection (b)(2) shall include the year in which he died, and (ii) his elapsed years referred to in subsection (b)(3) shall not include the year in which he died or any year thereafter. Such recomputation of such primary insurance amount shall be effective for and after the month in which he died.

(6) Upon the death after 1967 of an individual entitled to benefits under section 202(a) or section 223, if any person is entitled to monthly benefits or a lump-sum death payment, on

[238] P.L. 95–216, §201(f)(2); 91 Stat. 1521.

the wages and self-employment income of such individual, the Commissioner of Social Security shall recompute the decedent's primary insurance amount, but only if the decedent during his lifetime was paid compensation which was treated under section 205(o) as remuneration for employment.

(7) This subsection as in effect in December 1978 shall continue to apply to the recomputation of a primary insurance amount computed under subsection (a) or (d) as in effect (without regard to the table in subsection (a)) in that month, and, where appropriate, under subsection (d) as in effect in December 1977, including a primary insurance amount computed under any such subsection whose operation is modified as a result of the amendments made by section 5117 of the Omnibus Budget Reconciliation Act of 1990. For purposes of recomputing a primary insurance amount determined under subsection (a) or (d) (as so in effect) in the case of an individual to whom those subsections apply by reason of subsection (a)(4)(B) as in effect after December 1978, no remuneration shall be taken into account for the year in which the individual initially became eligible for an old-age or disability insurance benefit or died, or for any year thereafter, and (effective January 1982) the recomputation shall be modified by the application of subsection (a)(6) where applicable.

(8) The Commissioner of Social Security shall recompute the primary insurance amounts applicable to beneficiaries whose benefits are based on a primary insurance amount which was computed under subsection (a)(3) effective prior to January 1979, or would have been so computed if the dollar amount specified therein were $11.50. Such recomputation shall be effective January 1979, and shall include the effect of the increase in the dollar amount provided by subsection (a)(1)(C)(i). Such primary insurance amount shall be deemed to be provided under such section for purposes of subsection (i).

(9)(A)In the case of an individual who becomes entitled to a periodic payment determined under subsection (a)(7)(A) (including a payment determined under subsection (a)(7)(C)) in a month subsequent to the first month in which he or she becomes entitled to an old-age or disability insurance benefit, and whose primary insurance amount has been computed without regard to either such subsection or subsection (d)(3), such individual's primary insurance amount shall be recomputed (notwithstanding paragraph (4) of this subsection), in accordance with either such subsection or subsection (d)(3), as may be applicable, effective with the first month of his or her concurrent entitlement to such benefit and such periodic payment.

(B) If an individual's primary insurance amount has been computed under subsection (a)(7) or (d)(3), and it becomes necessary to recompute that primary insurance amount under this subsection—

(i) so as to increase the monthly benefit amount payable with respect to such primary insurance amount (except in the case of the individual's death), such increase shall be determined as though the recomputed primary insurance amount were being computed under subsection (a)(7) or (d)(3), or

(ii) by reason of the individual's death, such primary insurance amount shall be recomputed without regard to (and as though it had never been computed with regard to) subsection (a)(7) or (d)(3).

Rounding of Benefits

(g) The amount of any monthly benefit computed under section 202 or 223 which (after any reduction under sections 203(a) and 224 and any deduction under section 203(b), and after any deduction under section 1840(a)(1)) is not a multiple of $1 shall be rounded to the next lower multiple of $1.

Service of Certain Public Health Service Officers

(h)(1) Notwithstanding the provisions of subchapter III of chapter 83 of title 5, United States Code[239], remuneration paid for service to which the provisions of section 210(l)(1) of this Act are applicable and which is performed by an individual as a commissioned officer of the Reserve Corps of the Public Health Service prior to July 1, 1960, shall not be included in computing entitlement to or the amount of any monthly benefit under this title, on the basis of his wages and self-employment income, for any month after June 1960 and prior to the first month with respect to which the Director of the Office of Personnel Management certifies to the Commissioner of Social Security that, by reason of a waiver filed as provided in paragraph (2), no further annuity will be paid to him, his wife, and his children, or, if he has died, to his widow and children, under subchapter III of chapter 83 of title 5, United States Code, on the basis of such service.

(2) In the case of a monthly benefit for a month prior to that in which the individual, on whose wages and self-employment income such benefit is based, dies, the waiver must be filed by such individual; and such waiver shall be irrevocable and shall constitute a waiver on behalf of himself, his wife, and his children. If such individual did not file such a waiver before he died, then in the case of a benefit for the month in which he died or any month thereafter, such waiver must be filed by his widow, if any, and by or on behalf of all his children, if any; and such waivers shall be irrevocable. Such a waiver by a child shall be filed by his legal guardian or guardians, or, in the absence thereof, by the person (or persons) who has the child in his care.

Cost-of-Living Increases in Benefits

(i)(1) For purposes of this subsection—

(A) the term "base quarter" means (i) the calendar quarter ending on September 30 in each year after 1982, or (ii) any other calendar quarter in which occurs the effective month of a general benefit increase under this title;

(B) the term "cost-of-living computation quarter" means a base quarter, as defined in subparagraph (A)(i), with respect to which the applicable increase percentage is greater than zero; except that there shall be no cost-of-living

[239] See Vol. II, Title 5.

computation quarter in any calendar year if in the year prior to such year a law has been enacted providing a general benefit increase under this title or if in such prior year such a general benefit increase becomes effective;

(C) the term "applicable increase percentage" means—

(i) with respect to a base quarter or cost-of-living computation quarter in any calendar year before 1984, or in any calendar year after 1983 and before 1989 for which the OASDI fund ratio is 15.0 percent or more, or in any calendar year after 1988 for which the OASDI fund ratio is 20.0 percent or more, the CPI increase percentage; and

(ii) with respect to a base quarter or cost-of-living computation quarter in any calendar year after 1983 and before 1989 for which the OASDI fund ratio is less than 15.0 percent, or in any calendar year after 1988 for which the OASDI fund ratio is less than 20.0 percent, the CPI increase percentage or the wage increase percentage, whichever (with respect to that quarter) is the lower;

(D) the term "CPI increase percentage", with respect to a base quarter or cost-of-living computation quarter in any calendar year, means the percentage (rounded to the nearest one-tenth of 1 percent) by which the Consumer Price Index for that quarter (as prepared by the Department of Labor) exceeds such index for the most recent prior calendar quarter which was a base quarter under subparagraph (A)(ii) or, if later, the most recent cost-of-living computation quarter under subparagraph (B);

(E) the term "wage increase percentage", with respect to a base quarter or cost-of-living computation quarter in any calendar year, means the percentage (rounded to the nearest one-tenth of 1 percent) by which the national average wage index (as defined in section 209(k)(1)) for the year immediately preceding such calendar year exceeds such index for the year immediately preceding the most recent prior calendar year which included a base quarter under subparagraph (A)(ii) or, if later, which included a cost-of-living computation quarter;

(F) the term "OASDI fund ratio", with respect to any calendar year, means the ratio of—

(i) the combined balance in the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund as of the beginning of such year, including the taxes transferred under section 201(a) on the first day of such year and reduced by the outstanding amount of any loan (including interest thereon) theretofore made to either such Fund from the Federal Hospital Insurance Trust Fund under section 201(l), to

(ii) the total amount which (as estimated by the Commissioner of Social Security) will be paid from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund during such calendar year for all purposes authorized by section 201 (other than payments of interest on, or re-

payments of, loans from the Federal Hospital Insurance Trust Fund under section 201(l)), but excluding any transfer payments between such trust funds and reducing the amount of any transfers to the Railroad Retirement Account by the amount of any transfers into either such trust fund from that Account;

(G) the Consumer Price Index for a base quarter, a cost-of-living computation quarter, or any other calendar quarter shall be the arithmetical mean of such index for the 3 months in such quarter.

(2)(A)(i) The Commissioner of Social Security shall determine each year beginning with 1975 (subject to the limitation in paragraph (1)(B)) whether the base quarter (as defined in paragraph (1)(A)(i)) in such year is a cost-of-living computation quarter.

(ii) If the Commissioner of Social Security determines that the base quarter in any year is a cost–of–living computation quarter, the Commissioner shall, effective with the month of December of that year as provided in subparagraph (B), increase—

(I) the benefit amount to which individuals are entitled for that month under section 227 or 228,

(II) the primary insurance amount of each other individual on which benefit entitlement is based under this title, and

(III) the amount of total monthly benefits based on any primary insurance amount which is permitted under section 203 (and such total shall be increased, unless otherwise so increased under another provision of this title, at the same time as such primary insurance amount) or, in the case of a primary insurance amount computed under subsection (a) as in effect (without regard to the table contained therein) prior to January 1979, the amount to which the beneficiaries may be entitled under section 203 as in effect in December 1978, except as provided by section 203(a)(7) and (8) as in effect after December 1978.

The increase shall be derived by multiplying each of the amounts described in subdivisions (I), (II), and (III) (including each of those amounts as previously increased under this subparagraph) by the applicable increase percentage; and any amount so increased that is not a multiple of $0.10 shall be decreased to the next lower multiple of $0.10. Any increase under this subsection in a primary insurance amount determined under subparagraph (C)(i) of subsection (a)(1) shall be applied after the initial determination of such primary insurance amount under that subparagraph (with the amount of such increase, in the case of an individual who becomes eligible for old-age or disability insurance benefits or dies in a calendar year after 1979, being determined from the range of possible primary insurance amounts published by the Commissioner of Social Security under the last sentence of subparagraph (D)).

(iii) In the case of an individual who becomes eligible for an old-age or disability insurance benefit, or who dies prior to becoming so eligible, in a year in which there occurs an increase provided under clause

(ii), the individual's primary insurance amount (without regard to the time of entitlement to that benefit) shall be increased (unless otherwise so increased under another provision of this title and, with respect to a primary insurance amount determined under subsection (a)(1)(C)(i)(I) in the case of an individual to whom that subsection (as in effect in December 1981) applied, subject to the provisions of subsection (a)(1)(C)(i) and clauses (iv) and (v) of this subparagraph (as then in effect)) by the amount of that increase and subsequent applicable increases, but only with respect to benefits payable for months after November of that year.

(B) The increase provided by subparagraph (A) with respect to a particular cost-of-living computation quarter shall apply in the case of monthly benefits under this title for months after November of the calendar year in which occurred such cost-of-living computation quarter, and in the case of lump-sum death payments with respect to deaths occurring after November of such calendar year.

(C)(i) Whenever the Commissioner of Social Security determines that a base quarter in a calendar year is also a cost-of-living computation quarter, the Commissioner shall notify the House Committee on Ways and Means and the Senate Committee on Finance of such determination within 30 days after the close of such quarter, indicating the amount of the benefit increase to be provided, the Commissioner's estimate of the extent to which the cost of such increase would be met by an increase in the contribution and benefit base under section 230 and the estimated amount of the increase in such base, the actuarial estimates of the effect of such increase, and the actuarial assumptions and methodology used in preparing such estimates.

(ii) The Commissioner of Social Security shall determine and promulgate the OASDI fund ratio for the current calendar year on or before November 1 of the current calendar year, based upon the most recent data then available. The Commissioner of Social Security shall include a statement of the fund ratio and the national average wage index (as defined in section 209(k)(1)) and a statement of the effect such ration and the level of such index may have upon benefit increases under this subsection in any notification made under clause (i) and any determination published under subparagraph (D).

(D) If the Commissioner of Social Security determines that a base quarter in a calendar year is also a cost-of-living computation quarter, the Commissioner shall publish in the Federal Register within 45 days after the close of such quarter a determination that a benefit increase is resultantly required and the percentage thereof. The Commissioner shall also publish in the Federal Register at that time (i) a revision of the range of the primary insurance amounts which are possible after the application of this subsection based on the dollar amount specified in subparagraph (C)(i) of subsection (a)(1) (with such revised pri-

mary insurance amounts constituting the increased amounts determined for purposes of such subparagraph (C)(i) under this subsection), or specified in subsection (a)(3) as in effect prior to 1979, and (ii) a revision of the range of maximum family benefits which correspond to such primary insurance amounts (with such maximum benefits being effective notwithstanding section 203(a) except for paragraph (3)(B) thereof (or paragraph (2) thereof as in effect prior to 1979)). Notwithstanding the preceding sentence, such revision of maximum family benefits shall be subject to paragraph (6) of section 203(a) (as added by section 101(a)(3) of the Social Security Disability Amendments of 1980[240]).

(3) As used in this subsection, the term "general benefit increase under this title" means an increase (other than an increase under this subsection) in all primary insurance amounts on which monthly insurance benefits under this title are based.

(4) This subsection as in effect in December 1978, and as amended by sections 111(a)(6), 111(b)(2), and 112 of the Social Security Amendments of 1983[241] and by section 9001 of the Omnibus Budget Reconciliation Act of 1986[242], shall continue to apply to subsections (a) and (d), as then in effect and as amended by section 5117 of the Omnibus Budget Reconciliation Act of 1990[243], for purposes of computing the primary insurance amount of an individual to whom subsection (a), as in effect after December 1978, does not apply (including an individual to whom subsection (a) does not apply in any year by reason of paragraph (4)(B) of that subsection (but the application of this subsection in such cases shall be modified by the application of subdivision (I) in the last sentence of paragraph (4) of that subsection)), except that for this purpose, in applying paragraphs (2)(A)(ii), (2)(D)(iv), and (2)(D)(v) of this subsection as in effect in December 1978, the phrase "increased to the next higher multiple of $0.10" shall be deemed to read "decreased to the next lower multiple of $0.10". For purposes of computing primary insurance amounts and maximum family benefits (other than primary insurance amounts and maximum family benefits for individuals to whom such paragraph (4)(B) applies), the Commissioner of Social Security shall revise the table of benefits contained in subsection (a), as in effect in December 1978, in accordance with the requirements of paragraph (2)(D) of this subsection as then in effect, except that the requirement in such paragraph (2)(D) that the Commissioner of Social Security publish such revision of the table of benefits in the Federal Register shall not apply.

(5)(A) If—

(i) with respect to any calendar year the "applicable increase percentage" was determined under clause (ii) of paragraph (1)(C) rather than under clause (i) of such paragraph, and the increase becoming effective under paragraph (2) in such year was accordingly determined on the basis of the wage increase percentage

[240] P.L. 96–265.
[241] P.L. 98–21.
[242] P.L. 99–509.
[243] P.L. 101–508.

rather than the CPI increase percentage (or there was no such increase becoming effective under paragraph (2) in that year because there was no wage increase percentage greater than zero), and

(ii) for any subsequent calendar year in which an increase under paragraph (2) becomes effective the OASDI fund ratio is greater than 32.0 percent,

then each of the amounts described in subdivisions (I), (II), and (III) of paragraph (2)(A)(ii), as increased under paragraph (2) effective with the month of December in such subsequent calendar year, shall be further increased (effective with such month) by an additional percentage, which shall be determined under subparagraph (B) and shall apply as provided in subparagraph (C). Any amount so increased that is not a multiple of $0.10 shall be decreased to the next lower multiple of $0.10.

(B) The applicable additional percentage by which the amounts described in subdivisions (I), (II), and (III) of paragraph (2)(A)(ii) are to be further increased under subparagraph (A) in the subsequent calendar year involved shall be the amount derived by—

(i) subtracting (I) the compounded percentage benefit increases that were actually paid under paragraph (2) and this paragraph from (II) the compounded percentage benefit increases that would have been paid if all increases under paragraph (2) had been made on the basis of the CPI increase percentage,

(ii) dividing the difference by the sum of the compounded percentage in clause (i)(I) and 100 percent, and

(iii) multiplying such quotient by 100 so as to yield such applicable additional percentage (which shall be rounded to the nearest one-tenth of 1 percent),

with the compounded increases referred to in clause (i) being measured—

(iv) in the case of amounts described in subdivision (I) of paragraph (2)(A)(ii), over the period beginning with the calendar year in which monthly benefits described in such subdivision were first increased on the basis of the wage increase percentage and ending with the year before such subsequent calendar year, and

(v) in the case of amounts described in subdivisions (II) and (III) of paragraph (2)(A)(ii), over the period beginning with the calendar year in which the individual whose primary insurance amount is increased under such subdivision (II) became eligible (as defined in subsection (a)(3)(B)) for the old-age or disability insurance benefit that is being increased under this subsection, or died before becoming so eligible, and ending with the year before such subsequent calendar year;

except that if the Commissioner of Social Security determines in any case that the application (in accordance with subparagraph (C)) of the additional percentage as computed under the preceding provisions of this subparagraph would cause the OASDI fund ratio to fall below 32.0 percent in the calendar year immediately following such subsequent year, the Commissioner shall reduce such applicable additional percentage to the extent necessary to ensure

that the OASDI fund ratio will remain at or above 32.0 percent through the end of such following year.

(C) Any applicable additional percentage increase in an amount described in subdivision (I), (II), or (III) of paragraph (2)(A)(ii), made under this paragraph in any calendar year, shall thereafter be treated for all the purposes of this Act as a part of the increase made in such amount under paragraph (2) for that year.

OTHER DEFINITIONS

SEC. 216. [42 U.S.C. 416] For the purposes of this title—

Spouse; Surviving Spouse

(a)(1) The term "spouse" means a wife as defined in subsection (b) or a husband as defined in subsection (f).

(2) The term "surviving spouse" means a widow as defined in subsection (c) or a widower as defined in subsection (g).

Wife (b) The term "wife" means the wife of an individual, but only if she (1) is the mother of his son or daughter, (2) was married to him for a period of not less than one year immediately preceding the day on which her application is filed, or (3) in the month prior to the month of her marriage to him (A) was entitled to, or on application therefor and attainment of age 62 in such prior month would have been entitled to, benefits under subsection (b), (e), or (h) of section 202, (B) had attained age eighteen and was entitled to, or on application therefor would have been entitled to, benefits under subsection (d) of such section (subject, however, to section 202(s)), or (C) was entitled to, or upon application therefor and attainment of the required age (if any) would have been entitled to, a widow's, child's (after attainment of age 18), or parent's insurance annuity under section 2 of the Railroad Retirement Act of 1974[244], as amended. For purposes of clause (2), a wife shall be deemed to have been married to an individual for a period of one year throughout the month in which occurs the first anniversary of her marriage to such individual. For purposes of subparagraph (C) of section 202(b)(1), a divorced wife shall be deemed not to be married throughout the month in which she becomes divorced.

Widow

(c)(1)[245] The term "widow" (except when used in the first sentence of section 202(i)) means the surviving wife of an individual, but only if (A)[246] she is the mother of his son or daughter, (B) she legally adopted his son or daughter while she was married to him and while such son or daughter was under the age of eighteen, (C) he legally adopted her son or daughter while she was married to him and while such son or daughter was under the age of eighteen, (D) she was married to him at the time both of them legally adopted a child under the age of eighteen, (E) except as provided in

[244] See Vol. II, P.L. 75–162 [as amended by P.L. 93–445].
[245] P.L. 108–203, §414(a)(4), inserted "(1)".
[246] P.L. 108–203, §414(a)(2), redesignated the former clauses (1) through (6) as clauses (A) through (F).

paragraph (2),[247] she was married to him for a period of not less than nine months immediately prior to the day on which he died, or (F) in the month prior to the month of her marriage to him (i)[248] she was entitled to, or on application therefor and attainment of age 62 in such prior month would have been entitled to, benefits under subsection (b), (e), or (h) of section 202, (ii) she had attained age eighteen and was entitled to, or on application therefor would have been entitled to, benefits under subsection (d) of such section (subject, however, to section 202(s)), or (iii) she was entitled to, or upon application therefor and attainment of the required age (if any) would have been entitled to, a widow's, child's (after attainment of age 18), or parent's insurance annuity under section 2 of the Railroad Retirement Act of 1974, as amended[249].

(2)[250] The requirements of paragraph (1)(E) in connection with the surviving wife of an individual shall be treated as satisfied if—

(A) the individual had been married prior to the individual's marriage to the surviving wife,

(B) the prior wife was institutionalized during the individual's marriage to the prior wife due to mental incompetence or similar incapacity,

(C) during the period of the prior wife's institutionalization, the individual would have divorced the prior wife and married the surviving wife, but the individual did not do so because such divorce would have been unlawful, by reason of the prior wife's institutionalization, under the laws of the State in which the individual was domiciled at the time (as determined based on evidence satisfactory to the Commissioner of Social Security),

(D) the prior wife continued to remain institutionalized up to the time of her death, and

(E) the individual married the surviving wife within 60 days after the prior wife's death.

Divorced Spouses; Divorce

(d)(1) The term "divorced wife" means a woman divorced from an individual, but only if she had been married to such individual for a period of 10 years immediately before the date the divorce became effective.

(2) The term "surviving divorced wife" means a woman divorced from an individual who has died, but only if she had been married to the individual for a period of 10 years immediately before the date the divorce became effective.

(3) The term "surviving divorced mother" means a woman divorced from an individual who has died, but only if (A) she is the mother of his son or daughter, (B) she legally adopted his son or daughter while she was married to him and while such son or daughter was under the age of 18, (C) he legally adopted her son or daughter while she was married to (him and while such son or daughter was under the age of 18, or (D) she was

[247] P.L. 108–203, §414(a)(3), inserted "except as provided in paragraph (2),".

[248] P.L. 108–203, §414(a)(1), redesignated the former subclauses (A) through (C) as subclauses (i) through (iii).

[249] See Vol. II, P.L. 75–162.

[250] P.L. 108–203, §414(a)(5), added paragraph (2), effective with respect to applications for benefits under title II filed during months ending after March 2, 2004.

married to him at the time both of them legally adopted a child under the age of 18.

(4) The term "divorced husband" means a man divorced from an individual, but only if he had been married to such individual for a period of 10 years immediately before the date the divorce became effective.

(5) The term "surviving divorced husband" means a man divorced from an individual who has died, but only if he had been married to the individual for a period of 10 years immediately before the divorce became effective.

(6) The term "surviving divorced father" means a man divorced from an individual who has died, but only if (A) he is the father of her son or daughter, (B) he legally adopted her son or daughter while he was married to her and while such son or daughter was under the age of 18, (C) she legally adopted his son or daughter while he was married to her and while such son or daughter was under the age of 18, or (D) he was married to her at the time both of them legally adopted a child under the age of 18.

(7) The term "surviving divorced parent" means a surviving divorced mother as defined in paragraph (3) of this subsection or a surviving divorced father as defined in paragraph (6).

(8) The terms "divorce" and "divorced" refer to a divorce a vinculo matrimonii.

Child

(e) The term "child" means (1) the child or legally adopted child of an individual, (2) a stepchild who has been such stepchild for not less than one year immediately preceding the day on which application for child's insurance benefits is filed or (if the insured individual is deceased) not less than nine months immediately preceding the day on which such individual died, and (3) a person who is the grandchild or stepgrandchild of an individual or his spouse, but only if (A) there was no natural or adoptive parent (other than such a parent who was under a disability, as defined in section 223(d)) of such person living at the time (i) such individual became entitled to old-age insurance benefits or disability insurance benefits or died, or (ii) if such individual had a period of disability which continued until such individual (became entitled to old-age insurance benefits or disability insurance benefits, or died, at the time such period of disability began, or (B) such person was legally adopted after the death of such individual by such individual's surviving spouse in an adoption that was decreed by a court of competent jurisdiction within the United States and such person's natural or adopting parent or stepparent was not living in such individual's household and making regular contributions toward such person's support at the time such individual died. For purposes of clause (1), a person shall be deemed, as of the date of death of an individual, to be the legally adopted child of such individual if such person was either living with or receiving at least one-half of his support from such individual at the time of such individual's death and was legally adopted by such individual's surviving spouse after such individual's death but only if (A) proceedings for the adoption of the child had been instituted by such individual before his death, or (B) such child was adopted by such individual's surviving spouse

before the end of two years after (i) the day on which such individual died or (ii) the date of enactment of the Social Security Amendments of 1958.[251] For purposes of clause (2), a person who is not the stepchild of an individual shall be deemed the stepchild of such individual if such individual was not the mother or adopting mother or the father or adopting father of such person and such individual and the mother or adopting mother, or the father or adopting father, as the case may be, of such person went through a marriage ceremony resulting in a purported marriage between them which, but for a legal impediment described in the last sentence of subsection (h)(1)(B), would have been a valid marriage. For purposes of clause (2), a child shall be deemed to have been the stepchild of an individual for a period of one year throughout the month in which occurs the expiration of such one year. For purposes of clause (3), a person shall be deemed to have no natural or adoptive parent living (other than a parent who was under a disability) throughout the most recent month in which a natural or adoptive parent (not under a disability) dies.

Husband

(f) The term "husband" means the husband of an individual, but only if (1) he is the father of her son or daughter, (2) he was married to her for a period of not less than one year immediately preceding the day on which his application is filed, or (3) in the month prior to the month of his marriage to her (A) he was entitled to, or on application (therefor and attainment of age 62 in such prior month would have been entitled to, benefits under subsection (c), (f) or (h) of section 202, (B) he had attained age eighteen and was entitled to, or on application therefor would have been entitled to, benefits under subsection (d) of such section (subject, however, to section 202(s)), or (C) he was entitled to, or upon application therefor and attainment of the required age (if any) he would have been entitled to, a widower's, child's (after attainment of age 18), or parent's insurance annuity under section 2 of the Railroad Retirement Act of 1974[252], as amended. For purposes of clause (2), a husband shall be deemed to have been married to an individual for a period of one year throughout the month in which occurs the first anniversary of his marriage to her. For purposes of subparagraph (C) of section 202(c)(1), a divorced husband shall be deemed not to be married throughout the month which he becomes divorced.

Widower

(g)(1)[253] The term "widower" (except when used in the first sentence of section 202(i)) means the surviving husband of an individual, but only if (A)[254] he is the father of her son or daughter, (B) he legally adopted her son or daughter while he was married to her and while such son or daughter was under the age of eighteen, (C) she legally adopted his son or daughter while he was married to her and while such son or daughter was under the age of eighteen, (D) he was married to her at the time both of them legally adopted

[251] August 28, 1958 [P.L. 85–840; 72 Stat. 1013].
[252] See Vol. II, P.L. 75–162 [as amended by P.L. 93–445].
[253] P.L. 108–203, §414(b)(4), inserted "(1)".
[254] P.L. 108–203, §414(b)(2), redesignated the former clauses (1) through (6) as clauses (A) through (F).

a child under the age of eighteen, (E) except as provided in paragraph (2),[255] he was married to her for a period of not less than nine months immediately prior to the day on which she died, or (F) in the month before the month of his marriage to her (i)[256] he was entitled to, or on application therefor and attainment of age 62 in such prior month would have been entitled to, benefits under subsection (c), (f) or (h) of section 202, (ii) he had attained age eighteen and was entitled to, or on application therefor would have been entitled to, benefits under subsection (d) of such section (subject, however, to section 202(s)), or (iii) he was entitled to, or on application therefor and attainment of the required age (if any) he would have been entitled to, a widower's, child's (after attainment of age 18), or parent's insurance annuity under section 2 of the Railroad Retirement Act of 1974[257], as amended.

(2)[258] The requirements of paragraph (1)(E) in connection with the surviving husband of an individual shall be treated as satisfied if—

(A) the individual had been married prior to the individual's marriage to the surviving husband,

(B) the prior husband was institutionalized during the individual's marriage to the prior husband due to mental incompetence or similar incapacity,

(C) during the period of the prior husband's institutionalization, the individual would have divorced the prior husband and married the surviving husband, but the individual did not do so because such divorce would have been unlawful, by reason of the prior husband's institutionalization, under the laws of the State in which the individual was domiciled at the time (as determined based on evidence satisfactory to the Commissioner of Social Security),

(D) the prior husband continued to remain institutionalized up to the time of his death, and

(E) the individual married the surviving husband within 60 days after the prior husband's death.

Determination of Family Status

(h)(1)(A)(i) An applicant is the wife, husband, widow, or widower of a fully or currently insured individual for purposes of this title if the courts of the State in which such insured individual is domiciled at the time such applicant files an application, or, if such insured individual is dead, the courts of the State in which he was domiciled at the time of death, or, if such insured individual is or was not so domiciled in any State, the courts of the District of Columbia, would find that such applicant and such insured individual were validly married at the time such applicant files such application or, if such insured individual is dead, at the time he died.

(ii) If such courts would not find that such applicant and such insured individual were validly married at such time, such applicant shall, nevertheless be deemed to be the wife, husband, widow, or widower, as

[255] P.L. 108–203, §414(b)(3), inserted "except as provided in paragraph (2),".

[256] P.L. 108–203, §414(b)(1), redesignated the former subclauses (A) through (C) as subclauses (i) through (iii).

[257] See Vol. II, P.L. 75–162 [as amended by P.L. 93–445].

[258] P.L. 108–203, §414(b)(5), added paragraph (2), effective with respect to applications for benefits under title II filed during months ending after March 2, 2004.

the case may be, of such insured individual if such applicant would, under the laws applied by such courts in determining the devolution of intestate personal property, have the same status with respect to the taking of such property as a wife, husband, widow, or widower of such insured individual.

(B)(i) In any case where under subparagraph (A) an applicant is not (and is not deemed to be) the wife, widow, husband, or widower of a fully or currently insured individual, or where under subsection (b), (c), (d), (f), or (g) such applicant is not the wife, divorced wife, widow, surviving divorced wife, husband, divorced husband, widower, or surviving divorced husband of such individual, but it is established to the satisfaction of the Commissioner of Social Security that such applicant in good faith went through a marriage ceremony with such individual resulting in a purported marriage between them which, but for a legal impediment not known to the applicant at the time of such ceremony, would have been a valid marriage, then, for purposes of subparagraph (A) and subsections (b), (c), (d), (f), and (g), such purported marriage shall be deemed to be a valid marriage. Notwithstanding the preceding sentence, in the case of any person who would be deemed under the preceding sentence a wife, widow, husband, or widower of the insured individual, such marriage shall not be deemed to be a valid marriage unless the applicant and the insured individual were living in the same household at the time of the death of (the insured individual or (if the insured individual is living) at the time the applicant files the application. A marriage that is deemed to be a valid marriage by reason of the preceding sentence shall continue to be deemed a valid marriage if the insured individual and the person entitled to benefits as the wife or husband of the insured individual are no longer living in the same household at the time of the death of such insured individual.

(ii) The provisions of clause (i) shall not apply if the Commissioner of Social Security determines, on the basis of information brought to the Commissioner's attention, that such applicant entered into such purported marriage with such insured individual with knowledge that it would not be a valid marriage.

(iii) The entitlement to a monthly benefit under subsection (b) or (c) of section 202, based on the wages and self-employment income of such insured individual, of a person who would not be deemed to be a wife or husband of such insured individual but for this subparagraph, shall end with the month before the month in which such person enters into a marriage, valid without regard to this subparagraph, with a person other than such insured individual.

(iv) For purposes of this subparagraph, a legal impediment to the validity of a purported marriage includes only an impediment (I) resulting from the lack of dissolution of a previous marriage or otherwise arising out of such previous marriage or its dissolution, or

(II) resulting from a defect in the procedure followed in connection with such purported marriage.

(2)(A) In determining whether an applicant is the child or parent of a fully or currently insured individual for purposes of this title, the Commissioner of Social Security shall apply such law as would be applied in determining the devolution of intestate personal property by the courts of the State in which such insured individual is domiciled at the time such applicant files application, or, if such insured individual is dead, by the courts of the State in which he was domiciled at the time of his death, or, if such insured individual is or was not so domiciled in any State, by the courts of the District of Columbia. Applicants who according to such law would have the same status relative to taking intestate personal property as a child or parent shall be deemed such.

(B) If an applicant is a son or daughter of a fully or currently insured individual but is not (and is not deemed to (be) the child of such insured individual under subparagraph (A), such applicant shall nevertheless be deemed to be the child of such insured individual if such insured individual and the mother or father, as the case may be, of such applicant went through a marriage ceremony resulting in a purported marriage between them which, but for a legal impediment described in the last sentence of paragraph (1)(B), would have been a valid marriage.

(3) An applicant who is the son or daughter of a fully or currently insured individual, but who is not (and is not deemed to be) the child of such insured individual under paragraph (2), shall nevertheless be deemed to be the child of such insured individual if:

(A) in the case of an insured individual entitled to old-age insurance benefits (who was not, in the month preceding such entitlement, entitled to disability insurance benefits)—

(i) such insured individual—

(I) has acknowledged in writing that the applicant is his or her son or daughter,

(II) has been decreed by a court to be the mother or father of the applicant, or

(III) has been ordered by a court to contribute to the support of the applicant because the applicant is his or her son or daughter,

and such acknowledgment, court decree, or court order was made not less than one year before such insured individual became entitled to old-age insurance benefits or attained retirement age (as defined in subsection (l)), whichever is earlier; or

(ii) such insured individual is shown by evidence satisfactory to the Commissioner of Social Security to be the mother or father of the applicant and was living with or contributing to the support of the applicant at the time such applicant's application for benefits was filed;

(B) in the case of an insured individual entitled to disability insurance benefits, or who was entitled to such ben-

efits in the month preceding the first month for which he or she was entitled to old-age insurance benefits—

(i) such insured individual—

(I) has acknowledged in writing that the applicant is his or her son or daughter,

(II) has been decreed by a court to be the mother or father of the applicant, or

(III) has been ordered by a court to contribute to the support of the applicant because the applicant is his or her son or daughter,

and such acknowledgment, court decree, or court order was made before such insured individual's most recent period of disability began; or

(ii) such insured individual is shown by evidence satisfactory to the Commissioner of Social Security to be the mother or father of the applicant and was living with or contributing to the support of that applicant at the time such applicant's application for benefits was filed;

(C) in the case of a deceased individual—

(i) such insured individual—

(I) had acknowledged in writing that the applicant is his or her son or daughter,

(II) had been decreed by a court to be the mother or father of the applicant, or

(III) had been ordered by a court to contribute to the support of the applicant because the applicant was his or her son or daughter,

and such acknowledgment, court decree, or court order was made before the death of such insured individual, or

(ii) such insured individual is shown by evidence satisfactory to the Commissioner of Social Security to have been the mother or father of the applicant, and such insured individual was living with or contributing to the support of the applicant at the time such insured individual died.

For purposes of subparagraphs (A)(i) and (B)(i), an acknowledgement, court decree, or court order shall be deemed to have occurred on the first day of the month in which it actually occurred.

Disability; Period of Disability

(i)(1) Except for purposes of sections 202(d), 202(e), 202(f), 223, and 225, the term "disability" means (A) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months, or (B) blindness; and the term "blindness" means central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered for purposes of this paragraph as having a central visual acuity of 20/200 or less. The provisions of paragraphs (2)(A),(2)(B),(3), (4), (5), and (6) of section 223(d) shall be applied for purposes of determining whether an individual is under

a disability within the meaning of the first sentence of this paragraph in the same manner as they are applied for purposes of paragraph (1) of such section. Nothing in this title shall be construed as authorizing the Commissioner or any other officer or employee of the United States to interfere in any way with the practice of medicine or with relationships between practitioners of medicine and their patients, or to exercise any supervision or control over the administration or operation of any hospital.

(2)(A) The term "period of disability" means a continuous period (beginning and ending as hereinafter provided in this subsection) during which an individual was under a disability (as defined in paragraph (1)), but only if such period is of not less than five full calendar months' duration or such individual was entitled to benefits under section 223 for one or more months in such period.

(B) No period of disability shall begin as to any individual unless such individual files an application for a disability determination with respect to such period; and no such period shall begin as to any individual after such individual attains retirement age (as defined in subsection (l)). In the case of a deceased individual, the requirement of an application under the preceding sentence may be satisfied by an application for a disability determination filed with respect to such individual within 3 months after the month in which he died.

(C) A period of disability shall begin—

(i) on the day the disability began, but only if the individual satisfies the requirements of paragraph (3) on such day; or

(ii) if such individual does not satisfy the requirements of paragraph (3) on such day, then on the first day of the first quarter thereafter in which he satisfies such requirements.

(D) A period of disability shall end with the close of whichever of the following months is the earlier: (i) the month preceding the month in which the individual attains retirement age (as defined in subsection (l)), or (ii) the month preceding (I) the termination month (as defined in section 223(a)(1)), or, if earlier (II) the first month for which no benefit is payable by reason of section 223(e), where no benefit is payable for any of the succeeding months during the 36–month period referred to in such section. The provisions set forth in section 223(f) with respect to determinations of whether entitlement to benefits under this title or title XVIII based on the disability of any individual is terminated (on the basis of a finding that the physical or mental impairment on the basis of which such benefits are provided has ceased, does not exist, or is not disabling) shall apply in the same manner and to the same extent with respect to determinations of whether a period of disability has ended (on the basis of a finding that the physical or mental impairment on the basis of which the finding of disability was made has ceased, does not exist, or is not disabling).

(E) Except as is otherwise provided in subparagraph (F), no application for a disability determination which is filed more than 12 months after the month prescribed by sub-

paragraph (D) as the month in which the period of disability ends (determined without regard to subparagraph (B) and this subparagraph) shall be accepted as an application for purposes of this paragraph.

(F) An application for a disability determination which is filed more than 12 months after the month prescribed by subparagraph (D) as the month in which the period of disability ends (determined without regard to subparagraphs (B) and (E)) shall be accepted as an application for purposes of this paragraph if—

(i) in the case of an application filed by or on behalf of an individual with respect to a disability which ends after the month in which the Social Security Amendments of 1967 is enacted[259], such application is filed not more than 36 months after the month in which such disability ended, such individual is alive at the time the application is filed, and the Commissioner of Social Security finds in accordance with (regulations prescribed by the Commissioner that the failure of such individual to file an application for a disability determination within the time specified in subparagraph (E) was attributable to a physical or mental condition of such individual which rendered him incapable of executing such an application, and

(ii) in the case of an application filed by or on behalf of an individual with respect to a period of disability which ends in or before the month in which the Social Security Amendments of 1967 is enacted—

(I) such application is filed not more than 12 months after the month in which the Social Security Amendments of 1967 is enacted,

(II) a previous application for a disability determination has been filed by or on behalf of such individual (1) in or before the month in which the Social Security Amendments of 1967 is enacted[260] , and (2) not more than 36 months after the month in which his disability ended, and

(III) the Commissioner of Social Security finds in accordance with regulations prescribed by the Commissioner, that the failure of such individual to file an application within the then specified time period was attributable to a physical or mental condition of such individual which rendered him incapable of executing such an application.

In making a determination under this subsection, with respect to the disability or period of disability of any individual whose application for a determination thereof is accepted solely by reason of the provisions of this subparagraph (F), the provisions of this subsection (other than the provisions of this subparagraph) shall be applied as such provisions are in effect at the time such determination is made.

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[259] January 1968 [P.L. 90–248; 81 Stat. 821].
[260] January 1968 [P.L. 90–248; 81 Stat. 821].

(G) An application for a disability determination filed before the first day on which the applicant satisfies the requirements for a period of disability under this subsection shall be deemed a valid application (and shall be deemed to have been filed on such first day) only if the applicant satisfies the requirements for a period of disability before the Commissioner of Social Security makes a final decision on the application and no request under section 205(b) for notice and opportunity (for a hearing thereon is made or, if such a request is made, before a decision based upon the evidence adduced at the hearing is made (regardless of whether such decision becomes the final decision of the Commissioner of Social Security).

(3) The requirements referred to in clauses (i) and (ii) of paragraph (2)(C) are satisfied by an individual with respect to any quarter only if—

(A) he would have been a fully insured individual (as defined in section 214) had he attained age 62 and filed application for benefits under section 202(a) on the first day of such quarter; and

(B)(i) he had not less than 20 quarters of coverage during the 40-quarter period which ends with such quarter, or

(ii) if such quarter ends before he attains (or would attain) age 31, not less than one-half (and not less than 6) of the quarters during the period ending with such quarter and beginning after he attained the age of 21 were quarters of coverage, or (if the number of quarters in such period is less than 12) not less than 6 of the quarters in the 12-quarter period ending with such quarter were quarters of coverage, or

(iii) in the case of an individual (not otherwise insured under clause (i)) who, by reason of clause (ii), had a prior period of disability that began during a period before the quarter in which he or she attained age 31, not less than one-half of the quarters beginning after such individual attained age 21 and ending with such quarter are quarters of coverage, or (if the number of quarters in such period is less than 12) not less than 6 of the quarters in the 12-quarter period ending with such quarter are quarters of coverage;

except that the provisions of subparagraph (B) of this paragraph shall not apply in the case of an individual who is blind (within the meaning of "blindness" as defined in paragraph (1)). For purposes of subparagraph (B) of this paragraph, when the number of quarters in any period is an odd number, such number shall be reduced by one, and a quarter shall not be counted as part of any period if any part of such quarter was included in a prior period of disability unless such quarter was a quarter of coverage.

Periods of Limitation Ending on Nonwork Days

(j) Where this title, any provision of another law of the United (States (other than the Internal Revenue Code of 1986) relating to or changing the effect of this title, or any regulation issued by the Commissioner of Social Security pursuant thereto provides for a period within which an act is required to be done which affects eligi-

bility for or the amount of any benefit or payment under this title or is necessary to establish or protect any rights under this title, and such period ends on a Saturday, Sunday, or legal holiday, or on any other day all or part of which is declared to be a nonwork day for Federal employees by statute or Executive order, then such act shall be considered as done within such period if it is done on the first day thereafter which is not a Saturday, Sunday, or legal holiday or any other day all or part of which is declared to be a nonwork day for Federal employees by statute or Executive order. For purposes of this subsection, the day on which a period ends shall include the day on which an extension of such period, as authorized by law or by the Commissioner of Social Security pursuant to law, ends. The provisions of this subsection shall not extend the period during which benefits under this title may (pursuant to section 202(j)(1) or 223(b)) be paid for months prior to the day application for such benefits is filed, or during which an application for benefits under this title may (pursuant to section 202(j)(2) or 223(b)) be accepted as such.

Waiver of Nine-Month Requirement for Widow, Stepchild, or Widower in Case of Accidental Death or in Case of Serviceman Dying in Line of Duty, or in Case of Remarriage to the Same Individual

(k) The requirement in clause (E) of subsection (c)(1) or clause (E) of subsection (g)(1)[261] that the surviving spouse of an individual have been married to such individual for a period of not less than nine months immediately prior to the day on which such individual died in order to qualify as such individual's widow or widower, and the requirement in subsection (e) that the stepchild of a deceased individual have been such stepchild for not less than nine months immediately preceding the day on which such individual died in order to qualify as such individual's child, shall be deemed to be satisfied, where such individual dies within the applicable nine-month period, if—

(1) his death—

(A) is accidental, or

(B) occurs in line of duty while he is a member of a uniformed (service serving on active duty (as defined in section 210(l)(2)),

unless the Commissioner of Social Security determines that at the time of the marriage involved the individual could not have reasonably been expected to live for nine months, or

(2)(A) the widow or widower of such individual had been previously married to such individual and subsequently divorced and such requirement would have been satisfied at the time of such divorce if such previous marriage had been terminated by the death of such individual at such time instead of by divorce; or

(B) the stepchild of such individual had been the stepchild of such individual during a previous marriage of such stepchild's parent to such individual which ended in divorce and such requirement would have been satisfied at the time of such divorce if such previous marriage had

[261] P.L. 108–203, §414(c), struck out "clause (5) of subsection (c) or clause (5) of subsection (g)" and substituted "clause (E) of subsection (c)(1) or clause (E) of subsection (g)(1)".

been terminated by the death of such individual at such time instead of by divorce;

except that paragraph (2) of this subsection shall not apply if the Commissioner of Social Security determines that at the time of the marriage involved the individual could not have reasonably been expected to live for nine months. For purposes of paragraph (1)(A) of this subsection, the death of an individual is accidental if he receives bodily injuries solely through violent, external, and accidental means and, as a direct result of the bodily injuries and independently of all other causes, loses his life not later than three months after the day on which he receives such bodily injuries.

Retirement Age

(l)(1) The term "retirement age" means—

(A) with respect to an individual who attains early retirement age (as defined in paragraph (2)) before January 1, 2000, 65 years of age;

(B) with respect to an individual who attains early retirement age after December 31, 1999, and before January 1, 2005, 65 years of age plus the number of months in the age increase factor (as determined under paragraph (3)) for the calendar year in which such individual attains early retirement age;

(C) with respect to an individual who attains early retirement age after December 31, 2004, and before January 1, 2017, 66 (years of age;

(D) with respect to an individual who attains early retirement age after December 31, 2016, and before January 1, 2022, 66 years of age plus the number of months in the age increase factor (as determined under paragraph (3)) for the calendar year in which such individual attains early retirement age; and

(E) with respect to an individual who attains early retirement age after December 31, 2021, 67 years of age.

(2) The term "early retirement age" means age 62 in the case of an old-age, wife's, or husband's insurance benefit, and age 60 in the case of a widow's or widower's insurance benefit.

(3) The age increase factor for any individual who attains early retirement age in a calendar year within the period to which subparagraph (B) or (D) of paragraph (1) applies shall be determined as follows:

(A) With respect to an individual who attains early retirement age in the 5-year period consisting of the calendar years 2000 through 2004, the age increase factor shall be equal to two-twelfths of the number of months in the period beginning with January 2000 and ending with December of the year in which the individual attains early retirement age.

(B) With respect to an individual who attains early retirement age in the 5-year period consisting of the calendar years 2017 through 2021, the age increase factor shall be equal to two-twelfths of the number of months in the period beginning with January 2017 and ending with December of the year in which the individual attains early retirement age.

BENEFITS IN CASE OF VETERANS

SEC. 217. [42 U.S.C. 417] (a)(1) For purposes of determining entitlement to and the amount of any monthly benefit for any month after August 1950, or entitlement to and the amount of any lump-sum death payment in case of a death after such month, payable under this title on the basis of the wages and self-employment income of any World War II veteran, and for purposes of section 216(i)(3), such veteran shall be deemed to have been paid wages (in addition to the wages, if any, actually paid to him) of $160 in each month during any part of which he served in the active military or naval service of the United States during World War II. This subsection shall not be applicable in the case of any monthly benefit or lump-sum death payment if—

(A) a larger such benefit or payment, as the case may be, would be payable without its application; or

(B) a benefit (other than a benefit payable in a lump sum unless it is a commutation of, or a substitute for, periodic payments) which is based, in whole or in part, upon the active military or naval service of such veteran during World War II is determined by any agency or wholly owned instrumentality of the United States (other than the Department of Veterans Affairs) to be payable by it under any other law of the United States or under a system established by such agency or instrumentality.

The provisions of clause (B) shall not apply in the case of any monthly benefit or lump-sum death payment under this title if its application would reduce by $0.50 or less the primary insurance amount (as computed under section 215 prior to any recomputation thereof pursuant to subsection (f) of such section) of the individual on whose wages and self-employment income such benefit or payment is based. The provisions of clause (B) shall also not apply for purposes of section 216(i)(3).

(2) Upon application for benefits or a lump-sum death payment on the basis of the wages and self-employment income of any World War II veteran, the Commissioner of Social Security shall make a decision without regard to clause (B) of paragraph (1) of this subsection unless the Commissioner has been notified by some other agency or instrumentality of the United States that, on the basis of the military or naval service of such veteran during World War II, a benefit described in clause (B) of paragraph (1) has been determined by such agency or instrumentality to be payable by it. If the Commissioner has not been so notified, the Commissioner of Social Security shall then ascertain whether some other agency or wholly owned instrumentality of the United States has decided that a benefit described in clause (B) of paragraph (1) is payable by it. If any such agency or instrumentality has decided, or thereafter decides, that such a benefit is payable by it, it shall so notify the Commissioner of Social Security, and the Commissioner of Social Security shall certify no further benefits for payment or shall recompute the amount of any further benefits payable, as may be required by paragraph (1) of this subsection.

(3) Any agency or wholly owned instrumentality of the United States which is authorized by any law of the United States to pay benefits, or has a system of benefits which are based,

in whole or in part, on military or naval service during World War II shall, at the request of the Commissioner of Social Security, certify to the Commissioner, with respect to any veteran, such information as the Commissioner of Social Security deems necessary to carry out the Commissioner's functions under paragraph (2) of this subsection.

(b)(1) Subject to paragraph (3), any World War II veteran who died during the period of three years immediately following his separation from the active military or naval service of the United States shall be deemed to have died a fully insured individual whose primary insurance amount is the amount determined under section 215(c) as in effect in December 1978. Notwithstanding section 215(d) as in effect in December 1978, the primary insurance benefit (for purposes of section 215(c) as in effect in December 1978) of such veteran shall be determined as provided in this title as in effect prior to the enactment of this section[262], except that the 1 per centum addition provided for in section 209(a)(4)(B) of this Act as in effect prior to the enactment of this section shall be applicable only with respect to calendar years prior to 1951. This subsection shall not be applicable in the case of any monthly benefit or lump-sum death payment if—

(A) a larger such benefit or payment, as the case may be, would be payable without its application;

(B) any pension or compensation is determined by the Secretary of Veterans Affairs to be payable by him on the basis of the death of such veteran;

(C) the death of the veteran occurred while he was in the active military or naval service of the United States; or

(D) such veteran has been discharged or released from the active military or naval service of the United States subsequent to July 26, 1951.

(2) Upon an application for benefits or a lump-sum death payment on the basis of the wages and self-employment income of any World War II veteran, the Commissioner of Social Security shall make a decision without regard to paragraph (1)(B) of this subsection unless the Commissioner has been notified by the Secretary of Veterans Affairs that pension or compensation is determined to be payable by that Commissioner of Social Security by reason of the death of such veteran. The Commissioner of Social Security shall thereupon report such decision to the Secretary of Veterans Affairs. If the Secretary of Veterans Affairs in any such case has made an adjudication or thereafter makes an adjudication that any pension or compensation is payable under any law administered by it, the Secretary of Veterans Affairs shall notify the Commissioner of Social Security, and the Commissioner of Social Security shall certify no further benefits for payment, or shall recompute the amount of any further benefits payable, as may be required by paragraph (1) of this subsection. Any payments theretofore certified by the Commissioner of Social Security on the basis of paragraph (1) of this subsection to any individual, not exceeding the amount of any accrued pension or compensation payable to him by the Secretary of Veterans Affairs, shall (not-

[262] August 28, 1950 [P.L. 81–734; 64 Stat. 477].

withstanding the provisions of section 3101 of title 38, United States Code[263]) be deemed to have been paid to him by that Secretary on account of such accrued pension or compensation. No such payment certified by the Commissioner of Social Security, and no payment certified by the Commissioner for any month prior to the first month for which any pension or compensation is paid by the Secretary of Veterans Affairs shall be deemed by reason of this subsection to have been an erroneous payment.

(3)(A) The preceding provisions of this subsection shall apply for purposes of determining the entitlement to benefits under section 202, based on the primary insurance amount of the deceased World War II veteran, of any surviving individual only if such surviving individual makes application for such benefits before the end of the 18-month period after the month in which the Omnibus Budget Reconciliation Act of 1990 was enacted.[264]

(B) Subparagraph (A) shall not apply if any person is entitled to benefits under section 202 based on the primary insurance amount of such veteran for the month preceding the month in which such application is made.

(c) In the case of any World War II veteran to whom subsection (a) is applicable, proof of support required under section 202(h) may be filed by a parent at any time prior to July 1951 or prior to the expiration of two years after the date of the death of such veteran, whichever is the later.

(d) For the purposes of this section—

(1) The term "World War II" means the period beginning with September 16, 1940, and ending at the close of July 24, 1947.

(2) The term "World War II veteran" means any individual who served in the active military or naval service of the United States at any time during World War II and who, if discharged or released therefrom, was so discharged or released under conditions other than dishonorable after active service of ninety days or more or by reason of a disability or injury incurred or aggravated in service in line of duty; but such term shall not include any individual who died while in the active military or naval service of the United States if his death was inflicted (other than by an enemy of the United States) as lawful punishment for a military or naval offense.

(e)(1) For purposes of determining entitlement to and the amount of any monthly benefit or lump-sum death payment payable under this title on the basis of wages and self-employment income of any veteran (as defined in paragraph (4)), and for purposes of section 216(i)(3), such veteran shall be deemed to have been paid wages (in addition to the wages, if any, actually paid to him) of $160 in each month during any part of which he served in the active military or naval service of the United States on or after July 25, 1947, and prior to January 1, 1957. This subsection shall not be applicable in the case of any monthly benefit or lump-sum death payment if—

(A) a larger such benefit or payment, as the case may be, would be payable without its application; or

[263] See Vol. II, Title 38. P.L. 102–40 redesignated §3101 as §5301.
[264] P.L. 101–508 was enacted in November 1990.

(B) a benefit (other than a benefit payable in a lump sum unless it is a commutation of, or a substitute for, periodic payments) which is based, in whole or in part, upon the active military or naval service of such veteran on or after July 25, 1947, and prior to January 1, 1957, is determined by any agency or wholly owned instrumentality of the United States (other than the Department of Veterans Affairs) to be payable by it under any other law of the United States or under a system established by such agency or instrumentality.

The provisions of clause (B) shall not apply in the case of any monthly benefit or lump-sum death payment under this title if its application would reduce by $0.50 or less the primary insurance amount (as computed under section 215 prior to any recomputation thereof pursuant to subsection (f) of such section) of the individual on whose wages and self-employment income such benefit or payment is based. The provisions of clause (B) shall also not apply for purposes of section 216(i)(3). In the case of monthly benefits under this title for months after December 1956 (and any lump-sum death payment under this title with respect to a death occurring after December 1956) based on the wages and self-employment income of a veteran who performed service (as a member of a uniformed service) to which the provisions of section 210(l)(1) are applicable, wages which would, but for the provisions of clause (B), be deemed under this subsection to have been paid to such veteran with respect to his active military or naval service performed after December 1950 shall be deemed to have been paid to him with respect to such service notwithstanding the provisions of such clause, but only if the benefits referred to in such clause which are based (in whole or in part) on such service are payable solely by the Army, Navy, Air Force, Marine Corps, Coast Guard[265], Coast and Geodetic Survey, National Oceanic and Atmospheric Administration Corps, or Public Health Service[266].

(2) Upon application for benefits or a lump-sum death payment on the basis of the wages and self-employment income of any veteran, the Commissioner of Social Security shall make a decision without regard to clause (B) of paragraph (1) of this subsection unless the Commissioner has been notified by some other agency or instrumentality of the United States that, on the basis of the military or naval service of such veteran on or after July 25, 1947, and prior to January 1, 1957, a benefit described in clause (B) of paragraph (1) has been determined by such agency or instrumentality to be payable by it. If the Commissioner has not been so notified, the Commissioner of Social Security shall then ascertain whether some other agency or wholly owned instrumentality of the United States has decided that a benefit described in clause (B) of paragraph (1) is payable by it. If any such agency or instrumentality has decided, or thereafter decides, that such a benefit is payable by it, it shall so notify the Commissioner of Social Security, and the Commissioner of Social Security shall certify no further benefits for payment or shall recompute the amount of any further

[265] Department of Transportation.
[266] Department of Health and Human Services.

benefits payable, as may be required by paragraph (1) of this subsection.

(3) Any agency or wholly owned instrumentality of the United States which is authorized by any law of the United States to pay benefits, or has a system of benefits which are based, in whole or in part, on military or naval service on or after July 25, 1947, and prior to January 1, 1957, shall, at the request of the Commissioner of Social Security, certify to the Commissioner, with respect to any veteran, such information as the Commissioner of Social Security deems necessary to carry out the Commissioner's functions under paragraph (2) of this subsection.

(4) For the purposes of this subsection, the term "veteran" means any individual who served in the active military or naval service of the United States at any time on or after July 25, 1947, and prior to January 1, 1957, and who, if discharged or released therefrom, was so discharged or released under conditions other than dishonorable after active service of ninety days or more or by reason of a disability or injury incurred or aggravated in service in line of duty; but such term shall not include any individual who died while in the active military or naval service of the United States if his death was inflicted (other than by an enemy of the United States) as lawful punishment for a military or naval offense.

(f)(1) In any case where a World War II veteran (as defined in subsection (d)(2)) or a veteran (as defined in subsection (e)(4)) has died or shall hereafter die, and his or her surviving spouse or child is entitled under subchapter III of chapter 83 of title 5, United States Code, to an annuity in the computation of which his or her active military or naval service was included, clause (B) of subsection (a)(1) or clause (B) of subsection (e)(1) shall not operate (solely by reason of such annuity) to make such subsection inapplicable in the case of any monthly benefit under section 202 which is based on his or her wages and self-employment income; except that no such surviving spouse or child shall be entitled under section 202 to any monthly benefit in the computation of which such service is included by reason of this subsection (A) unless such surviving spouse or child after December 1956 waives his or her right to receive such annuity, or (B) for any month prior to the first month with respect to which the Director of the Office of Personnel Management certifies to the Commissioner of Social Security that (by reason of such waiver) no further annuity will be paid to such surviving spouse or child under such subchapter III on the basis of such veteran's military or civilian service. Any such waiver shall be irrevocable.

(2) Whenever a surviving spouse waives his or her right to receive such annuity such waiver shall constitute a waiver on his or her own behalf; a waiver by a legal guardian or guardians, or, in the absence of a legal guardian, the person (or persons) who has the child in his or her care, of the child's right to receive such annuity shall constitute a waiver on behalf of such child. Such a waiver with respect to an annuity based on a veteran's service shall be valid only if the surviving spouse and all children, or, if there is no surviving spouse, all the children, waive their rights to receive annuities under subchapter

III of chapter 83 of title 5, United States Code, based on such veteran's military or civilian service.

Appropriation to Trust Funds

(g)(1) Within thirty days after the date of the enactment of the Social Security Amendments of 1983[267], the Commissioner of Social Security shall determine the amount equal to the excess of—

(A) the actuarial present value as of such date of enactment of the past and future benefit payments from the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, and the Federal Hospital Insurance Trust Fund under this title and title XVIII, together with associated administrative costs, resulting from the operation of this section (other than this subsection) and section 210 of this Act as in effect before the enactment of the Social Security Amendments of 1950[268], over

(B) any amounts previously transferred from the general fund of the Treasury to such Trust Funds pursuant to the provisions of this subsection as in effect immediately before the date of the enactment of the Social Security Amendments of 1983[269].

Such actuarial present value shall be based on the relevant actuarial assumptions set forth in the report of the Board of Trustees of each such Trust Fund for 1983 under sections 201(c) and 1817(b). Within thirty days after the date of the enactment of the Social Security Amendments of 1983, the Secretary of the Treasury shall transfer the amount determined under this paragraph with respect to each such Trust Fund to such Trust Fund from amounts in the general fund of the Treasury not otherwise appropriated.

(2) The Commissioner of Social Security shall revise the amount determined under paragraph (1) with respect to each such Trust Fund in 1985 and each fifth year thereafter, as determined appropriate by the Commissioner of Social Security from data which becomes available to the Commissioner after the date of the determination under paragraph (1) on the basis of the amount of benefits and administrative expenses actually paid from such Trust Fund under this title or title XVIII and the relevant actuarial assumptions set forth in the report of the Board of Trustees of such Trust Fund for such year under section 201(c) or 1817(b). Within 30 days after any such revision, the Secretary of the Treasury, to the extent provided in advance in appropriation Acts, shall transfer to such Trust Fund, from amounts in the general fund of the Treasury not otherwise appropriated, or from such Trust Fund to the general fund of the Treasury, such amounts as the Secretary of the Treasury determines necessary to take into account such revision.

(h)(1) For the purposes of this section, any individual who the Commissioner of Social Security finds—

(A) served during World War II (as defined in subsection (d)(1)) in the active military or naval service of a country

[267] April 20, 1983 [P.L. 98–21; 97 Stat. 65].
[268] August 28, 1950 [P.L. 81–734; 64 Stat. 477].
[269] April 20, 1983 [P.L. 98–21; 97 Stat. 65].

which was on September 16, 1940, at war with a country with which the United States was at war during World War II;

(B) entered into such active service on or before December 8, 1941;

(C) was a citizen of the United States throughout such period of service or lost his United States citizenship solely because of his entrance into such service;

(D) had resided in the United States for a period or periods aggregating four years during the five-year period ending on the day of, and was domiciled in the United States on the day of, such entrance into such active service; and

(E)(i) was discharged or released from such service under conditions other than dishonorable after active service of ninety days or more or by reason of a disability or injury incurred or aggravated in service in line of duty, or

(ii) died while in such service,

shall be considered a World War II veteran (as defined in subsection (d)(2)) and such service shall be considered to have been performed in the active military or naval service of the United States.

(2) In the case of any individual to whom paragraph (1) applies, proof of support required under section 202(f) or (h) may be filed at any time prior to the expiration of two years after the date of such individual's death or the date of the enactment of this subsection [270], whichever is the later.

VOLUNTARY AGREEMENTS FOR COVERAGE OF STATE AND LOCAL EMPLOYEES [271]

Purpose of Agreement

SEC. 218. [42 U.S.C. 418] (a)(1) The Commissioner of Social Security shall, at the request of any State, enter into an agreement with such State for the purpose of extending the insurance system established by this title to services performed by individuals as employees of such State or any political subdivision thereof. Each such agreement shall contain such provisions, not inconsistent with the provisions of this section, as the State may request.

(2) Notwithstanding section 210(a), for the purposes of this title the term "employment" includes any service included under an agreement entered into under this section.

Definitions

(b) For the purposes of this section—

(1) The term "State" does not include the District of Columbia, Guam, or American Samoa.

(2) The term "political subdivision" includes an instrumentality of (A) a State, (B) one or more political subdivisions of a State, or (C) a State and one or more of its political subdivisions.

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[270] August 28, 1958 [P.L. 85–840; 72 Stat. 1013].

[271] See Vol. II, P.L. 99–272, §12114, with respect to coverage of Connecticut State Police.

See Vol. II, P.L. 100–203, §9008, with respect to modification of the agreement with Iowa to provide coverage for certain policemen and firemen.

(3) The term "employee" includes an officer of a State or political subdivision.

(4) The term "retirement system" means a pension, annuity, retirement, or similar fund or system established by a State or by a political subdivision thereof.

(5) The term "coverage group" means (A) employees of the State other than those engaged in performing service in connection with a proprietary function; (B) employees of a political subdivision of a State other than those engaged in performing service in connection with a proprietary function; (C) employees of a State engaged in performing service in connection with a single proprietary function; or (D) employees of a political subdivision of a State engaged in performing service in connection with a single proprietary function. If under the preceding sentence an employee would be included in more than one coverage group by reason of the fact that he performs service in connection with two or more proprietary functions or in connection with both a proprietary function and a nonproprietary function, he shall be included in only one such coverage group. The determination of the coverage group in which such employee shall be included shall be made in such manner as may be specified in the agreement. Persons employed under section 709 of title 32, United States Code[272], who elected under section 6 of the National Guard Technicians Act of 1968[273] to remain covered by an employee retirement system of, or plan sponsored by, a State or the Commonwealth of Puerto Rico, shall, for the purposes of this Act, be employees of the State or the Commonwealth of Puerto Rico and (notwithstanding the preceding provisions of this paragraph), shall be deemed to be a separate coverage group. For purposes of this section, individuals employed pursuant to an agreement, entered into pursuant to section 205 of the Agricultural Marketing Act of 1946[274] (7 U.S.C. 1624) or section 14 of the Perishable Agricultural Commodities Act, 1930[275] (7 U.S.C. 499n), between a State and the United States Department of Agriculture to perform services as inspectors of agricultural products may be deemed, at the option of the State, to be employees of the State and (notwithstanding the preceding provisions of this paragraph) shall be deemed to be a separate coverage group.

Services Covered

(c)(1) An agreement under this section shall be applicable to any one or more coverage groups designated by the State.

(2) In the case of each coverage group to which the agreement applies, the agreement must include all services (other than services excluded by or pursuant to subsection (d) or paragraph (3), (5), or (6) of this subsection) performed by individuals as members of such group.

(3) Such agreement shall, if the State requests it, exclude (in the case of any coverage group) any one or more of the following:

[272] See Vol. II, Title 32.
[273] See Vol. II, P.L. 90–486.
[274] See Vol. II, P.L. 79–733.
[275] See Vol. II, P.L. 71–325.

(A) All services in any class or classes of (i) elective positions, (ii) part-time positions, or (iii) positions the compensation for which is on a fee basis;

(B) All services performed by individuals as members of a coverage group in positions covered by a retirement system on the date such agreement is made applicable to such coverage group, but only in the case of individuals who, on such date (or, if later, the date on which they first occupy such positions), are not eligible to become members of such system and whose services in such positions have not already been included under such agreement pursuant to subsection (d)(3).

(4) The Commissioner of Social Security shall, at the request of any State, modify the agreement with such State so as to (A) include any coverage group to which the agreement did not previously apply, or (B) include, in the case of any coverage group to which the agreement applies, services previously excluded from the agreement; but the agreement as so modified may not be inconsistent with the provisions of this section applicable in the case of an original agreement with a State. A modification of an agreement pursuant to clause (B) of the preceding sentence may apply to individuals to whom paragraph (3)(B) is applicable (whether or not the previous exclusion of the service of such individuals was pursuant to such paragraph), but only if such individuals are, on the effective date specified in such modification, ineligible to be members of any retirement system or if the modification with respect to such individuals is pursuant to subsection (d)(3).

(5) Such agreement shall, if the State requests it, exclude (in the case of any coverage group) any agricultural labor, or service performed by a student, designated by the State. This paragraph shall apply only with respect to service which is excluded from employment by any provision of section 210(a) other than paragraph (7) of such section and service the remuneration for which is excluded from wages by subparagraph (B) of section 209(a)(7).

(6) Such agreement shall exclude—

(A) service performed by an individual who is employed to relieve him from unemployment,

(B) service performed in a hospital, home, or other institution by a patient or inmate thereof,

(C) covered transportation service (as determined under section 210(k)),

(D) service (other than agricultural labor or service performed by a student) which is excluded from employment by any provision of section 210(a) other than paragraph (7) of such section,

(E) service performed by an individual as an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or other similar emergency, and

(F) service described in section 210(a)(7)(F) which is included as "employment" under section 210(a).

(7) No agreement may be made applicable (either in the original agreement or by any modification thereof) to service performed by any individual to whom paragraph (3)(B) is applicable unless such agreement provides (in the case of each

coverage group involved) either that the service of any individual to whom such paragraph is applicable and who is a member of such coverage group shall continue to be covered by such agreement in case he thereafter becomes eligible to be a member of a retirement system, or that such service shall cease to be so covered when he becomes eligible to be a member of such a system (but only if the agreement is not already applicable to such system pursuant to subsection (d)(3)), whichever may be desired by the State.

(8)(A) Notwithstanding any other provision of this section, the agreement with any State entered into under this section may at the option of the State be modified at any time to exclude service performed by election officials or election workers if the remuneration paid in a calendar year for such service is less than $1,000 with respect to service performed during any calendar year commencing on or after January 1, 1995, ending on or before December 31, 1999, and the adjusted amount determined under subparagraph (B) for any calendar year commencing on or after January 1, 2000, with respect to service performed during such calendar year. Any modification of an agreement pursuant to this paragraph shall be effective with respect to services performed in and after the calendar year in which the modification is mailed or delivered by other means to the Commissioner of Social Security.

(B) For each year after 1999, the Commissioner of Social Security shall adjust the amount referred to in subparagraph (A) at the same time and in the same manner as is provided under section 215(a)(1)(B)(ii) with respect to the amounts referred to in section 215(a)(1)(B)(i), except that—

(i) for purposes of this subparagraph, 1997 shall be substituted for the calendar year referred to in section 215(a)(1)(B)(ii)(II), and

(ii) such amount as so adjusted, if not a multiple of $100, shall be rounded to the next higher multiple of $100 where such amount is a multiple of $50 and to the nearest multiple of $100 in any other case.

The Commissioner of Social Security shall determine and publish in the Federal Register each adjusted amount determined under this subparagraph not later than November 1 preceding the year for which the adjustment is made.

Positions Covered By Retirement Systems

(d)(1) No agreement with any State may be made applicable (either in the original agreement or by any modification thereof) to any service performed by employees as members of any coverage group in positions covered by a retirement system either (A) on the date such agreement is made applicable to such coverage group, or (B) on the date of enactment of the succeeding paragraph of this subsection[276] (except in the case of positions which are, by reason of action by such State or political subdivision thereof, as may be appropriate, taken prior to the date of enactment of such succeeding paragraph, no longer covered by a retirement system on the date referred to in clause (A), and except in the case of positions excluded by paragraph (5)(A)). The preceding sentence shall not be

[276] September 1, 1954 [P.L. 83–761; 68 Stat. 1056].

applicable to any service performed by an employee as a member of any coverage group in a position (other than a position excluded by paragraph (5)(A)) covered by a retirement system on the date an agreement is made applicable to such coverage group if, on such date (or, if later, the date on which such individual first occupies such position), such individual is ineligible to be a member of such system.

(2) It is hereby declared to be the policy of the Congress in enacting the succeeding paragraphs of this subsection that the protection afforded employees in positions covered by a retirement system on the date an agreement under this section is made applicable to service performed in such positions, or receiving periodic benefits under such retirement system at such time, will not be impaired as a result of making the agreement so applicable or as a result of legislative enactment in anticipation thereof.

(3) Notwithstanding paragraph (1), an agreement with a State may be made applicable (either in the original agreement or by any modification thereof) to service performed by employees in positions covered by a retirement system (including positions specified in paragraph (4) but not including positions excluded by or pursuant to paragraph (5)), if the governor of the State, or an official of the State designated by him for the purpose, certifies to the Commissioner of Social Security that the following conditions have been met:

(A) A referendum by secret written ballot was held on the question of whether service in positions covered by such retirement system should be excluded from or included under an agreement under this section;

(B) An opportunity to vote in such referendum was given (and was limited) to eligible employees;

(C) Not less than ninety days' notice of such referendum was given to all such employees;

(D) Such referendum was conducted under the supervision of the governor or an agency or individual designated by him; and

(E) A majority of the eligible employees voted in favor of including service in such positions under an agreement under this section.

An employee shall be deemed an "eligible employee" for purposes of any referendum with respect to any retirement system if, at the time such referendum was held, he was in a position covered by such retirement system and was a member of such system, and if he was in such a position at the time notice of such referendum was given as required by clause (C) of the preceding sentence; except that he shall not be deemed an "eligible employee" if, at the time the referendum was held, he was in a position to which the State agreement already applied, or if he was in a position excluded by or pursuant to paragraph (5). No referendum with respect to a retirement system shall be valid for purposes of this paragraph unless held within the two-year period which ends on the date of execution of the agreement or modification which extends the insurance system established by this title to such retirement system, nor shall any referendum with respect to a retirement system be valid for purposes of this paragraph if held less

than one year after the last previous referendum held with respect to such retirement system.

(4) For the purposes of subsection (c) of this section, the following employees shall be deemed to be a separate coverage group—

(A) all employees in positions which were covered by the same retirement system on the date the agreement was made applicable to such system (other than employees to whose services the agreement already applied on such date);

(B) all employees in positions which became covered by such system at any time after such date; and

(C) all employees in positions which were covered by such system at any time before such date and to whose services the insurance system established by this title has not been extended before such date because the positions were covered by such retirement system (including employees to whose services the agreement was not applicable on such date because such services were excluded pursuant to subsection (c)(3)(B)).

(5)(A) Nothing in paragraph (3) of this subsection shall authorize the extension of the insurance system established by this title to service in any policeman's or fireman's position.

(B) At the request of the State, any class or classes of positions covered by a retirement system which may be excluded from the agreement pursuant to paragraph (3) or (5) of subsection (c), and to which the agreement does not already apply, may be excluded from the agreement at the time it is made applicable to such retirement system; except that, notwithstanding the provisions of paragraph (3)(B) of such subsection, such exclusion may not include any services to which such paragraph (3)(B) is applicable. In the case of any such exclusion, each such class so excluded shall, for purposes of this subsection, constitute a separate retirement system in case of any modification of the agreement thereafter agreed to.

(6)(A) If a retirement system covers positions of employees of the State and positions of employees of one or more political subdivisions of the State, or covers positions of employees of two or more political subdivisions of the State, then, for purposes of the preceding paragraphs of this subsection, there shall, if the State so desires, be deemed to be a separate retirement system with respect to any one or more of the political subdivisions concerned and, where the retirement system covers positions of employees of the State, a separate retirement system with respect to the State or with respect to the State and any one or more of the political subdivisions concerned. Where a retirement system covering positions of employees of a State and positions of employees of one or more political subdivisions of the State, or covering positions of employees of two or more political subdivisions of the State, is not divided into separate retirement systems pursuant to the preceding sentence or pursuant to subparagraph (C), then the State may, for purposes of subsection (e) only, deem the system to be a separate retirement system with respect to any one or more of the political subdivisions concerned and, where the retirement sys-

tem covers positions of employees of the State, a separate retirement system with respect to the State or with respect to the State and any one or more of the political subdivisions concerned.

(B) If a retirement system covers positions of employees of one or more institutions of higher learning, then, for purposes of such preceding paragraphs there shall, if the State so desires, be deemed to be a separate retirement system for the employees of each such institution of higher learning. For the purposes of this subparagraph, the term "institutions of higher learning" includes junior colleges and teachers colleges. If a retirement system covers positions of employees of a hospital which is an integral part of a political subdivision, then, for purposes of the preceding paragraphs there shall, if the State so desires, be deemed to be a separate retirement system for the employees of such hospital.

(C) For the purposes of this subsection, any retirement system established by the State of Alaska, California, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana,[277] Massachusetts, Minnesota, Nevada, New Jersey, New Mexico, New York, North Dakota, Pennsylvania, Rhode Island, Tennessee, Texas, Vermont, Washington, Wisconsin, or Hawaii, or any political subdivision of any such State, which, on, before, or after the date of enactment of this subparagraph[278], is divided into two divisions or parts, one of which is composed of positions of members of such system who desire coverage under an agreement under this section and the other of which is composed of positions of members of such system who do not desire such coverage, shall, if the State so desires and if it is provided that there shall be included in such division or part composed of members desiring such coverage the positions of individuals who become members of such system after such coverage is extended, be deemed to be a separate retirement system with respect to each such division or part. If, in the case of a separate retirement system which is deemed to exist by reason of subparagraph (A) and which has been divided into two divisions or parts pursuant to the first sentence of this subparagraph, individuals become members of such system by reason of action taken by a political subdivision after coverage under an agreement under this section has been extended to the division or part thereof composed of positions of individuals who desire such coverage, the positions of such individuals who become members of such retirement system by reason of the action so taken shall be included in the division or part of such system composed of positions of members who do not desire such coverage if (i) such individuals, on the day before becoming such members, were in the division or part of another separate retirement system (deemed to exist by reason of subparagraph (A)) composed of positions of members of such system who do not desire coverage under an agree-

[277] P.L. 108–203, §416(a), inserted "Kentucky, Louisiana,", effective January 1, 2003.
[278] P.L. 84–880, §104(e), enacted this sentence August 1, 1956.
P.L. 85–840, §315(a)(1), enacted this subparagraph August 28, 1958.

ment under this section, and (ii) all of the positions in the separate retirement system of which such individuals so become members and all of the positions in the separate retirement system referred to in clause (i) would have been covered by a single retirement system if the State had not taken action to provide for separate retirement systems under this paragraph.

(D)(i) The position of any individual which is covered by any retirement system to which subparagraph (C) is applicable shall, if such individual is ineligible to become a member of such system on August 1, 1956, or, if later, the day he first occupies such position, be deemed to be covered by the separate retirement system consisting of the positions of members of the division or part who do not desire coverage under the insurance system established under this title.

(ii) Notwithstanding clause (i), the State may, pursuant to subsection (c)(4)(B) and subject to the conditions of continuation or termination of coverage provided for in subsection (c)(7), modify its agreement under this section to include services performed by all individuals described in clause (i) other than those individuals to whose services the agreement already applies. Such individuals shall be deemed (on and after the effective date of the modification) to be in positions covered by the separate retirement system consisting of the positions of members of the division or part who desire coverage under the insurance system established under this title.

(E) An individual who is in a position covered by a retirement system to which subparagraph (C) is applicable and who is not a member of such system but is eligible to become a member thereof shall, for purposes of this subsection (other than paragraph (8)), be regarded as a member of such system; except that, in the case of any retirement system a division or part of which is covered under the agreement (either in the original agreement or by a modification thereof), which coverage is agreed to prior to 1960, the preceding provisions of this subparagraph shall apply only if the State so requests and any such individual referred to in such preceding provisions shall, if the State so requests, be treated, after division of the retirement system pursuant to such subparagraph (C), the same as individuals in positions referred to in subparagraph (F).

(F) In the case of any retirement system divided pursuant to subparagraph (C), the position of any member of the division or part composed of positions of members who do not desire coverage may be transferred to the separate retirement system composed of positions of members who desire such coverage if it is so provided in a modification of such agreement which is mailed, or delivered by other means, to the Commissioner of Social Security prior to 1970 or, if later, the expiration of two years after the date on which such agreement, or the modification thereof making the agreement applicable to such separate retirement system, as the case may be, is agreed to, but only if, prior

to such modification or such later modification, as the case may be, the individual occupying such position files with the State a written request for such transfer. Notwithstanding subsection (e)(1), any such modification or later modification, providing for the transfer of additional positions within a retirement system previously divided pursuant to subparagraph (C) to the separate retirement system composed of positions of members who desire coverage, shall be effective with respect to services performed after the same effective date as that which was specified in the case of such previous division.

(G) For the purposes of this subsection, in the case of any retirement system of the State of Florida, Georgia, Minnesota, North Dakota, Pennsylvania, Washington, or Hawaii which covers positions of employees of such State who are compensated in whole or in part from grants made to such State under title III, there shall be deemed to be, if such State so desires, a separate retirement system with respect to any of the following:

(i) the positions of such employees;

(ii) the positions of all employees of such State covered by such retirement system who are employed in the department of such State in which the employees referred to in clause (i) are employed; or

(iii) employees of such State covered by such retirement system who are employed in such department of such State in positions other than those referred to in clause (i).

(7) The certification by the governor (or an official of the State designated by him for the purpose) required under paragraph (3) shall be deemed to have been made, in the case of a division or part (created under subparagraph (C) of paragraph (6) or the corresponding provision of prior law) consisting of the positions of members of a retirement system who desire coverage under the agreement under this section, if the governor (or the official so designated) certifies to the Commissioner of Social Security that—

(A) an opportunity to vote by written ballot on the question of whether they wish to be covered under an agreement under this section was given to all individuals who were members of such system at the time the vote was held;

(B) not less than ninety days' notice of such vote was given to all individuals who were members of such system on the date the notice was issued;

(C) the vote was conducted under the supervision of the governor or an agency or individual designated by him; and

(D) such system was divided into two parts or divisions in accordance with the provisions of subparagraphs (C) and (D) of paragraph (6) or the corresponding provision of prior law.

For purposes of this paragraph, an individual in a position to which the State agreement already applied or in a position excluded by or pursuant to paragraph (5) shall not be considered a member of the retirement system.

(8)(A) Notwithstanding paragraph (1), if under the provisions of this subsection an agreement is, after December 31, 1958, made applicable to service performed in positions covered by a retirement system, service performed by an individual in a position covered by such a system may not be excluded from the agreement because such position is also covered under another retirement system.

(B) Subparagraph (A) shall not apply to service performed by an individual in a position covered under a retirement system if such individual, on the day the agreement is made applicable to service performed in positions covered by such retirement system, is not a member of such system and is a member of another system.

(C) If an agreement is made applicable, prior to 1959, to service in positions covered by any retirement system, the preceding provisions of this paragraph shall be applicable in the case of such system if the agreement is modified to so provide.

(D) Except in the case of State agreements modified as provided in subsection (l) and agreements with interstate instrumentalities, nothing in this paragraph shall authorize the application of an agreement to service in any policeman's or fireman's position.

Effective Date of Agreement

(e)(1) Any agreement or modification of an agreement under this section shall be effective with respect to services performed after an effective date specified in such agreement or modification; except that such date may not be earlier than the last day of the sixth calendar year preceding the year in which such agreement or modification, as the case may be, is mailed or delivered by other means to the Commissioner of Social Security.

(2) In the case of service performed by members of any coverage group—

(A) to which an agreement under this section is made applicable, and

(B) with respect to which the agreement, or modification thereof making the agreement so applicable, specifies an effective date earlier than the date of execution of such agreement and such modification, respectively,

the agreement shall, if so requested by the State, be applicable to such services (to the extent the agreement was not already applicable) performed before such date of execution and after such effective date by any individual as a member of such coverage group if he is such a member on a date, specified by the State, which is earlier than such date of execution, except that in no case may the date so specified be earlier than the date such agreement or such modification, as the case may be, is mailed, or delivered by other means, to the Commissioner of Social Security.

(3) Notwithstanding the provisions of paragraph (2) of this subsection, in the case of services performed by individuals as members of any coverage group to which an agreement under this section is made applicable, and with respect to which there were timely paid in good faith to the Secretary of the Treasury amounts equivalent to the sum of the taxes which

would have been imposed by sections 3101 and 3111 of the Internal Revenue Code of 1986[279] had such services constituted employment for purposes of chapter 21 of such Code[280] at the time they were performed, and with respect to which refunds were not obtained, such individuals may, if so requested by the State, be deemed to be members of such coverage group on the date designated pursuant to paragraph (2).

Duration of Agreement

(f) No agreement under this section may be terminated, either in its entirety or with respect to any coverage group, on or after the date of the enactment of the Social Security Amendments of 1983[281].

Instrumentalities of Two or More States

(g)(1) The Commissioner of Social Security may, at the request of any instrumentality of two or more States, enter into an agreement with such instrumentality for the purpose of extending the insurance system established by this title to services performed by individuals as employees of such instrumentality. Such agreement, to the extent practicable, shall be governed by the provisions of this section applicable in the case of an agreement with a State.

(2) In the case of any instrumentality of two or more States, if—

(A) employees of such instrumentality are in positions covered by a retirement system of such instrumentality or of any of such States or any of the political subdivisions thereof, and

(B) such retirement system is (on, before, or after the date of enactment of this paragraph[282]) divided into two divisions or parts, one of which is composed of positions of members of such system who are employees of such instrumentality and who desire coverage under an agreement under this section and the other of which is composed of positions of members of such system who are employees of such instrumentality and who do not desire such coverage, and

(C) it is provided that there shall be included in such division or part composed of the positions of members desiring such coverage the positions of employees of such instrumentality who become members of such system after such coverage is extended,

then such retirement system shall, if such instrumentality so desires, be deemed to be a separate retirement system with respect to each such division or part. An individual who is in a position covered by a retirement system divided pursuant to the preceding sentence and who is not a member of such system but is eligible to become a member thereof shall, for purposes of this subsection, be regarded as a member of such system. Coverage under the agreement of any such individual shall be provided under the same conditions, to the extent practicable, as are applicable in the case

[279] See P.L. 83–591, §§3101 and 3111 (this volume).
[280] See P.L. 83–591, chapter 21 (this volume).
[281] April 20, 1983 [P.L. 98–21; 97 Stat. 65].
[282] August 30, 1957 [P.L. 85–226; 71 Stat. 511].

of the States to which the provisions of subsection (d)(6)(C) apply. The position of any employee of any such instrumentality which is covered by any retirement system to which the first sentence of this paragraph is applicable shall, if such individual is ineligible to become a member of such system on the date of enactment of this paragraph[283] or, if later, the day he first occupies such position, be deemed to be covered by the separate retirement system consisting of the positions of members of the division or part who do not desire coverage under the insurance system established under this title. Services in positions covered by a separate retirement system created pursuant to this subsection (and consisting of the positions of members who desire coverage under an agreement under this section) shall be covered under such agreement on compliance, to the extent practicable, with the same conditions as are applicable to coverage under an agreement under this section of services in positions covered by a separate retirement system created pursuant to subparagraph (C) of subsection (d)(6) or the corresponding provision of prior law (and consisting of the positions of members who desire coverage under such agreement).

(3) Any agreement with any instrumentality of two or more States entered into pursuant to this Act may, notwithstanding the provisions of subsection (d)(5)(A) and the references thereto in subsections (d)(1) and (d)(3), apply to service performed by employees of such instrumentality in any policeman's or fireman's position covered by a retirement system, but only upon compliance, to the extent practicable, with the requirements of subsection (d)(3). For the purpose of the preceding sentence, a retirement system which covers positions of policemen or firemen or both, and other positions shall, if the instrumentality concerned so desires, be deemed to be a separate retirement system with respect to the positions of such policemen or firemen, or both, as the case may be.

Delegation of Functions

(h) The Commissioner of Social Security is authorized, pursuant to agreement with the head of any Federal agency, to delegate any of the Commissioner's functions under this section to any officer or employee of such agency and otherwise to utilize the services and facilities of such agency in carrying out such functions, and payment therefor shall be in advance or by way of reimbursement, as may be provided in such agreement.

Wisconsin Retirement Fund

(i)(1) Notwithstanding paragraph (1) of subsection (d), the agreement with the State of Wisconsin may, subject to the provisions of this subsection, be modified so as to apply to service performed by employees in positions covered by the Wisconsin retirement fund or any successor system.

(2) All employees in positions covered by the Wisconsin retirement fund at any time on or after January 1, 1951, shall, for the purposes of subsection (c) only, be deemed to be a separate coverage group; except that there shall be excluded from

[283] August 30, 1957 [P.L. 85–226; 71 Stat. 511].

such separate coverage group all employees in positions to which the agreement applies without regard to this subsection.

(3) The modification pursuant to this subsection shall exclude (in the case of employees in the coverage group established by paragraph (2) of this subsection) service performed by any individual during any period before he is included under the Wisconsin retirement fund.

(4) The modification pursuant to this subsection shall, if the State of Wisconsin requests it, exclude (in the case of employees in the coverage group established by paragraph (2) of this subsection) all service performed in policemen's positions, all service performed in firemen's positions, or both.

Certain Positions No Longer Covered By Retirement Systems

(j) Notwithstanding subsection (d), an agreement with any State entered into under this section prior to the date of the enactment of this subsection[284] may, prior to January 1, 1958, be modified pursuant to subsection (c)(4) so as to apply to services performed by employees, as members of any coverage group to which such agreement already applies (and to which such agreement applied on such date of enactment), in positions (1) to which such agreement does not already apply, (2) which were covered by a retirement system on the date such agreement was made applicable to such coverage group, and (3) which, by reason of action by such State or political subdivision thereof, as may be appropriate, taken prior to the date of the enactment of this subsection, are no longer covered by a retirement system on the date such agreement is made applicable to such services.

Certain Employees of the State of Utah

(k) Notwithstanding the provisions of subsection (d), the agreement with the State of Utah entered into pursuant to this section may be modified pursuant to subsection (c)(4) so as to apply to services performed for any of the following, the employees performing services for each of which shall constitute a separate coverage group: Weber Junior College, Carbon Junior College, Dixie Junior College, Central Utah Vocational School, Salt Lake Area Vocational School, Center for the Adult Blind, Union High School (Roosevelt, Utah), Utah High School Activities Association, State Industrial School, State Training School, State Board of Education, and Utah School Employees Retirement Board. Any modification agreed to prior to January 1, 1955, may be made effective with respect to services performed by employees as members of any of such coverage groups after an effective date specified therein, except that in no case may any such date be earlier than December 31, 1950. Coverage provided for in this subsection shall not be affected by a subsequent change in the name of a group.

Policemen and Firemen in Certain States

(l) Any agreement with a State entered into pursuant to this section may, notwithstanding the provisions of subsection (d)(5)(A) and the references thereto in subsections (d)(1) and (d)(3), be modi-

[284] September 1, 1954 [P.L. 83–761; 68 Stat. 1058].

fied pursuant to subsection (c)(4) to apply to service performed by employees of such State or any political subdivision thereof in any policeman's or fireman's position covered by a retirement system in effect on or after the date of the enactment of this subsection, but only upon compliance with the requirements of subsection (d)(3). For the purposes of the preceding sentence, a retirement system which covers positions of policemen or firemen, or both, and other positions shall, if the State concerned so desires, be deemed to be a separate retirement system with respect to the positions of such policemen or firemen, or both, as the case may be.

Positions Compensated Solely on a Fee Basis

(m)(1) Notwithstanding any other provision in this section, an agreement entered into under this section may be made applicable to service performed after 1967 in any class or classes of positions compensated solely on a fee basis to which such agreement did not apply prior to 1968 only if the State specifically requests that its agreement be made applicable to such service in such class or classes of positions.

(2) Notwithstanding any other provision in this section, an agreement entered into under this section may be modified, at the option of the State, at any time after 1967, so as to exclude services performed in any class or classes of positions compensation for which is solely on a fee basis.

(3) Any modification made under this subsection shall be effective with respect to services performed after the last day of the calendar year in which the modification is mailed or delivered by other means to the Commissioner of Social Security.

(4) If any class or classes of positions have been excluded from coverage under the State agreement by a modification agreed to under this subsection, the Commissioner of Social Security and the State may not thereafter modify such agreement so as to again make the agreement applicable with respect to such class or classes of positions.

(n)(1) The Commissioner of Social Security shall, at the request of any State, enter into or modify an agreement with such State under this section for the purpose of extending the provisions of title XVIII, and sections 226 and 226A, to services performed by employees of such State or any political subdivision thereof who are described in paragraph (2).

(2) This subsection shall apply only with respect to employees—

(A) whose services are not treated as employment as that term applies under section 210(p) by reason of paragraph (3) of such section; and

(B) who are not otherwise covered under the State's agreement under this section.

(3) For purposes of sections 226 and 226A of this Act, services covered under an agreement pursuant to this subsection shall be treated as "medicare qualified government employment".

(4) Except as otherwise provided in this subsection, the provisions of this section shall apply with respect to services covered under the agreement pursuant to this subsection.

SEC. 219. [Repealed.[285]]

DISABILITY PROVISIONS INAPPLICABLE IF BENEFIT RIGHTS IMPAIRED

SEC. 220. [42 U.S.C. 420] None of the provisions of this title relating to periods of disability shall apply in any case in which their application would result in the denial of monthly benefits or a lump-sum death payment which would otherwise be payable under this title; nor shall they apply in the case of any monthly benefit or lump-sum death payment under this title if such benefit or payment would be greater without their application.

DISABILITY DETERMINATIONS[286]

SEC. 221. [42 U.S.C. 421] (a)(1) In the case of any individual, the determination of whether or not he is under a disability (as defined in section 216(i) or 223(d)) and of the day such disability began, and the determination of the day on which such disability ceases, shall be made by a State agency, notwithstanding any other provision of law, in any State that notifies the Commissioner of Social Security in writing that it wishes to make such disability determinations commencing with such month as the Commissioner of Social Security and the State agree upon, but only if (A) the Commissioner of Social Security has not found, under subsection (b)(1), that the State agency has substantially failed to make disability determinations in accordance with the applicable provisions of this section or rules issued thereunder, and (B) the State has not notified the Commissioner of Social Security, under subsection (b)(2), that it does not wish to make such determinations. If the Commissioner of Social Security once makes the finding described in clause (A) of the preceding sentence, or the State gives the notice referred to in clause (B) of such sentence, the Commissioner of Social Security may thereafter determine whether (and, if so, beginning with which month and under what conditions) the State may again make disability determinations under this paragraph.

(2) The disability determinations described in paragraph (1) made by a State agency shall be made in accordance with the pertinent provisions of this title and the standards and criteria contained in regulations or other written guidelines of the Commissioner of Social Security pertaining to matters such as disability determinations, the class or classes of individuals with respect to which a State may make disability determinations (if it does not wish to do so with respect to all individuals in the State), and the conditions under which it may choose not to make all such determinations. In addition, the Commissioner of Social Security shall promulgate regulations specifying, in such detail as the Commissioner deems appropriate, performance standards and administrative requirements and procedures to be followed in performing the disability determination function in order to assure effective and uniform administration of the disability insurance program throughout the United States. The regulations may, for example, specify matters such as—

[285] P.L. 86–778, §103(j)(1); 74 Stat. 937.

[286] See Vol. II, P.L. 108–203, §413, with respect to the reinstatement of reporting requirements under §221(c)(3)(C) and (i)(3).

(A) the administrative structure and the relationship between various units of the State agency responsible for disability determinations,

(B) the physical location of and relationship among agency staff units, and other individuals or organizations performing tasks for the State agency, and standards for the availability to applicants and beneficiaries of facilities for making disability determinations,

(C) State agency performance criteria, including the rate of accuracy of decisions, the time periods within which determinations must be made, the procedures for and the scope of review by the Commissioner of Social Security, and, as the Commissioner finds appropriate, by the State, of its performance in individual cases and in classes of cases, and rules governing access of appropriate Federal officials to State offices and to State records relating to its administration of the disability determination function,

(D) fiscal control procedures that the State agency may be required to adopt, and

(E) the submission of reports and other data, in such form and at such time as the Commissioner of Social Security may require, concerning the State agency's activities relating to the disability determination.

Nothing in this section shall be construed to authorize the Commissioner of Social Security to take any action except pursuant to law or to regulations promulgated pursuant to law.

(b)(1) If the Commissioner of Social Security finds, after notice and opportunity for a hearing, that a State agency is substantially failing to make disability determinations in a manner consistent with the Commissioner's regulations and other written guidelines, the Commissioner of Social Security shall, not earlier than 180 days following the Commissioner's finding, and after the Commissioner has complied with the requirements of paragraph (3), make the disability determinations referred to in subsection (a)(1).

(2) If a State, having notified the Commissioner of Social Security of its intent to make disability determinations under subsection (a)(1), no longer wishes to make such determinations, it shall notify the Commissioner of Social Security in writing of that fact, and, if an agency of the State is making disability determinations at the time such notice is given, it shall continue to do so for not less than 180 days, or (if later) until the Commissioner of Social Security has complied with the requirements of paragraph (3). Thereafter, the Commissioner of Social Security shall make the disability determinations referred to in subsection (a)(1).

(3)(A) The Commissioner of Social Security shall develop and initiate all appropriate procedures to implement a plan with respect to any partial or complete assumption by the Commissioner of Social Security of the disability determination function from a State agency, as provided in this section, under which employees of the affected State agency who are capable of performing duties in the disability determination process for the Commissioner of Social Security shall, notwithstanding any other provision of law, have a preference over any other individual in filling an appropriate employment position with the Commissioner of Social Security (subject to any system estab-

lished by the Commissioner of Social Security for determining hiring priority among such employees of the State agency) unless any such employee is the administrator, the deputy administrator, or assistant administrator (or his equivalent) of the State agency, in which case the Commissioner of Social Security may accord such priority to such employee.

(B) The Commissioner of Social Security shall not make such assumption of the disability determination function until such time as the Secretary of Labor determines that, with respect to employees of such State agency who will be displaced from their employment on account of such assumption by the Commissioner of Social Security and who will not be hired by the Commissioner of Social Security to perform duties in the disability determination process, the State has made fair and equitable arrangements to protect the interests of employees so displaced. Such protective arrangements shall include only those provisions which are provided under all applicable Federal, State and local statutes including, but not limited to, (i) the preservation of rights, privileges, and benefits (including continuation of pension rights and benefits) under existing collective-bargaining agreements; (ii) the continuation of collective-bargaining rights; (iii) the assignment of affected employees to other jobs or to retraining programs; (iv) the protection of individual employees against a worsening of their positions with respect to their employment; (v) the protection of health benefits and other fringe benefits; and (vi) the provision of severance pay, as may be necessary.

(c)(1) The Commissioner of Social Security may on the Commissioner's own motion or as required under paragraphs (2) and (3) review a determination, made by a State agency under this section, that an individual is or is not under a disability (as defined in section 216(i) or 223(d)) and, as a result of such review, may modify such agency's determination and determine that such individual either is or is not under a disability (as so defined) or that such individual's disability began on a day earlier or later than that determined by such agency, or that such disability ceased on a day earlier or later than that determined by such agency. A review by the Commissioner of Social Security on the Commissioner's own motion of a State agency determination under this paragraph may be made before or after any action is taken to implement such determination.

(2) The Commissioner of Social Security (in accordance with paragraph (3)) shall review determinations, made by State agencies pursuant to this section, that individuals are under disabilities (as defined in section 216(i) or 223(d)). Any review by the Commissioner of Social Security of a State agency determination under this paragraph shall be made before any action is taken to implement such determination.

(3)(A) In carrying out the provisions of paragraph (2) with respect to the review of determinations made by State agencies pursuant to this section that individuals are under disabilities (as defined in section 216(i) or 223(d)), the Commissioner of Social Security shall review—

(i) at least 50 percent of all such determinations made by State agencies on applications for benefits under this title, and

(ii) other determinations made by State agencies pursuant to this section to the extent necessary to assure a high level of accuracy in such other determinations.

(B) In conducting reviews pursuant to subparagraph (A), the Commissioner of Social Security shall, to the extent feasible, select for review those determinations which the Commissioner of Social Security identifies as being the most likely to be incorrect.

(C) Not later than April 1, 1992, and annually thereafter, the Commissioner of Social Security shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a written report setting forth the number of reviews conducted under subparagraph (A)(ii) during the preceding fiscal year and the findings of the Commissioner of Social Security based on such reviews of the accuracy of the determinations made by State agencies pursuant to this section.

(d) Any individual dissatisfied with any determination under subsection (a), (b), (c), or (g) shall be entitled to a hearing thereon by the Commissioner of Social Security to the same extent as is provided in section 205(b) with respect to decisions of the Commissioner of Social Security, and to judicial review of the Commissioner's final decision after such hearing as is provided in section 205(g).

(e) Each State which is making disability determinations under subsection (a)(1) shall be entitled to receive from the Trust Funds, in advance or by way of reimbursement, as determined by the Commissioner of Social Security, the cost to the State of making disability determinations under subsection (a)(1). The Commissioner of Social Security shall from time to time certify such amount as is necessary for this purpose to the Managing Trustee, reduced or increased, as the case may be, by any sum (for which adjustment hereunder has not previously been made) by which the amount certified for any prior period was greater or less than the amount which should have been paid to the State under this subsection for such period; and the Managing Trustee, prior to audit or settlement by the General Accounting Office[287], shall make payment from the Trust Funds at the time or times fixed by the Commissioner of Social Security, in accordance with such certification. Appropriate adjustments between the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund with respect to the payments made under this subsection shall be made in accordance with paragraph (1) of subsection (g) of section 201 (but taking into account any refunds under subsection (f) of this section) to insure that the Federal Disability Insurance Trust Fund is charged with all expenses incurred which are attributable to the administration of section 223 and the

[287] P.L. 108–271, §8(b), provided that any reference to the General Accounting Office in any law, rule, regulation, certificate, directive, instruction, or other official paper in force on July 7, 2004, shall be considered to refer and apply to the Government Accountability Office.

Federal Old-Age and Survivors Insurance Trust Fund is charged with all other expenses.

(f) All money paid to a State under this section shall be used solely for the purposes for which it is paid; and any money so paid which is not used for such purposes shall be returned to the Treasury of the United States for deposit in the Trust Funds.

(g) In the case of individuals in a State which does not undertake to perform disability determinations under subsection (a)(1), or which has been found by the Commissioner of Social Security to have substantially failed to make disability determinations in a manner consistent with the Commissioner's regulations and guidelines, in the case of individuals outside the United States, and in the case of any class or classes of individuals for whom no State undertakes to make disability determinations, the determinations referred to in subsection (a) shall be made by the Commissioner of Social Security in accordance with regulations prescribed by the Commissioner.

(h) An initial determination under subsection (a), (c), (g), or (i) that an individual is not under a disability, in any case where there is evidence which indicates the existence of a mental impairment, shall be made only if the Commissioner of Social Security has made every reasonable effort to ensure that a qualified psychiatrist or psychologist has completed the medical portion of the case review and any applicable residual functional capacity assessment.

(i)(1) In any case where an individual is or has been determined to be under a disability, the case shall be reviewed by the applicable State agency or the Commissioner of Social Security (as may be appropriate), for purposes of continuing eligibility, at least once every 3 years, subject to paragraph (2); except that where a finding has been made that such disability is permanent, such reviews shall be made at such times as the Commissioner of Social Security determines to be appropriate. Reviews of cases under the preceding sentence shall be in addition to, and shall not be considered as a substitute for, any other reviews which are required or provided for under or in the administration of this title.

(2) The requirement of paragraph (1) that cases be reviewed at least every 3 years shall not apply to the extent that the Commissioner of Social Security determines, on a State-by-State basis, that such requirement should be waived to insure that only the appropriate number of such cases are reviewed. The Commissioner of Social Security shall determine the appropriate number of cases to be reviewed in each State after consultation with the State agency performing such reviews, based upon the backlog of pending reviews, the projected number of new applications for disability insurance benefits, and the current and projected staffing levels of the State agency, but the Commissioner of Social Security shall provide for a waiver of such requirement only in the case of a State which makes a good faith effort to meet proper staffing requirements for the State agency and to process case reviews in a timely fashion. The Commissioner of Social Security shall report annually to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives with respect to the determinations made by the Commissioner of Social Security under the preceding sentence.

(3) The Commissioner of Social Security shall report annually to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives with respect to the number of reviews of continuing disability carried out under paragraph (1), the number of such reviews which result in an initial termination of benefits, the number of requests for reconsideration of such initial termination or for a hearing with respect to such termination under subsection (d), or both, and the number of such initial terminations which are overturned as the result of a reconsideration or hearing.

(4) In any case in which the Commissioner of Social Security initiates a review under this subsection of the case of an individual who has been determined to be under a disability, the Commissioner of Social Security shall notify such individual of the nature of the review to be carried out, the possibility that such review could result in the termination of benefits, and the right of the individual to provide medical evidence with respect to such review.

(5) For suspension of reviews under this subsection in the case of an individual using a ticket to work and self–sufficiency, see section 1148(i).

(j) The Commissioner of Social Security shall prescribe regulations which set forth, in detail—

(1) the standards to be utilized by State disability determination services and Federal personnel in determining when a consultative examination should be obtained in connection with disability determinations;

(2) standards for the type of referral to be made; and

(3) procedures by which the Commissioner of Social Security will monitor both the referral processes used and the product of professionals to whom cases are referred.

Nothing in this subsection shall be construed to preclude the issuance, in accordance with section 553(b)(A) of title 5, United States Code, of interpretive rules, general statements of policy, and rules of agency organization relating to consultative examinations if such rules and statements are consistent with such regulations.

(k)(1) The Commissioner of Social Security shall establish by regulation uniform standards which shall be applied at all levels of determination, review, and adjudication in determining whether individuals are under disabilities as defined in section 216(i) or 223(d).

(2) Regulations promulgated under paragraph (1) shall be subject to the rulemaking procedures established under section 553 of title 5, United States Code[288].

(l)(1) In any case where an individual who is applying for or receiving benefits under this title on the basis of disability by reason of blindness is entitled to receive notice from the Commissioner of Social Security of any decision or determination made or other action taken or proposed to be taken with respect to his or her rights under this title, such individual shall at his or her election be entitled either (A) to receive a supplementary notice of such decision, determination, or action, by telephone, within 5 working days after the initial notice is mailed, (B) to receive the initial notice in the form of a certified letter, or (C) to receive notification by some al-

[288] See Vol. II, Title 5.

ternative procedure established by the Commissioner of Social Security and agreed to by the individual.

(2) The election under paragraph (1) may be made at any time, but an opportunity to make such an election shall in any event be given, to every individual who is an applicant for benefits under this title on the basis of disability by reason of blindness, at the time of his or her application. Such an election, once made by an individual, shall apply with respect to all notices of decisions, determinations, and actions which such individual may thereafter be entitled to receive under this title until such time as it is revoked or changed.

(m)(1) In any case where an individual entitled to disability insurance benefits under section 223 or to monthly insurance benefits under section 202 based on such individual's disability (as defined in section 223(d)) has received such benefits for at least 24 months—

(A) no continuing disability review conducted by the Commissioner may be scheduled for the individual solely as a result of the individual's work activity;

(B) no work activity engaged in by the individual may be used as evidence that the individual is no longer disabled; and

(C) no cessation of work activity by the individual may give rise to a presumption that the individual is unable to engage in work.

(2) An individual to which paragraph (1) applies shall continue to be subject to—

(A) continuing disability reviews on a regularly scheduled basis that is not triggered by work; and

(B) termination of benefits under this title in the event that the individual has earnings that exceed the level of earnings established by the Commissioner to represent substantial gainful activity.

REHABILITATION SERVICES

Referral for Rehabilitation Services

SEC. 222. [42 U.S.C. 422] (a) [Repealed.[289]]
(b) [Repealed.[290]]

Period of Trial Work

(c)(1) The term "period of trial work", with respect to an individual entitled to benefits under section 223, 202(d), 202(e), or 202(f), means a period of months beginning and ending as provided in paragraphs (3) and (4).

(2) For purposes of sections 216(i) and 223, any services rendered by an individual during a period of trial work shall be deemed not to have been rendered by such individual in determining whether his disability has ceased in a month during such period. For purposes of this subsection the term "services" means activity (whether legal or illegal) which is performed for remuneration or gain or is determined by the Commissioner of

[289] P.L. 106-170, §101(b)(1)(B); 113 Stat.1873.
[290] P.L. 106-170, §101(b)(1)(C); 113 Stat.1873.

Social Security to be of a type normally performed for remuneration or gain.

(3) A period of trial work for any individual shall begin with the month in which he becomes entitled to disability insurance benefits, or, in the case of an individual entitled to benefits under section 202(d) who has attained the age of eighteen, with the month in which he becomes entitled to such benefits or the month in which he attains the age of eighteen, whichever is later, or, in the case of an individual entitled to widow's or widower's insurance benefits under section 202(e) or (f) who became entitled to such benefits prior to attaining age 60, with the month in which such individual becomes so entitled. Notwithstanding the preceding sentence, no period of trial work may begin for any individual prior to the beginning of the month following the month in which this paragraph is enacted[291]; and no such period may begin for an individual in a period of disability of such individual in which he had a previous period of trial work.

(4) A period of trial work for any individual shall end with the close of whichever of the following months is the earlier:

(A) the ninth month, in any period of 60 consecutive months, in which the individual renders services (whether or not such nine months are consecutive); or

(B) the month in which his disability (as defined in section 223(d)) ceases (as determined after application of paragraph (2) of this subsection).

(5)[292] Upon conviction by a Federal court that an individual has fraudulently concealed work activity during a period of trial work from the Commissioner of Social Security by—

(A) providing false information to the Commissioner of Social Security as to whether the individual had earnings in or for a particular period, or as to the amount thereof;

(B) receiving disability insurance benefits under this title while engaging in work activity under another identity, including under another social security account number or a number purporting to be a social security account number; or

(C) taking other actions to conceal work activity with an intent fraudulently to secure payment in a greater amount than is due or when no payment is authorized,

no benefit shall be payable to such individual under this title with respect to a period of disability for any month before such conviction during which the individual rendered services during the period of trial work with respect to which the fraudulently concealed work activity occurred, and amounts otherwise due under this title as restitution, penalties, assessments, fines, or other repayments shall in all cases be in addition to any amounts for which such individual is liable as overpayments by reason of such concealment.

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[291] The month is October 1960; the paragraph was enacted on September 13, 1960, as part of P.L. 86–778 [74 Stat. 968].

[292] P.L. 108–203, §208(a), added paragraph (5), applicable to work activity performed after March 2, 2004.

Costs of Rehabilitation Services From Trust Funds

(d)(1) For purposes of making vocational rehabilitation services more readily available to disabled individuals who are—

(A) entitled to disability insurance benefits under section 223,

(B) entitled to child's insurance benefits under section 202(d) after having attained age 18 (and are under a disability),

(C) entitled to widow's insurance benefits under section 202(e) prior to attaining age 60, or

(D) entitled to widower's insurance benefits under section 202(f) prior to attaining age 60,

to the end that savings will accrue to the Trust Funds as a result of rehabilitating such individuals, there are authorized to be transferred from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund each fiscal year such sums as may be necessary to enable the Commissioner of Social Security to reimburse the State for the reasonable and necessary costs of vocational rehabilitation services furnished such individuals (including services during their waiting periods), under a State plan for vocational rehabilitation services approved under title I of the Rehabilitation Act of 1973[293] (29 U.S.C. 701 et seq.), (i) in cases where the furnishing of such services results in the performance by such individuals of substantial gainful activity for a continuous period of nine months, (ii) in cases where such individuals receive benefits as a result of section 225(b) (except that no reimbursement under this paragraph shall be made for services furnished to any individual receiving such benefits for any period after the close of such individual's ninth consecutive month of substantial gainful activity or the close of the month in which his or her entitlement to such benefits ceases, whichever first occurs), and (iii) in cases where such individuals, without good cause, refuse to continue to accept vocational rehabilitation services or fail to cooperate in such a manner as to preclude their successful rehabilitation. The determination that the vocational rehabilitation services contributed to the successful return of an individual to substantial gainful activity, the determination that an individual, without good cause, refused to continue to accept vocational rehabilitation services or failed to cooperate in such a manner as to preclude successful rehabilitation, and the determination of the amount of costs to be reimbursed under this subsection shall be made by the Commissioner of Social Security in accordance with criteria formulated by the Commissioner.

(2) In the case of any State which is unwilling to participate or does not have a plan which meets the requirements of paragraph (1), the Commissioner of Social Security may provide such services in such State by agreement or contract with other public or private agencies, organizations, institutions, or individuals. The provision of such services shall be subject to the same conditions as otherwise apply under paragraph (1).

(3) Payments under this subsection shall be made in advance or by way of reimbursement, with necessary adjustments for overpayments and underpayments.

[293] P.L. 93–112.

(4) Money paid from the Trust Funds under this subsection for the reimbursement of the costs of providing services to individuals who are entitled to benefits under section 223 (including services during their waiting periods), or who are entitled to benefits under section 202(d) on the basis of the wages and self-employment income of such individuals, shall be charged to the Federal Disability Insurance Trust Fund, and all other money paid from the Trust Funds under this subsection shall be charged to the Federal Old-Age and Survivors Insurance Trust Fund. The Commissioner of Social Security shall determine according to such methods and procedures as the Commissioner may deem appropriate—

(A) the total amount to be reimbursed for the cost of services under this subsection, and

(B) subject to the provisions of the preceding sentence, the amount which should be charged to each of the Trust Funds.

(5) For purposes of this subsection the term "vocational rehabilitation services" shall have the meaning assigned to it in title I of the Rehabilitation Act of 1973[294] (29 U.S.C. 701 et seq.), except that such services may be limited in type, scope, or amount in accordance with regulations of the Commissioner of Social Security designed to achieve the purpose of this subsection.

Treatment Referrals for Individuals With An Alcoholism or Drug Addiction Condition

(e) In the case of any individual whose benefits under this title are paid to a representative payee pursuant to section 205(j)(1)(B), the Commissioner of Social Security shall refer such individual to the appropriate State agency administering the State plan for substance abuse treatment services approved under subpart II of part B of title XIX of the Public Health Service Act (42 U.S.C. 300x–21 et seq.).

DISABILITY INSURANCE BENEFIT PAYMENTS[295]

Disability Insurance Benefits

SEC. 223. [42 U.S.C. 423] (a)(1) Every individual who—

(A) is insured for disability insurance benefits (as determined under subsection (c)(1)),

(B) has not attained retirement age (as defined in section 216(l)),

(C)[296] if not a United States citizen or national—

(i) has been assigned a social security account number that was, at the time of assignment, or at any

[294] P.L. 93–112.

[295] See Vol. II, P.L. 96–265, §505(a) [as amended by P.L. 101–239], with respect to experiments and demonstration projects regarding work activity of disabled beneficiaries, and §505(c), with respect to the Secretary's report to Congress on the experiments and demonstration projects conducted.

See Vol. II, P.L. 97–248, §278(d), with respect to deemed entitlement for hospital insurance benefits purposes.

See Vol. II, P.L. 106–170, §302, with respect to demonstration projects providing for reductions in disability benefits based on earnings.

[296] P.L. 108–203, §211(b)(2), added this subparagraph (C), applicable to benefit applications based on social security account numbers issued on or after January 1, 2004.

later time, consistent with the requirements of subclause (I) or (III) of section 205(c)(2)(B)(i); or

(ii) at the time any quarters of coverage are earned—

(I) is described in subparagraph (B) or (D) of section 101(a)(15) of the Immigration and Nationality Act,

(II) is lawfully admitted temporarily to the United States for business (in the case of an individual described in such subparagraph (B)) or the performance as a crewman (in the case of an individual described in such subparagraph (D)), and

(III) the business engaged in or service as a crewman performed is within the scope of the terms of such individual's admission to the United States.

(D)[297] has filed application for disability insurance benefits, and

(E)[298] is under a disability (as defined in subsection (d)) shall be entitled to a disability insurance benefit (i) for each month beginning with the first month after his waiting period (as defined in subsection (c)(2)) in which he becomes so entitled to such insurance benefits, or (ii) for each month beginning with the first month during all of which he is under a disability and in which he becomes so entitled to such insurance benefits, but only if he was entitled to disability insurance benefits which terminated, or had a period of disability (as defined in section 216(i)) which ceased, within the 60-month period preceding the first month in which he is under such disability, and ending with the month preceding whichever of the following months is the earliest: the month in which he dies, the month in which he attains retirement age (as defined in section 216(l)), or, subject to subsection (e), the termination month. For purposes of the preceding sentence, the termination month for any individual shall be the third month following the month in which his disability ceases; except that, in the case of an individual who has a period of trial work which ends as determined by application of section 222(c)(4)(A), the termination month shall be the earlier of (I) the third month following the earliest month after the end of such period of trial work with respect to which such individual is determined to no longer be suffering from a disabling physical or mental impairment, or (II) the third month following the earliest month in which such individual engages or is determined able to engage in substantial gainful activity, but in no event earlier than the first month occurring after the 36 months following such period of trial work in which he engages or is determined able to engage in substantial gainful activity. No payment under this paragraph may be made to an individual who would not meet the definition of disability in subsection (d) except for paragraph (1)(B) thereof for any month in which he engages in substantial gainful activity, and no payment may be made for such month under subsection (b), (c), or (d) of section 202 to any person on the basis of the wages and self-employment income of such individual. In the

[297] P.L. 108–203, §211(b)(1), redesignated the former subparagraph (C) as subparagraph (D).
[298] P.L. 108–203, §211(b)(1), redesignated the former subparagraph (D) as subparagraph (E).

case of a deceased individual, the requirement of subparagraph (C) may be satisfied by an application for benefits filed with respect to such individual within 3 months after the month in which he died.

(2) Except as provided in section 202(q) and section 215(b)(2)(A)(ii), such individual's disability insurance benefit for any month shall be equal to his primary insurance amount for such month determined under section 215 as though he had attained age 62 in—

(A) the first month of his waiting period, or

(B) in any case in which clause (ii) of paragraph (1) of this subsection is applicable, the first month for which he becomes entitled to such disability insurance benefits,

and as though he had become entitled to old-age insurance benefits in the month in which the application for disability insurance benefits was filed and he was entitled to an old-age insurance benefit for each month for which (pursuant to subsection (b)) he was entitled to a disability insurance benefit. For the purposes of the preceding sentence, in the case of an individual who attained age 62 in or before the first month referred to in subparagraph (A) or (B) of such sentence, as the case may be, the elapsed years referred to in section 215(b)(3) shall not include the year in which he attained age 62, or any year thereafter.

Filing of Application

(b) An application for disability insurance benefits filed before the first month in which the applicant satisfies the requirements for such benefits (as prescribed in subsection (a)(1)) shall be deemed a valid application (and shall be deemed to have been filed in such first month) only if the applicant satisfies the requirements for such benefits before the Commissioner of Social Security makes a final decision on the application and no request under section 205(b) for notice and opportunity for a hearing thereon is made, or if such a request is made, before a decision based upon the evidence adduced at the hearing is made (regardless of whether such decision becomes the final decision of the Commissioner of Social Security). An individual who would have been entitled to a disability insurance benefit for any month had he filed application therefor before the end of such month shall be entitled to such benefit for such month if such application is filed before the end of the 12th month immediately succeeding such month.

Definitions of Insured Status and Waiting Period

(c) For purposes of this section—

(1) An individual shall be insured for disability insurance benefits in any month if—

(A) he would have been a fully insured individual (as defined in section 214) had he attained age 62 and filed application for benefits under section 202(a) on the first day of such month, and

(B)(i) he had not less than 20 quarters of coverage during the 40-quarter period which ends with the quarter in which such month occurred, or

(ii) if such month ends before the quarter in which he attains (or would attain) age 31, not less than one-half (and not less than 6) of the quarters during the

period ending with the quarter in which such month occurred and beginning after he attained the age of 21 were quarters of coverage, or (if the number of quarters in such period is less than 12) not less than 6 of the quarters in the 12-quarter period ending with such quarter were quarters of coverage, or

(iii) in the case of an individual (not otherwise insured under clause (i)) who, by reason of section 216(i)(3)(B)(ii), had a prior period of disability that began during a period before the quarter in which he or she attained age 31, not less than one-half of the quarters beginning after such individual attained age 21 and ending with the quarter in which such month occurs are quarters of coverage, or (if the number of quarters in such period is less than 12) not less than 6 of the quarters in the 12-quarter period ending with such quarter are quarters of coverage;

except that the provisions of subparagraph (B) of this paragraph shall not apply in the case of an individual who is blind (within the meaning of "blindness" as defined in section 216(i)(1)). For purposes of subparagraph (B) of this paragraph, when the number of quarters in any period is an odd number, such number shall be reduced by one, and a quarter shall not be counted as part of any period if any part of such quarter was included in a period of disability unless such quarter was a quarter of coverage.

(2) The term "waiting period" means, in the case of any application for disability insurance benefits, the earliest period of five consecutive calendar months—

(A) throughout which the individual with respect to whom such application is filed has been under a disability, and

(B)(i) which begins not earlier than with the first day of the seventeenth month before the month in which such application is filed if such individual is insured for disability insurance benefits in such seventeenth month, or (ii) if he is not so insured in such month, which begins not earlier than with the first day of the first month after such seventeenth month in which he is so insured.

Notwithstanding the preceding provisions of this paragraph, no waiting period may begin for any individual before January 1, 1957.

Definition of Disability

(d)(1) The term "disability" means—

(A) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months; or

(B) in the case of an individual who has attained the age of 55 and is blind (within the meaning of "blindness" as defined in section 216(i)(1)), inability by reason of such blindness to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful ac-

tivity in which he has previously engaged with some regularity and over a substantial period of time.

(2) For purposes of paragraph (1)(A)—

(A) An individual shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. For purposes of the preceding sentence (with respect to any individual), "work which exists in the national economy" means work which exists in significant numbers either in the region where such individual lives or in several regions of the country.

(B) In determining whether an individual's physical or mental impairment or impairments are of a sufficient medical severity that such impairment or impairments could be the basis of eligibility under this section, the Commissioner of Social Security shall consider the combined effect of all of the individual's impairments without regard to whether any such impairment, if considered separately, would be of such severity. If the Commissioner of Social Security does find a medically severe combination of impairments, the combined impact of the impairments shall be considered throughout the disability determination process.

(C) An individual shall not be considered to be disabled for purposes of this title if alcoholism or drug addiction would (but for this subparagraph) be a contributing factor material to the Commissioner's determination that the individual is disabled.

(3) For purposes of this subsection, a "physical or mental impairment" is an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.

(4)(A) The Commissioner of Social Security shall by regulations prescribe the criteria for determining when services performed or earnings derived from services demonstrate an individual's ability to engage in substantial gainful activity. No individual who is blind shall be regarded as having demonstrated an ability to engage in substantial gainful activity on the basis of earnings that do not exceed an amount equal to the exempt amount which would be applicable under section 203(f)(8), to individuals described in subparagraph (D) thereof, if section 102 of the Senior Citizens' Right to Work Act of 1996 had not been enacted. Notwithstanding the provisions of paragraph (2), an individual whose services or earnings meet such criteria shall, except for purposes of section 222(c), be found not to be disabled. In determining whether an individual is able to engage in substantial gainful activity by reason of his earnings, where his disability is sufficiently severe to result in a functional limitation requiring assistance in order for him to

work, there shall be excluded from such earnings an amount equal to the cost (to such individual) of any attendant care services, medical devices, equipment, prostheses, and similar items and services (not including routine drugs or routine medical services unless such drugs or services are necessary for the control of the disabling condition) which are necessary (as determined by the Commissioner of Social Security in regulations) for that purpose, whether or not such assistance is also needed to enable him to carry out his normal daily functions; except that the amount to be excluded shall be subject to such reasonable limits as the Commissioner of Social Security may prescribe.

(B) In determining under subparagraph (A) when services performed or earnings derived from services demonstrate an individual's ability to engage in substantial gainful activity, the Commissioner of Social Security shall apply the criteria described in subparagraph (A) with respect to services performed by any individual without regard to the legality of such services.

(5)(A) An individual shall not be considered to be under a disability unless he furnishes such medical and other evidence of the existence thereof as the Commissioner of Social Security may require. An individual's statement as to pain or other symptoms shall not alone be conclusive evidence of disability as defined in this section; there must be medical signs and findings, established by medically acceptable clinical or laboratory diagnostic techniques, which show the existence of a medical impairment that results from anatomical, physiological, or psychological abnormalities which could reasonably be expected to produce the pain or other symptoms alleged and which, when considered with all evidence required to be furnished under this paragraph (including statements of the individual or his physician as to the intensity and persistence of such pain or other symptoms which may reasonably be accepted as consistent with the medical signs and findings), would lead to a conclusion that the individual is under a disability. Objective medical evidence of pain or other symptoms established by medically acceptable clinical or laboratory techniques (for example, deteriorating nerve or muscle tissue) must be considered in reaching a conclusion as to whether the individual is under a disability. Any non-Federal hospital, clinic, laboratory, or other provider of medical services, or physician not in the employ of the Federal Government, which supplies medical evidence required and requested by the Commissioner of Social Security under this paragraph shall be entitled to payment from the Commissioner of Social Security for the reasonable cost of providing such evidence.

(B) In making any determination with respect to whether an individual is under a disability or continues to be under a disability, the Commissioner of Social Security shall consider all evidence available in such individual's case record, and shall develop a complete medical history of at least the preceding twelve months for any case in which a determination is made that the individual is not under a disability. In making any determination the Commissioner of Social Security shall make every reasonable

effort to obtain from the individual's treating physician (or other treating health care provider) all medical evidence, including diagnostic tests, necessary in order to properly make such determination, prior to evaluating medical evidence obtained from any other source on a consultative basis.

(6)(A) Notwithstanding any other provision of this title, any physical or mental impairment which arises in connection with the commission by an individual (after the date of the enactment of this paragraph[299]) of an offense which constitutes a felony under applicable law and for which such individual is subsequently convicted, or which is aggravated in connection with such an offense (but only to the extent so aggravated), shall not be considered in determining whether an individual is under a disability.

(B) Notwithstanding any other provision of this title, any physical or mental impairment which arises in connection with an individual's confinement in a jail, prison, or other penal institution or correctional facility pursuant to such individual's conviction of an offense (committed after the date of the enactment of this paragraph) constituting a felony under applicable law, or which is aggravated in connection with such a confinement (but only to the extent so aggravated), shall not be considered in determining whether such individual is under a disability for purposes of benefits payable for any month during which such individual is so confined.

(e)(1) No benefit shall be payable under subsection (d)(1)(B)(ii), (d)(6)(A)(ii), (d)(6)(B), (e)(1)(B)(ii), or (f)(1)(B)(ii) of section 202 or under subsection (a)(1) of this section to an individual for any month, after the third month, in which he engages in substantial gainful activity during the 36-month period following the end of his trial work period determined by application of section 222(c)(4)(A).

(2) No benefit shall be payable under section 202 on the basis of the wages and self-employment income of an individual entitled to a benefit under subsection (a)(1) of this section for any month for which the benefit of such individual under subsection (a)(1) is not payable under paragraph (1).

Standard of Review for Termination of Disability Benefits

(f) A recipient of benefits under this title or title XVIII based on the disability of any individual may be determined not to be entitled to such benefits on the basis of a finding that the physical or mental impairment on the basis of which such benefits are provided has ceased, does not exist, or is not disabling only if such finding is supported by—

(1)substantial evidence which demonstrates that—

(A)there has been any medical improvement in the individual's impairment or combination of impairments (other than medical improvement which is not related to the individual's ability to work), and

(B)the individual is now able to engage in substantial gainful activity; or

(2) substantial evidence which—

[299] October 19, 1980 [P.L. 96–473; 94 Stat. 2263].

(A) consists of new medical evidence and a new assessment of the individual's residual functional capacity, and demonstrates that—

(i) although the individual has not improved medically, he or she is nonetheless a beneficiary of advances in medical or vocational therapy or technology (related to the individual's ability to work), and

(ii) the individual is now able to engage in substantial gainful activity, or

(B) demonstrates that—

(i) although the individual has not improved medically, he or she has undergone vocational therapy (related to the individual's ability to work), and

(ii) the individual is now able to engage in substantial gainful activity; or

(3) substantial evidence which demonstrates that, as determined on the basis of new or improved diagnostic techniques or evaluations, the individual's impairment or combination of impairments is not as disabling as it was considered to be at the time of the most recent prior decision that he or she was under a disability or continued to be under a disability, and that therefore the individual is able to engage in substantial gainful activity; or

(4) substantial evidence (which may be evidence on the record at the time any prior determination of the entitlement to benefits based on disability was made, or newly obtained evidence which relates to that determination) which demonstrates that a prior determination was in error.

Nothing in this subsection shall be construed to require a determination that a recipient of benefits under this title or title XVIII based on an individual's disability is entitled to such benefits if the prior determination was fraudulently obtained or if the individual is engaged in substantial gainful activity, cannot be located, or fails, without good cause, to cooperate in a review of the entitlement to such benefits or to follow prescribed treatment which would be expected to restore his or her ability to engage in substantial gainful activity. In making for purposes of the preceding sentence any determination relating to fraudulent behavior by any individual or failure by any individual without good cause to cooperate or to take any required action, the Commissioner of Social Security shall specifically take into account any physical, mental, educational, or linguistic limitation such individual may have (including any lack of facility with the English language). Any determination under this section shall be made on the basis of all the evidence available in the individual's case file, including new evidence concerning the individual's prior or current condition which is presented by the individual or secured by the Commissioner of Social Security. Any determination made under this section shall be made on the basis of the weight of the evidence and on a neutral basis with regard to the individual's condition, without any initial inference as to the presence or absence of disability being drawn from the fact that the individual has previously been determined to be disabled. For purposes of this subsection, a benefit under this title is based on an individual's disability if it is a disability insurance benefit, a child's, widow's, or widower's insurance benefit based on disability, or a mother's or father's insurance benefit

based on the disability of the mother's or father's child who has attained age 16.

Continued Payment of Disability Benefits During Appeal

(g)(1) In any case where—

(A) an individual is a recipient of disability insurance benefits, or of child's, widow's, or widower's insurance benefits based on disability,

(B) the physical or mental impairment on the basis of which such benefits are payable is found to have ceased, not to have existed, or to no longer be disabling, and as a consequence such individual is determined not to be entitled to such benefits, and

(C) a timely request for a hearing under section 221(d), or for an administrative review prior to such hearing, is pending with respect to the determination that he is not so entitled,

such individual may elect (in such manner and form and within such time as the Commissioner of Social Security shall by regulations prescribe) to have the payment of such benefits, the payment of any other benefits under this title based on such individual's wages and self-employment income, the payment of mother's or father's insurance benefits to such individual's mother or father based on the disability of such individual as a child who has attained age 16, and the payment of benefits under title XVIII based on such individual's disability, continued for an additional period beginning with the first month beginning after the date of the enactment of this subsection[300] for which (under such determination) such benefits are no longer otherwise payable, and ending with the earlier of (i) the month preceding the month in which a decision is made after such a hearing, or (ii) the month preceding the month in which no such request for a hearing or an administrative review is pending.

(2)(A) If an individual elects to have the payment of his benefits continued for an additional period under paragraph (1), and the final decision of the Commissioner of Social Security affirms the determination that he is not entitled to such benefits, any benefits paid under this title pursuant to such election (for months in such additional period) shall be considered overpayments for all purposes of this title, except as otherwise provided in subparagraph (B).

(B) If the Commissioner of Social Security determines that the individual's appeal of his termination of benefits was made in good faith, all of the benefits paid pursuant to such individual's election under paragraph (1) shall be subject to waiver consideration under the provisions of section 204. In making for purposes of this subparagraph any determination of whether any individual's appeal is made in good faith, the Commissioner of Social Security shall specifically take into account any physical, mental, educational, or linguistic limitation such individual may have (including any lack of facility with the English language).

[300] January 12, 1983 [P.L. 97–455; 96 Stat. 2497].

Interim Benefits in Cases of Delayed Final Decisions

(h)(1) In any case in which an administrative law judge has determined after a hearing as provided under section 205(b) that an individual is entitled to disability insurance benefits or child's, widow's, or widower's insurance benefits based on disability and the Commissioner of Social Security has not issued the Commissioner's final decision in such case within 110 days after the date of the administrative law judge's determination, such benefits shall be currently paid for the months during the period beginning with the month preceding the month in which such 110–day period expires and ending with the month preceding the month in which such final decision is issued.

(2) For purposes of paragraph (1), in determining whether the 110-day period referred to in paragraph (1) has elapsed, any period of time for which the action or inaction of such individual or such individual's representative without good cause results in the delay in the issuance of the Commissioner's final decision shall not be taken into account to the extent that such period of time exceeds 20 calendar days.

(3) Any benefits currently paid under this title pursuant to this subsection (for the months described in paragraph (1)) shall not be considered overpayments for any purpose of this title (unless payment of such benefits was fraudulently obtained), and such benefits shall not be treated as past-due benefits for purposes of section 206(b)(1).

Reinstatement of Entitlement

(i)(1)(A) Entitlement to benefits described in subparagraph (B)(i)(I) shall be reinstated in any case where the Commissioner determines that an individual described in subparagraph (B) has filed a request for reinstatement meeting the requirements of paragraph (2)(A) during the period prescribed in subparagraph (C). Reinstatement of such entitlement shall be in accordance with the terms of this subsection.

(B) An individual is described in this subparagraph if—

(i) prior to the month in which the individual files a request for reinstatement—

(I) the individual was entitled to benefits under this section or section 202 on the basis of disability pursuant to an application filed therefor; and

(II) such entitlement terminated due to the performance of substantial gainful activity;

(ii) the individual is under a disability and the physical or mental impairment that is the basis for the finding of disability is the same as (or related to) the physical or mental impairment that was the basis for the finding of disability that gave rise to the entitlement described in clause (i); and

(iii) the individual's disability renders the individual unable to perform substantial gainful activity.

(C)(i) Except as provided in clause (ii), the period prescribed in this subparagraph with respect to an individual is 60 consecutive months beginning with the month following the most recent month for which the individual was

entitled to a benefit described in subparagraph (B)(i)(I) prior to the entitlement termination described in subparagraph (B)(i)(II).

(ii) In the case of an individual who fails to file a reinstatement request within the period prescribed in clause (i), the Commissioner may extend the period if the Commissioner determines that the individual had good cause for the failure to so file.

(2)(A)(i) A request for reinstatement shall be filed in such form, and containing such information, as the Commissioner may prescribe.

(ii) A request for reinstatement shall include express declarations by the individual that the individual meets the requirements specified in clauses (ii) and (iii) of paragraph (1)(B).

(B) A request for reinstatement filed in accordance with subparagraph (A) may constitute an application for benefits in the case of any individual who the Commissioner determines is not entitled to reinstated benefits under this subsection.

(3) In determining whether an individual meets the requirements of paragraph (1)(B)(ii), the provisions of subsection (f) shall apply.

(4)(A)(i) Subject to clause (ii), entitlement to benefits reinstated under this subsection shall commence with the benefit payable for the month in which a request for reinstatement is filed.

(ii) An individual whose entitlement to a benefit for any month would have been reinstated under this subsection had the individual filed a request for reinstatement before the end of such month shall be entitled to such benefit for such month if such request for reinstatement is filed before the end of the twelfth month immediately succeeding such month.

(B)(i) Subject to clauses (ii) and (iii), the amount of the benefit payable for any month pursuant to the reinstatement of entitlement under this subsection shall be determined in accordance with the provisions of this title.

(ii) For purposes of computing the primary insurance amount of an individual whose entitlement to benefits under this section is reinstated under this subsection, the date of onset of the individual's disability shall be the date of onset used in determining the individual's most recent period of disability arising in connection with such benefits payable on the basis of an application.

(iii) Benefits under this section or section 202 payable for any month pursuant to a request for reinstatement filed in accordance with paragraph (2) shall be reduced by the amount of any provisional benefit paid to such individual for such month under paragraph (7).

(C) No benefit shall be payable pursuant to an entitlement reinstated under this subsection to an individual for any month in which the individual engages in substantial gainful activity.

(D) The entitlement of any individual that is reinstated under this subsection shall end with the benefits payable for the month preceding whichever of the following months is the earliest:

(i) The month in which the individual dies.

(ii) The month in which the individual attains retirement age.

(iii) The third month following the month in which the individual's disability ceases.

(5) Whenever an individual's entitlement to benefits under this section is reinstated under this subsection, entitlement to benefits payable on the basis of such individual's wages and self–employment income may be reinstated with respect to any person previously entitled to such benefits on the basis of an application if the Commissioner determines that such person satisfies all the requirements for entitlement to such benefits except requirements related to the filing of an application. The provisions of paragraph (4) shall apply to the reinstated entitlement of any such person to the same extent that they apply to the reinstated entitlement of such individual.

(6) An individual to whom benefits are payable under this section or section 202 pursuant to a reinstatement of entitlement under this subsection for 24 months (whether or not consecutive) shall, with respect to benefits so payable after such twenty–fourth month, be deemed for purposes of paragraph (1)(B)(i)(I) and the determination, if appropriate, of the termination month in accordance with subsection (a)(1) of this section, or subsection (d)(1), (e)(1), or (f)(1) of section 202, to be entitled to such benefits on the basis of an application filed therefor.

(7)(A) An individual described in paragraph (1)(B) who files a request for reinstatement in accordance with the provisions of paragraph (2)(A) shall be entitled to provisional benefits payable in accordance with this paragraph, unless the Commissioner determines that the individual does not meet the requirements of paragraph (1)(B)(i) or that the individual's declaration under paragraph (2)(A)(ii) is false. Any such determination by the Commissioner shall be final and not subject to review under subsection (b) or (g) of section 205.

(B) The amount of a provisional benefit for a month shall equal the amount of the last monthly benefit payable to the individual under this title on the basis of an application increased by an amount equal to the amount, if any, by which such last monthly benefit would have been increased as a result of the operation of section 215(i).

(C)(i) Provisional benefits shall begin with the month in which a request for reinstatement is filed in accordance with paragraph (2)(A).

(ii) Provisional benefits shall end with the earliest of—

(I) the month in which the Commissioner makes a determination regarding the individual's entitlement to reinstated benefits;

(II) the fifth month following the month described in clause (i);

(III) the month in which the individual performs substantial gainful activity; or

(IV) the month in which the Commissioner determines that the individual does not meet the requirements of paragraph (1)(B)(i) or that the individual's declaration made in accordance with paragraph (2)(A)(ii) is false.

(D) In any case in which the Commissioner determines that an individual is not entitled to reinstated benefits, any provisional benefits paid to the individual under this paragraph shall not be subject to recovery as an overpayment unless the Commissioner determines that the individual knew or should have known that the individual did not meet the requirements of paragraph (1)(B).

Limitation on Payments to Prisoners

(j) For provisions relating to limitation on payments to prisoners, see section 202(x).

REDUCTION OF BENEFITS BASED ON DISABILITY

SEC. 224. [42 U.S.C. 424a] (a) If for any month prior to the month in which an individual attains the age of 65—

(1) such individual is entitled to benefits under section 223, and

(2) such individual is entitled for such month to—

(A) periodic benefits on account of his or her total or partial disability (whether or not permanent) under a workmen's compensation law or plan of the United States or a State, or

(B) periodic benefits on account of his or her total or partial disability (whether or not permanent) under any other law or plan of the United States, a State, a political subdivision (as that term is used in section 218(b)(2)), or an instrumentality of two or more States (as that term is used in section 218(g)), other than (i) benefits payable under title 38, United States Code, (ii) benefits payable under a program of assistance which is based on need, (iii) benefits based on service all or substantially all of which was included under an agreement entered into by a State and the Commissioner of Social Security under section 218, and (iv) benefits under a law or plan of the United States based on service all or substantially all of which is employment as defined in section 210,

the total of his benefits under section 223 for such month and of any benefits under section 202 for such month based on his wages and self-employment income shall be reduced (but not below zero) by the amount by which the sum of—

(3) such total of benefits under sections 223 and 202 for such month, and

(4) such periodic benefits payable (and actually paid) for such month to such individual under such laws or plans,

exceeds the higher of—

(5) 80 per centum of his "average current earnings", or

(6) the total of such individual's disability insurance benefits under section 223 for such month and of any monthly insur-

ance benefits under section 202 for such month based on his wages and self-employment income, prior to reduction under this section.

In no case shall the reduction in the total of such benefits under sections 223 and 202 for a month (in a continuous period of months) reduce such total below the sum of—

(7) the total of the benefits under sections 223 and 202, after reduction under this section, with respect to all persons entitled to benefits on the basis of such individual's wages and self-employment income for such month which were determined for such individual and such persons for the first month for which reduction under this section was made (or which would have been so determined if all of them had been so entitled in such first month), and

(8) any increase in such benefits with respect to such individual and such persons, before reduction under this section, which is made effective for months after the first month for which reduction under this section is made.

For purposes of clause (5), an individual's average current earnings means the largest of (A) the average monthly wage (determined under section 215(b) as in effect prior to January 1979) used for purposes of computing his benefits under section 223, (B) one-sixtieth of the total of his wages and self-employment income (computed without regard to the limitations specified in sections 209(a)(1) and 211(b)(1)) for the five consecutive calendar years after 1950 for which such wages and self-employment income were highest, or (C) one-twelfth of the total of his wages and self-employment income (computed without regard to the limitations specified in sections 209(a)(1) and 211(b)(1)) for the calendar year in which he had the highest such wages and income during the period consisting of the calendar year in which he became disabled (as defined in section 223(d)) and the five years preceding that year.

(b) If any periodic benefit for a total or partial disability under a law or plan described in subsection (a)(2) is payable on other than a monthly basis (excluding a benefit payable as a lump sum except to the extent that it is a commutation of, or a substitute for, periodic payments), the reduction under this section shall be made at such time or times and in such amounts as the Commissioner of Social Security finds will approximate as nearly as practicable the reduction prescribed by subsection (a).

(c) Reduction of benefits under this section shall be made after any reduction under subsection (a) of section 203, but before deductions under such section and under section 222(b).

(d) The reduction of benefits required by this section shall not be made if the law or plan described in subsection (a)(2) under which a periodic benefit is payable provides for the reduction thereof when anyone is entitled to benefits under this title on the basis of the wages and self-employment income of an individual entitled to benefits under section 223, and such law or plan so provided on February 18, 1981.

(e) If it appears to the Commissioner of Social Security that an individual may be eligible for periodic benefits under a law or plan which would give rise to reduction under this section, he may require, as a condition of certification for payment of any benefits under section 223 to any individual for any month and of any benefits under section 202 for such month based on such individual's

wages and self-employment income, that such individual certify (i) whether he has filed or intends to file any claim for such periodic benefits, and (ii) if he has so filed, whether there has been a decision on such claim. The Commissioner of Social Security may, in the absence of evidence to the contrary, rely upon such a certification by such individual that he has not filed and does not intend to file such a claim, or that he has so filed and no final decision thereon has been made, in certifying benefits for payment pursuant to section 205(i).

(f)(1) In the second calendar year after the year in which reduction under this section in the total of an individual's benefits under section 223 and any benefits under section 202 based on his wages and self-employment income was first required (in a continuous period of months), and in each third year thereafter, the Commissioner of Social Security shall redetermine the amount of such benefits which are still subject to reduction under this section; but such redetermination shall not result in any decrease in the total amount of benefits payable under this title on the basis of such individual's wages and self-employment income. Such redetermined benefit shall be determined as of, and shall become effective with, the January following the year in which such redetermination was made.

(2) In making the redetermination required by paragraph (1), the individual's average current earnings (as defined in subsection (a)) shall be deemed to be the product of—

(A) his average current earnings as initially determined under subsection (a); and

(B) the ratio of (i) the national average wage index (as defined in section 209(k)(1)) for the calendar year before the year in which such redetermination is made to (ii) the national average wage index (as so defined) for the calendar year before the year in which the reduction was first computed (but not counting any reduction made in benefits for a previous period of disability).

Any amount determined under this paragraph which is not a multiple of $1 shall be reduced to the next lower multiple of $1.

(g) Whenever a reduction in the total of benefits for any month based on an individual's wages and self-employment income is made under this section, each benefit, except the disability insurance benefit, shall first be proportionately decreased, and any excess of such reduction over the sum of all such benefits other than the disability insurance benefits shall then be applied to such disability insurance benefit.

(h)(1) Notwithstanding any other provision of law, the head of any Federal agency shall provide such information within its possession as the Commissioner of Social Security may require for purposes of making a timely determination of the amount of the reduction, if any, required by this section in benefits payable under this title, or verifying other information necessary in carrying out the provisions of this section.

(2) The Commissioner of Social Security is authorized to enter into agreements with States, political subdivisions, and other organizations that administer a law or plan subject to the provisions of this section, in order to obtain such information as he may require to carry out the provisions of this section.

ADDITIONAL RULES RELATING TO BENEFITS BASED ON DISABILITY

Suspension of Benefits

SEC. 225. [42 U.S.C. 425] (a) If the Commissioner of Social Security, on the basis of information obtained by or submitted to him, believes that an individual entitled to benefits under section 223, or that a child who has attained the age of eighteen and is entitled to benefits under section 202(d), or that a widow or surviving divorced wife who has not attained age 60 and is entitled to benefits under section 202(e), or that a widower or surviving divorced husband who has not attained age 60 and is entitled to benefits under section 202(f), may have ceased to be under a disability, the Commissioner of Social Security may suspend the payment of benefits under such section 202(d), 202(e), 202(f), or 223 until it is determined (as provided in section 221) whether or not such individual's disability has ceased or until the Commissioner of Social Security believes that such disability has not ceased. In the case of any individual whose disability is subject to determination under an agreement with a State under section 221(b), the Commissioner of Social Security shall promptly notify the appropriate State of his action under this subsection and shall request a prompt determination of whether such individual's disability has ceased. For purposes of this subsection, the term "disability" has the meaning assigned to such term in section 223(d). Whenever the benefits of an individual entitled to a disability insurance benefit are suspended for any month, the benefits of any individual entitled thereto under subsection (b), (c), or (d) of section 202, on the basis of the wages and self-employment income of such individual, shall be suspended for such month. The first sentence of this subsection shall not apply to any child entitled to benefits under section 202(d), if he has attained the age of 18 but has not attained the age of 22, for any month during which he is a full-time student (as defined and determined under section 202(d)).

Continued Payments During Rehabilitation Program

(b) Notwithstanding any other provision of this title, payment to an individual of benefits based on disability (as described in the first sentence of subsection (a)) shall not be terminated or suspended because the physical or mental impairment, on which the individual's entitlement to such benefits is based, has or may have ceased, if—

(1) such individual is participating in a program consisting of the Ticket to Work and Self-Sufficiency Program under section 1148 or another program of vocational rehabilitation services, employment services, or other support services approved by the Commissioner of Social Security, and

(2) the Commissioner of Social Security determines that the completion of such program, or its continuation for a specified period of time, will increase the likelihood that such individual may (following his participation in such program) be permanently removed from the disability benefit rolls.

ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS

SEC. 226. [42 U.S.C. 426] (a) Every individual who—

(1) has attained age 65, and

(2)(A) is entitled to monthly insurance benefits under section 202, would be entitled to those benefits except that he has not filed an application therefor (or application has not been made for a benefit the entitlement to which for any individual is a condition of entitlement therefor), or would be entitled to such benefits but for the failure of another individual, who meets all the criteria of entitlement to monthly insurance benefits, to meet such criteria throughout a month, and, in conformity with regulations of the Secretary, files an application for hospital insurance benefits under part A of title XVIII,

(B) is a qualified railroad retirement beneficiary, or

(C)(i) would meet the requirements of subparagraph (A) upon filing application for the monthly insurance benefits involved if medicare qualified government employment (as defined in section 210(p)) were treated as employment (as defined in section 210(a)) for purposes of this title, and (ii) files an application, in conformity with regulations of the Secretary, for hospital insurance benefits under part A of title XVIII,

shall be entitled to hospital insurance benefits under part A of title XVIII for each month for which he meets the condition specified in paragraph (2), beginning with the first month after June 1966 for which he meets the conditions specified in paragraphs (1) and (2).

(b) Every individual who—

(1) has not attained age 65, and

(2)(A) is entitled to, and has for 24 calendar months been entitled to, (i) disability insurance benefits under section 223 or (ii) child's insurance benefits under section 202(d) by reason of a disability (as defined in section 223(d)) or (iii) widow's insurance benefits under section 202(e) or widower's insurance benefits under section 202(f) by reason of a disability (as defined in section 223(d)), or

(B) is, and has been for not less than 24 months, a disabled qualified railroad retirement beneficiary, within the meaning of section 7(d) of the Railroad Retirement Act of 1974[301], or

(C)(i) has filed an application, in conformity with regulations of the Secretary, for hospital insurance benefits under part A of title XVIII pursuant to this subparagraph, and

(ii) would meet the requirements of subparagraph (A) (as determined under the disability criteria, including reviews, applied under this title), including the requirement that he has been entitled to the specified benefits for 24 months, if—

(I) medicare qualified government employment (as defined in section 210(p)) were treated as employment (as defined in section 210(a)) for purposes of this title, and

(II) the filing of the application under clause (i) of this subparagraph were deemed to be the filing

[301] See Vol. II, P.L. 75–162 [as amended by P.L. 93–445].

of an application for the disability-related benefits referred to in clause (i), (ii), or (iii) of subparagraph (A),

shall be entitled to hospital insurance benefits under part A of title XVIII for each month beginning with the later of (I) July 1973 or (II) the twenty-fifth month of his entitlement or status as a qualified railroad retirement beneficiary described in paragraph (2), and ending (subject to the last sentence of this subsection) with the month following the month in which notice of termination of such entitlement to benefits or status as a qualified railroad retirement beneficiary described in paragraph (2) is mailed to him, or if earlier, with the month before the month in which he attains age 65. In applying the previous sentence in the case of an individual described in paragraph (2)(C), the "twenty-fifth month of his entitlement" refers to the first month after the twenty-fourth month of entitlement to specified benefits referred to in paragraph (2)(C) and "notice of termination of such entitlement" refers to a notice that the individual would no longer be determined to be entitled to such specified benefits under the conditions described in that paragraph. For purposes of this subsection, an individual who has had a period of trial work which ended as provided in section 222(c)(4)(A), and whose entitlement to benefits or status as a qualified railroad retirement beneficiary as described in paragraph (2) has subsequently terminated, shall be deemed to be entitled to such benefits or to occupy such status (notwithstanding the termination of such entitlement or status) for the period of consecutive months throughout all of which the physical or mental impairment, on which such entitlement or status was based, continues, and throughout all of which such individual would have been entitled to monthly insurance benefits under title II or as a qualified railroad retirement beneficiary had such individual been unable to engage in substantial gainful activity, but not in excess of 78 such months. In determining when an individual's entitlement or status terminates for purposes of the preceding sentence, the term "36 months" in the second sentence of section 223(a)(1), in section 202(d)(1)(G)(i), in the last sentence of section 202(e)(1), and in the last sentence of section 202(f)(1) shall be applied as though it read "15 months".

(c) For purposes of subsection (a)—

(1) entitlement of an individual to hospital insurance benefits for a month shall consist of entitlement to have payment made under, and subject to the limitations in, part A of title XVIII on his behalf for inpatient hospital services, post-hospital extended care services, and home health services (as such terms are defined in part C[302] of title XVIII) furnished him in the United States (or outside the United States in the case of inpatient hospital services furnished under the conditions described in section 1814(f)) during such month; except that (A) no such payment may be made for post-hospital extended care services furnished before January 1967, and (B) no such payment may be made for post-hospital extended care services unless the discharge from the hospital required to qualify such

[302] P.L. 105–33, §4002(f)(1), provided that any reference to part C of title XVIII is deemed a reference to part D of title XVIII as of August 5, 1997.

P.L. 108–173, §101(e)(1), provides that any reference to part D of title XVIII is deemed a reference to part E of title XVIII.

services for payment under part A of title XVIII occurred (i) after June 30, 1966, or on or after the first day of the month in which he attains age 65, whichever is later, or (ii) if he was entitled to hospital insurance benefits pursuant to subsection (b), at a time when he was so entitled; and

(2) an individual shall be deemed entitled to monthly insurance benefits under section 202 or section 223, or to be a qualified railroad retirement beneficiary, for the month in which he died if he would have been entitled to such benefits, or would have been a qualified railroad retirement beneficiary, for such month had he died in the next month.

(d) For purposes of this section, the term "qualified railroad retirement beneficiary" means an individual whose name has been certified to the Secretary by the Railroad Retirement Board under section 7(d) of the Railroad Retirement Act of 1974[303]. An individual shall cease to be a qualified railroad retirement beneficiary at the close of the month preceding the month which is certified by the Railroad Retirement Board as the month in which he ceased to meet the requirements of section 7(d) of the Railroad Retirement Act of 1974.

(e)(1)(A) For purposes of determining entitlement to hospital insurance benefits under subsection (b) in the case of widows and widowers described in paragraph (2)(A)(iii) thereof—

(i) the term "age 60" in sections 202(e)(1)(B)(ii), 202(e)(4), 202(f)(1)(B)(ii), and 202(f)(4)[304] shall be deemed to read "age 65"; and

(ii) the phrase "before she attained age 60" in the matter following subparagraph (F) of section 202(e)(1) and the phrase "before he attained age 60" in the matter following subparagraph (F) of section 202(f)(1) shall each be deemed to read "based on a disability".

(B) For purposes of subsection (b)(2)(A)(iii), each month in the period commencing with the first month for which an individual is first eligible for supplemental security income benefits under title XVI, or State supplementary payments of the type referred to in section 1616(a) of this Act (or payments of the type described in section 212(a) of Public Law 93–66) which are paid by the Secretary under an agreement referred to in section 1616(a) (or in section 212(b) of Public Law 93–66), shall be included as one of the 24 months for which such individual must have been entitled to widow's or widower's insurance benefits on the basis of disability in order to become entitled to hospital insurance benefits on that basis.

(2) For purposes of determining entitlement to hospital insurance benefits under subsection (b) in the case of an individual under age 65 who is entitled to benefits under section 202, and who was entitled to widow's insurance benefits or widower's insurance benefits based on disability for the month before the first month in which such individual was so entitled to old-age insurance benefits (but ceased to be entitled to such widow's or widower's insurance benefits upon becoming entitled to such old-age insurance benefits), such individual shall be

[303] See Vol. II, P.L. 75–162 [as amended by P.L. 93–445].
[304] P.L. 108–203, §418(b)(4)(B)(vii), struck out "and 202(f)(5)" and substituted "and 202(f)(4)".

deemed to have continued to be entitled to such widow's insurance benefits or widower's insurance benefits for and after such first month.

(3) For purposes of determining entitlement to hospital insurance benefits under subsection (b), any disabled widow aged 50 or older who is entitled to mother's insurance benefits (and who would have been entitled to widow's insurance benefits by reason of disability if she had filed for such widow's benefits), and any disabled widower aged 50 or older who is entitled to father's insurance benefits (and who would have been entitled to widower's insurance benefits by reason of disability if he had filed for such widower's benefits), shall, upon application for such hospital insurance benefits be deemed to have filed for such widow's or widower's insurance benefits.

(4) For purposes of determining entitlement to hospital insurance benefits under subsection (b) in the case of an individual described in clause (iii) of subsection (b)(2)(A), the entitlement of such individual to widow's or widower's insurance benefits under section 202(e) or (f) by reason of a disability shall be deemed to be the entitlement to such benefits that would result if such entitlement were determined without regard to the provisions of section 202(j)(4).

(f) For purposes of subsection (b) (and for purposes of section 1837(g)(1) of this Act and section 7(d)(2)(ii) of the Railroad Retirement Act of 1974[305]), the 24 months for which an individual has to have been entitled to specified monthly benefits on the basis of disability in order to become entitled to hospital insurance benefits on such basis effective with any particular month (or to be deemed to have enrolled in the supplementary medical insurance program, on the basis of such entitlement, by reason of section 1837(f)), where such individual had been entitled to specified monthly benefits of the same type during a previous period which terminated—

(1) more than 60 months before the month in which his current disability began in any case where such monthly benefits were of the type specified in clause (A)(i) or (B) of subsection (b)(2), or

(2) more than 84 months before the month in which his current disability began in any case where such monthly benefits were of the type specified in clause (A)(ii) or (A)(iii) of such subsection,

shall not include any month which occurred during such previous period, unless the physical or mental impairment which is the basis for disability is the same as (or directly related to) the physical or mental impairment which served as the basis for disability in such previous period.

(g) The Secretary and Director of the Office of Personnel Management shall jointly prescribe and carry out procedures designed to assure that all individuals who perform medicare qualified government employment by virtue of service described in section 210(a)(5) are fully informed with respect to (1) their eligibility or potential eligibility for hospital insurance benefits (based on such employment) under part A of title XVIII, (2) the requirements for and conditions of such eligibility, and (3) the necessity of timely application as a condition of entitlement under subsection (b)(2)(C), giving par-

[305] See Vol. II, P.L. 75–162 [as amended by P.L. 93–445].

ticular attention to individuals who apply for an annuity under chapter 83 of title 5, United States Code, or under another similar Federal retirement program, and whose eligibility for such an annuity is or would be based on a disability.

(h) For purposes of applying this section in the case of an individual medically determined to have amyotrophic lateral sclerosis (ALS), the following special rules apply:

(1) Subsection (b) shall be applied as if there were no requirement for any entitlement to benefits, or status, for a period longer than 1 month.

(2) The entitlement under such subsection shall begin with the first month (rather than twenty-fifth month) of entitlement or status.

(3) Subsection (f) shall not be applied.

(i) For purposes of this section, each person whose monthly insurance benefit for any month is terminated or is otherwise not payable solely by reason of paragraph (1) or (7) of section 225(c) shall be treated as entitled to such benefit for such month.

(j) For entitlement to hospital insurance benefits in the case of certain benefit for any month is terminated or is otherwise not payable solely by reason of paragraph (1) or (7) of section 225(c) shall be treated as entitled to such benefit for such month.

SPECIAL PROVISIONS RELATING TO COVERAGE UNDER MEDICARE PROGRAM FOR END STAGE RENAL DISEASE

SEC. 226A. [42 U.S.C. 426-1] (a) Notwithstanding any provision to the contrary in section 226 or title XVIII, every individual who—

(1)(A) is fully or currently insured (as such terms are defined in section 214), or would be fully or currently insured if (i) his service as an employee (as defined in the Railroad Retirement Act of 1974[306]) after December 31, 1936, were included within the meaning of the term "employment" for purposes of this title, and (ii) his medicare qualified government employment (as defined in section 210(p)) were included within the meaning of the term "employment" for purposes of this title;

(B)(i) is entitled to monthly insurance benefits under this title, (ii) is entitled to an annuity under the Railroad Retirement Act of 1974, or (iii) would be entitled to a monthly insurance benefit under this title if medicare qualified government employment (as defined in section 210(p)) were included within the meaning of the term "employment" for purposes of this title; or

(C) is the spouse or dependent child (as defined in regulations) of an individual described in subparagraph (A) or (B);

(2) is medically determined to have end stage renal disease; and

(3) has filed an application for benefits under this section;

shall, in accordance with the succeeding provisions of this section, be entitled to benefits under part A and eligible to enroll under part B of title XVIII, subject to the deductible, premium, and coinsurance provisions of that title.

[306] P.L. 75–162 [as amended by P.L. 93–445].

(b) Subject to subsection (c), entitlement of an individual to benefits under part A and eligibility to enroll under part B of title XVIII by reasons of this section on the basis of end stage renal disease—

(1) shall begin with—

(A) the third month after the month in which a regular course of renal dialysis is initiated, or

(B) the month in which such individual receives a kidney transplant, or (if earlier) the first month in which such individual is admitted as an inpatient to an institution which is a hospital meeting the requirements of section 1861(e) (and such additional requirements as the Secretary may prescribe under section 1881(b) for such institutions) in preparation for or anticipation of kidney transplantation, but only if such transplantation occurs in that month or in either of the next two months,

whichever first occurs (but no earlier than one year preceding the month of the filing of an application for benefits under this section); and

(2) shall end, in the case of an individual who receives a kidney transplant, with the thirty-sixth month after the month in which such individual receives such transplant or, in the case of an individual who has not received a kidney transplant and no longer requires a regular course of dialysis, with the twelfth month after the month in which such course of dialysis is terminated.

(c) Notwithstanding the provisions of subsection (b)—

(1) in the case of any individual who participates in a self-care dialysis training program prior to the third month after the month in which such individual initiates a regular course of renal dialysis in a renal dialysis facility or provider of services meeting the requirements of section 1881(b), entitlement to benefits under part A and eligibility to enroll under part B of title XVIII shall begin with the month in which such regular course of renal dialysis is initiated;

(2) in any case in which a kidney transplant fails (whether during or after the thirty-six-month period specified in subsection (b)(2)) and as a result the individual who received such transplant initiates or resumes a regular course of renal dialysis, entitlement to benefits under part A and eligibility to enroll under part B of title XVIII shall begin with the month in which such course is initiated or resumed; and

(3) in any case in which a regular course of renal dialysis is resumed subsequent to the termination of an earlier course, entitlement to benefits under part A and eligibility to enroll under part B of title XVIII shall begin with the month in which such regular course of renal dialysis is resumed.

(c)[307] For purposes of this section, each person whose monthly insurance benefit for any month is terminated or is otherwise not payable solely by reason of paragraph (1) or (7) of section 225(c) shall be treated as entitled to such benefit for such month.

[307] As in original. P.L. 103–296, §201(a)(3)(D)(ii), added a second subsection (c).

TRANSITIONAL INSURED STATUS[308]

SEC. 227. [42 U.S.C. 427] (a) In the case of any individual who attains the age of 72 before 1969 but who does not meet the requirements of section 214(a), the 6 quarters of coverage referred to in paragraph (1) of section 214(a) shall, instead, be 3 quarters of coverage for purposes of determining entitlement of such individual to benefits under section 202(a), and of the spouse to benefits under section 202(b) or section 202(c), but, in the case of such spouse, only if he or she attains the age of 72 before 1969 and only with respect to spouse's insurance benefits under section 202(b) or section 202(c) for and after the month in which he or she attains such age. For each month before the month in which any such individual meets the requirements of section 214(a), the amount of the old-age insurance benefit shall, notwithstanding the provisions of section 202(a), be the larger of $64.40 or the amount most recently established in lieu thereof under section 215(i) and the amount of the spouse's insurance benefit of the spouse shall, notwithstanding the provisions of section 202(b) or section 202(c), be the larger of $32.20 or the amount most recently established in lieu thereof under section 215(i).

(b) In the case of any individual who has died, who does not meet the requirements of section 214(a), and whose surviving spouse attains age 72 before 1969, the 6 quarters of coverage referred to in paragraph (3) of section 214(a) and in paragraph (1) thereof shall, for purposes of determining the entitlement to surviving spouse's insurance benefits under section 202(e) or section 202(f), instead be—

(1) 3 quarters of coverage if such surviving spouse attains the age of 72 in or before 1966,

(2) 4 quarters of coverage if such surviving spouse attains the age of 72 in 1967, or

(3) 5 quarters of coverage if such surviving spouse attains the age of 72 in 1968.

The amount of the surviving spouse's insurance benefit for each month shall, notwithstanding the provisions of section 202(e) or section 202(f) (and section 202(m)), be the larger of $64.40 or the amount most recently established in lieu thereof under section 215(i).

(c) In the case of any individual who becomes, or upon filing application therefor would become, entitled to benefits under section 202(a) by reason of the application of subsection (a) of this section, who dies, and whose surviving spouse attains the age of 72 before 1969, such deceased individual shall be deemed to meet the requirements of subsection (b) of this section for purposes of determining entitlement of such surviving spouse to surviving spouse's insurance benefits under section 202(e) or section 202(f).

[308] See Vol. II, Appendices, Cost-of-Living Increase and Other Determinations, with respect to flat-rate benefits to workers age 72 and not insured under usual requirements.

BENEFITS AT AGE 72 FOR CERTAIN UNINSURED INDIVIDUALS[309]

Eligibility

SEC. 228. [42 U.S.C. 428] (a) Every individual who—

(1) has attained the age of 72,

(2)(A) attained such age before 1968, or (B) (i) attained such age after 1967 and before 1972, and (ii) has not less than 3 quarters of coverage, whenever acquired, for each calendar year elapsing after 1966 and before the year in which he or she attained such age,

(3) is a resident of the United States (as defined in subsection (e)), and is (A) a citizen of the United States or (B) an alien lawfully admitted for permanent residence who has resided in the United States (as defined in section 210(i)) continuously during the 5 years immediately preceding the month in which he or she files application under this section, and

(4) has filed application for benefits under this section,

shall (subject to the limitations in this section) be entitled to a benefit under this section for each month beginning with the first month after September 1966 in which he or she becomes so entitled to such benefits and ending with the month preceding the month in which he or she dies. No application under this section which is filed by an individual more than 3 months before the first month in which he or she meets the requirements of paragraphs (1), (2), and (3) shall be accepted as an application for purposes of this section.

Benefit Amount

(b) The benefit amount to which an individual is entitled under this section for any month shall be the larger of $64.40 or the amount most recently established in lieu thereof under section 215(i).

Reduction for Governmental Pension System Benefits

(c)(1) The benefit amount of any individual under this section for any month shall be reduced (but not below zero) by the amount of any periodic benefit under a governmental pension system for which he or she is eligible for such month.

(2) In the case of a husband and wife only one of whom is entitled to benefits under this section for any month, the benefit amount, after any reduction under paragraph (1), shall be further reduced (but not below zero) by the excess (if any) of (A) the total amount of any periodic benefits under governmental pension systems for which the spouse who is not entitled to benefits under this section is eligible for such month, over (B) the benefit amount as determined without regard to this subsection.

(3) In the case of a husband or wife both of whom are entitled to benefits under this section for any month, the benefit amount of each spouse, after any reduction under paragraph

[309] See Vol. II, Appendices, Cost-of-Living Increase and Other Determinations, with respect to flat-rate benefits at age 72 for certain uninsured persons.

See Vol. II, P.L. 98–21, §305(e), with respect to changes in payment amounts under this section.

(1), shall be further reduced (but not below zero) by the excess (if any) of (A) the total amount of any periodic benefits under governmental pension systems for which the other spouse is eligible for such month, over (B) the benefit amount of such other spouse as determined without regard to this subsection.

(4) For purposes of this subsection, in determining whether an individual is eligible for periodic benefits under a governmental pension system—

(A) such individual shall be deemed to have filed application for such benefits,

(B) to the extent that entitlement depends on an application by such individual's spouse, such spouse shall be deemed to have filed application, and

(C) to the extent that entitlement depends on such individual or his or her spouse having retired, such individual and his or her spouse shall be deemed to have retired before the month for which the determination of eligibility is being made.

(5) For purposes of this subsection, if any periodic benefit is payable on any basis other than a calendar month, the Commissioner of Social Security shall allocate the amount of such benefit to the appropriate calendar months.

(6) If, under the foregoing provisions of this section, the amount payable for any month would be less than $1, such amount shall be reduced to zero. In the case of a husband and wife both of whom are entitled to benefits under this section for the month, the preceding sentence shall be applied with respect to the aggregate amount so payable for such month.

(7) If any benefit amount computed under the foregoing provisions of this section is not a multiple of $0.10, it shall be raised to the next higher multiple of $0.10.

(8) Under regulations prescribed by the Commissioner of Social Security, benefit payments under this section to an individual (or aggregate benefit payments under this section in the case of a husband and wife) of less than $5 may be accumulated until they equal or exceed $5.

Suspension for Months in Which Cash Payments Are Made Under Public Assistance

(d) The benefit to which any individual is entitled under this section for any month shall not be paid for such month if—

(1) such individual receives aid or assistance in the form of money payments in such month under a State plan approved under title I, X, XIV, or XVI, or under a State program funded under part A of title IV, or

(2) such individual's husband or wife receives such aid or assistance in such month, and under the State plan the needs of such individual were taken into account in determining eligibility for (or amount of) such aid or assistance,

unless the State agency administering or supervising the administration of such plan notifies the Commissioner of Social Security, at such time and in such manner as may be prescribed in accordance with regulations of the Commissioner of Social Security, that such payments to such individual (or such individual's husband or wife) under such plan are being terminated with the payment or

payments made in such month and such individual is not an individual with respect to whom supplemental security income benefits are payable pursuant to title XVI or section 211 of Public Law 93–66 for the following month, nor shall such benefit be paid for such month if such individual is an individual with respect to whom supplemental security income benefits are payable pursuant to title XVI or section 211 of Public Law 93–66 for such month, unless the Commissioner of Social Security determines that such benefits are not payable with respect to such individual for the month following such month.

Suspension Where Individual Is Residing Outside the United States

(e) The benefit to which any individual is entitled under this section for any month shall not be paid if, during such month, such individual is not a resident of the United States. For purposes of this subsection, the term "United States" means the 50 States and the District of Columbia.

Treatment as Monthly Insurance Benefits

(f) For purposes of subsections (t) and (u) of section 202, and of section 1840, a monthly benefit under this section shall be treated as a monthly insurance benefit payable under section 202.

Annual Reimbursement of Federal Old-Age and Survivors Insurance Trust Fund

(g) There are authorized to be appropriated to the Federal Old-Age and Survivors Insurance Trust Fund for the fiscal year ending June 30, 1969, and for each fiscal year thereafter, such sums as the Commissioner of Social Security deems necessary on account of—

(1) payments made under this section during the second preceding fiscal year and all fiscal years prior thereto to individuals who, as of the beginning of the calendar year in which falls the month for which payment was made, had less than 3 quarters of coverage,

(2) the additional administrative expenses resulting from the payments described in paragraph (1), and

(3) any loss in interest to such Trust Fund resulting from such payments and expenses,

in order to place such Trust Fund in the same position at the end of such fiscal year as it would have been in if such payments had not been made.

Definitions

(h) For purposes of this section—

(1) The term "quarter of coverage" includes a quarter of coverage as defined in section 5(l) of the Railroad Retirement Act of 1937 [310].

(2) The term "governmental pension system" means the insurance system established by this title or any other system or fund established by the United States, a State, any political

[310] P.L. 75-162. P.L. 93-445, §101, amended the Railroad Retirement Act of 1937 in its entirety, effective January 1, 1975. See Vol. II, P.L. 75-162, §2, instead.

subdivision of a State, or any wholly owned instrumentality of any one or more of the foregoing which provides for payment of (A) pensions, (B) retirement or retired pay, or (C) annuities or similar amounts payable on account of personal services performed by any individual (not including any payment under any workmen's compensation law or any payment by the Secretary of Veterans Affairs as compensation for service-connected disability or death).

(3) The term "periodic benefit" includes a benefit payable in a lump sum if it is a commutation of, or a substitute for, periodic payments.

(4) The determination of whether an individual is a husband or wife for any month shall be made under subsection (h) of section 216 without regard to subsections (b) and (f) of section 216.

BENEFITS IN CASE OF MEMBERS OF THE UNIFORMED SERVICES[312]

SEC. 229. [42 U.S.C. 429] [313] For purposes of determining entitlement to and the amount of any monthly benefit for any month after December 1972, or entitlement to and the amount of any lump-sum death payment in case of a death after such month, payable under this title on the basis of the wages and self-employment income of any individual, and for purposes of section 216(i)(3), such individual, if he was paid wages for service as a member of a uniformed service (as defined in section 210(m)) which was included in the term "employment" as defined in section 210(a) as a result of the provisions of section 210(l)(1)(A), shall be deemed to have been paid—

(1) in each calendar quarter occurring after 1956 and before 1978 in which he was paid such wages, additional wages of $300, and

(2) in each calendar year occurring after 1977 and before 2002[314] in which he was paid such wages, additional wages of $100 for each $300 of such wages, up to a maximum of $1,200 of additional wages for any calendar year.

ADJUSTMENT OF THE CONTRIBUTION AND BENEFIT BASE

SEC. 230. [42 U.S.C. 430] (a) Whenever the Commissioner of Social Security pursuant to section 215(i) increases benefits effective with the December following a cost-of-living computation quarter, the Commissioner shall also determine and publish in the Federal Register on or before November 1 of the calendar year in which such quarter occurs the contribution and benefit base determined under subsection (b) or (c) which shall be effective with respect to remuneration paid after the calendar year in which such quarter occurs and taxable years beginning after such year.

(b) The amount of such contribution and benefit base shall (subject to subsection (c)) be the amount of the contribution and benefit base in effect in the year in which the determination is made or, if larger, the product of—

(1) $60,600, and

[311] See Vol. II, 38 U.S.C. 5303A.

[312] P.L. 108-203, §420(b)(1)(A), struck out "(a)".

[313] P.L. 108-203, §420(b)(2), inserted "and before 2002", effective March 2, 2004. [(b) Stricken.[311]]

(2) the ratio of (A) the national average wage index (as defined in section 209(k)(1)) for the calendar year before the calendar year in which the determination under subsection (a) is made to (B) the national average wage index (as so defined) for 1992,

with such product, if not a multiple of $300, being rounded to the next higher multiple of $300 where such product is a multiple of $150 but not of $300 and to the nearest multiple of $300 in any other case.

(c) For purposes of this section, and for purposes of determining wages and self-employment income under sections 209, 211, 213, and 215 of this Act and sections 1402, 3121, 3122, 3125, 6413, and 6654 of the Internal Revenue Code of 1986[315], (1) the "contribution and benefit base" with respect to remuneration paid in (and taxable years beginning in) any calendar year after 1973 and prior to the calendar year with the June of which the first increase in benefits pursuant to section 215(i) of this Act becomes effective shall be $13,200 or (if applicable) such other amount as may be specified in a law enacted subsequent to the law which added this section, and (2) the "contribution and benefit base" with respect to remuneration paid (and taxable years beginning)—

(A) in 1978 shall be $17,700,
(B) in 1979 shall be $22,900,
(C) in 1980 shall be $25,900, and
(D) in 1981 shall be $29,700.

For purposes of determining under subsection (b) the "contribution and benefit base" with respect to remuneration paid (and taxable years beginning) in 1982 and subsequent years, the dollar amounts specified in clause (2) of the preceding sentence shall be considered to have resulted from the application of such subsection (b) and to be the amount determined (with respect to the years involved) under that subsection.

(d) Notwithstanding any other provision of law, the contribution and benefit base determined under this section for any calendar year after 1976 for purposes of section 4022(b)(3)(B) of Public Law 93–406[316], with respect to any plan, shall be the contribution and benefit base that would have been determined for such year if this section as in effect immediately prior to the enactment of the Social Security Amendments of 1977[317] had remained in effect without change (except that, for purposes of subsection (b) of such section 230 as so in effect, the reference to the contribution and benefit base in paragraph (1) of such subsection (b) shall be deemed a reference to an amount equal to $45,000, each reference in paragraph (2) of such subsection (b) to the average of the wages of all employees as reported to the Secretary of Treasury shall be deemed a reference to the national average wage index (as defined in section 209(k)(1)), the reference to a preceding calendar year in paragraph (2)(A) of such subsection (b) shall be deemed a reference to the calendar year before the calendar year in which the determination under subsection (a) of such section 230 is made, and the reference to a calendar year in paragraph (2)(B) of such subsection (b) shall be deemed a reference to 1992).

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[314] P.L. 108-203, §420(b)(1)(B), struck out subsection (b), effective March 2, 2004. For subsection (b) as it formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L. 108-203.

[315] See P.L. 83–591, §§1402, 3121, 3122, and 3125 (this volume) and Vol. II for §§6413 and 6654.

BENEFITS IN CASE OF CERTAIN INDIVIDUALS INTERNED DURING WORLD WAR II

SEC. 231. [42 U.S.C. 431] (a) For the purposes of this section the term "internee" means an individual who was interned during any period of time from December 7, 1941, through December 31, 1946, at a place within the United States operated by the Government of the United States for the internment of United States citizens of Japanese ancestry.

(b)(1) For purposes of determining entitlement to and the amount of any monthly benefit for any month after December 1972, or entitlement to and the amount of any lump-sum death payment in the case of a death after such month, payable under this title on the basis of the wages and self-employment income of any individual, and for purposes of section 216(i)(3), such individual shall be deemed to have been paid during any period after he attained age 18 and for which he was an internee, wages (in addition to any wages actually paid to him) at a weekly rate of basic pay during such period as follows—

(A) in the case such individual was not employed prior to the beginning of such period, 40 multiplied by the minimum hourly rate or rates in effect at any such time under section 206(a)(1) of title 29, United States Code, for each full week during such period; and

(B) in the case such individual who was employed prior to the beginning of such period, 40 multiplied by the greater of (i) the highest hourly rate received during any such employment, or (ii) the minimum hourly rate or rates in effect at any such time under section 206(a)(1) of title 29, United States Code[318], for each full week during such period.

(2) This subsection shall not be applicable in the case of any monthly benefit or lump-sum death payment if—

(A) a larger such benefit or payment, as the case may be, would be payable without its application; or

(B) a benefit (other than a benefit payable in a lump-sum unless it is a commutation of, or a substitute for, periodic payments) which is based, in whole or in part, upon internment during any period from December 7, 1941, through December 31, 1946, at a place within the United States operated by the Government of the United States for the internment of United States citizens of Japanese ancestry, is determined by any agency or wholly owned instrumentality of the United States to be payable by it under any other law of the United States or under a system established by such agency or instrumentality.

The provisions of clause (B) shall not apply in the case of any monthly benefit or lump-sum death payment under this title if its application would reduce by $0.50 or less the primary insurance amount (as computed under section 215 prior to any recomputation thereof pursuant to subsection (f) of such section) of the individual on whose wages and self-employment income such benefit or payment is based. The provisions of clause (B) shall also not apply for purposes of section 216(i)(3).

[316] See Vol. II, Title 29.

(3) Upon application for benefits, a recalculation of benefits (by reason of this section), or a lump-sum death payment on the basis of the wages and self-employment income of any individual who was an internee, the Commissioner of Social Security shall accept the certification of the Secretary of Defense or his designee concerning any period of time for which an internee is to receive credit under paragraph (1) and shall make a decision without regard to clause (B) of paragraph (2) of this subsection unless the Commissioner has been notified by some other agency or instrumentality of the United States that, on the basis of the period for which such individual was an internee, a benefit described in clause (B) of paragraph (2) has been determined by such agency or instrumentality to be payable by it. If the Commissioner of Social Security has not been so notified, the Commissioner shall then ascertain whether some other agency or wholly owned instrumentality of the United States has decided that a benefit described in clause (B) of paragraph (2) is payable by it. If any such agency or instrumentality has decided, or thereafter decides, that such a benefit is payable by it, it shall so notify the Commissioner of Social Security, and the Commissioner of Social Security shall certify no further benefits for payment or shall recompute the amount of any further benefits payable, as may be required by this section.

(4) Any agency or wholly owned instrumentality of the United States which is authorized by any law of the United States to pay benefits, or has a system of benefits which are based, in whole or in part, on any period for which any individual was an internee shall, at the request of the Commissioner of Social Security, certify to the Commissioner, with respect to any individual who was an internee, such information as the Commissioner of Social Security deems necessary to carry out the Commissioner's functions under paragraph (3) of this subsection.

(c) There are authorized to be appropriated to the Trust Funds and the Federal Hospital Insurance Trust Fund for the fiscal year ending June 30, 1978, such sums as the Commissioner of Social Security and the Secretary jointly determine would place the Trust Funds and the Federal Hospital Insurance Trust Fund in the position in which they would have been if the preceding provisions of this section had not been enacted.

PROCESSING OF TAX DATA [319]

SEC. 232. [42 U.S.C. 432] The Secretary of the Treasury shall make available information returns filed pursuant to part III of subchapter A of chapter 61 of subtitle F of the Internal Revenue Code of 1954, to the Commissioner of Social Security for the purposes of this title and title XI. The Commissioner of Social Security and the Secretary of the Treasury are authorized to enter into an agreement for the processing by the Commissioner of Social Security of information contained in returns filed pursuant to part III of subchapter A of chapter 61 of subtitle F of the Internal Revenue

[317] See Vol. II, P.L. 83–591, §6103(l), with respect to disclosure of returns and return information by the Secretary of the Treasury to the Social Security Administration, and §7213(a)(1) with respect to the penalty for unauthorized disclosure of that tax return information.

See Vol. II, P.L. 88–525, §11(e)(19), with respect to requesting and exchanging information for purposes of verifying income and eligibility for food stamps.

Code of 1986. Notwithstanding the provisions of section 6103(a) of the Internal Revenue Code of 1986, the Secretary of the Treasury shall make available to the Commissioner of Social Security such documents as may be agreed upon as being necessary for purposes of such processing. The Commissioner of Social Security shall process any withholding tax statements or other documents made available to the Commissioner by the Secretary of the Treasury pursuant to this section. Any agreement made pursuant to this section shall remain in full force and effect until modified or otherwise changed by mutual agreement of the Commissioner of Social Security and the Secretary of the Treasury.

INTERNATIONAL AGREEMENTS

Purpose of Agreement

SEC. 233. [42 U.S.C. 433] (a) The President is authorized (subject to the succeeding provisions of this section) to enter into agreements establishing totalization arrangements between the social security system established by this title and the social security system of any foreign country, for the purposes of establishing entitlement to and the amount of old-age, survivors, disability, or derivative benefits based on a combination of an individual's periods of coverage under the social security system established by this title and the social security system of such foreign country.

Definitions

(b) For the purposes of this section—

(1) the term "social security system" means, with respect to a foreign country, a social insurance or pension system which is of general application in the country and under which periodic benefits, or the actuarial equivalent thereof, are paid on account of old age, death, or disability; and

(2) the term "period of coverage" means a period of payment of contributions or a period of earnings based on wages for employment or on self-employment income, or any similar period recognized as equivalent thereto under this title or under the social security system of a country which is a party to an agreement entered into under this section.

Crediting Periods of Coverage; Conditions of Payment of Benefits

(c)(1) Any agreement establishing a totalization arrangement pursuant to this section shall provide—

(A) that in the case of an individual who has at least 6 quarters of coverage as defined in section 213 of this Act and periods of coverage under the social security system of a foreign country which is a party to such agreement, periods of coverage of such individual under such social security system of such foreign country may be combined with periods of coverage under this title and otherwise considered for the purposes of establishing entitlement to and the amount of old-age, survivors, and disability insurance benefits under this title;

(B)(i) that employment or self-employment, or any service which is recognized as equivalent to employment or

self-employment under this title or the social security system of a foreign country which is a party to such agreement, shall, on or after the effective date of such agreement, result in a period of coverage under the system established under this title or under the system established under the laws of such foreign country, but not under both, and (ii) the methods and conditions for determining under which system employment, self-employment, or other service shall result in a period of coverage; and

(C) that where an individual's periods of coverage are combined, the benefit amount payable under this title shall be based on the proportion of such individual's periods of coverage which was completed under this title.

(2) Any such agreement may provide that an individual who is entitled to cash benefits under this title shall, notwithstanding the provisions of section 202(t), receive such benefits while he resides in a foreign country which is a party to such agreement.

(3) Section 226 shall not apply in the case of any individual to whom it would not be applicable but for this section or any agreement or regulation under this section.

(4) Any such agreement may contain other provisions which are not inconsistent with the other provisions of this title and which the President deems appropriate to carry out the purposes of this section.

Regulations

(d) The Commissioner of Social Security shall make rules and regulations and establish procedures which are reasonable and necessary to implement and administer any agreement which has been entered into in accordance with this section.

Reports to Congress; Effective Date of Agreements

(e)(1) Any agreement to establish a totalization arrangement entered into pursuant to this section shall be transmitted by the President to the Congress together with a report on the estimated number of individuals who will be affected by the agreement and the effect of the agreement on the estimated income and expenditures of the programs established by this Act.

(2) Such an agreement shall become effective on any date, provided in the agreement, which occurs after the expiration of the period (following the date on which the agreement is transmitted in accordance with paragraph (1)) during which at least one House of the Congress has been in session on each of 60 days; except that such agreement shall not become effective if, during such period, either House of the Congress adopts a resolution of disapproval of the agreement.

DEMONSTRATION PROJECT AUTHORITY[320]

SEC. 234. [42 U.S.C. 434] (a) AUTHORITY.—

(1) IN GENERAL.—The Commissioner of Social Security (in this section referred to as the "Commissioner") shall develop and carry out experiments and demonstration projects designed to determine the relative advantages and disadvantages of—

(A) various alternative methods of treating the work activity of individuals entitled to disability insurance benefits under section 223 or to monthly insurance benefits under section 202 based on such individual's disability (as defined in section 223(d)), including such methods as a reduction in benefits based on earnings, designed to encourage the return to work of such individuals;

(B) altering other limitations and conditions applicable to such individuals (including lengthening the trial work period (as defined in section 222(c)), altering the 24–month waiting period for hospital insurance benefits under section 226, altering the manner in which the program under this title is administered, earlier referral of such individuals for rehabilitation, and greater use of employers and others to develop, perform, and otherwise stimulate new forms of rehabilitation); and

(C) implementing sliding scale benefit offsets using variations in—

(i) the amount of the offset as a proportion of earned income;

(ii) the duration of the offset period; and

(iii) the method of determining the amount of income earned by such individuals, to the end that savings will accrue to the Trust Funds, or to otherwise promote the objectives or facilitate the administration of this title.

(2) AUTHORITY FOR EXPANSION OF SCOPE.—The Commissioner may expand the scope of any such experiment or demonstration project to include any group of applicants for benefits under the program established under this title with impairments that reasonably may be presumed to be disabling for purposes of such demonstration project, and may limit any such demonstration project to any such group of applicants, subject to the terms of such demonstration project which shall define the extent of any such presumption.

(b) REQUIREMENTS.—The experiments and demonstration projects developed under subsection (a) shall be of sufficient scope and shall be carried out on a wide enough scale to permit a thorough evaluation of the alternative methods under consideration while giving assurance that the results derived from the experiments and projects will obtain generally in the operation of the disability insurance program under this title without committing such program to the adoption of any particular system either locally or nationally.

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[318] See Vol. II, P.L. 106–170, §302(c), with respect to expansion of waiver authority available in connection with demonstration projects providing for reductions in disability insurance benefits based on earnings and §302(f), with respect to funding of such demonstration projects.

(c) AUTHORITY TO WAIVE COMPLIANCE WITH BENEFITS REQUIREMENTS.—In the case of any experiment or demonstration project initiated under subsection (a) on or before December 17, 2005[321], the Commissioner may waive compliance with the benefit requirements of this title and the requirements of section 1148 as they relate to the program established under this title, and the Secretary may (upon the request of the Commissioner) waive compliance with the benefits requirements of title XVIII, insofar as is necessary for a thorough evaluation of the alternative methods under consideration. No such experiment or project shall be actually placed in operation unless at least 90 days prior thereto a written report, prepared for purposes of notification and information only and containing a full and complete description thereof, has been transmitted by the Commissioner to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate. Periodic reports on the progress of such experiments and demonstration projects shall be submitted by the Commissioner to such committees. When appropriate, such reports shall include detailed recommendations for changes in administration or law, or both, to carry out the objectives stated in subsection (a).

(d) REPORTS.—

(1) INTERIM REPORTS.—On or before June 9 of each year, the Commissioner shall submit to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate an annual interim report on the progress of the experiments and demonstration projects carried out under this subsection together with any related data and materials that the Commissioner may consider appropriate.

(2) TERMINATION AND FINAL REPORT.—The authority to initiate projects under the preceding provisions of this section shall terminate on December 18, 2005.[322] Not later than 90 days after the termination of any experiment or demonstration project carried out under this section, the Commissioner shall submit to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate a final report with respect to that experiment or demonstration project.

[319] P.L. 108–203, §401(1), struck out "conducted under subsection (a)" and substituted "initiated under subsection (a) on or before December 17, 2005", effective March 2, 2004.

[320] P.L. 108–203, §401(2), struck out the first sentence of (d)(2) and substituted this sentence, effective March 2, 2004.

TITLE III—GRANTS TO STATES FOR UNEMPLOYMENT COMPENSATION ADMINISTRATION [1]

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APPROPRIATIONS

SEC. 301. [42 U.S.C. 501] The amounts made available pursuant to section 901(c)(1)(A) for the purpose of assisting the States in the administration of their unemployment compensation laws shall be used as hereinafter provided.

PAYMENTS TO STATES

SEC. 302. [42 U.S.C. 502] (a) The Secretary of Labor shall from time to time certify to the Secretary of the Treasury for payment to each State which has an unemployment compensation law approved by the Secretary of Labor under the Federal Unemployment Tax Act [3], such amounts as the Secretary of Labor determines to be necessary for the proper and efficient administration of such law during the fiscal year for which such payment is to be made, including 100 percent of so much of the reasonable expenditures of the State as are attributable to the costs of the implementation and operation of the immigration status verification system described in section 1137(d). The Secretary of Labor's determination shall be based on (1) the population of the State; (2) an estimate of the number of persons covered by the State law and of the cost of proper and efficient administration of such law; and (3) such other fac-

[1] The President's Reorganization Plan No. 2 of 1949, §1 (14 FR 5225, 63 Stat. 1065), transferred the Bureau of Employment Security, including the United States Employment Service, from the Federal Security Agency to the Department of Labor, effective August 20, 1949.

Title III of the Social Security Act is administered by the Department of Labor.

Title III appears in the United States Code as §§501–504 of subchapter III, chapter 7, Title 42.

Regulations of the Secretary of Labor relating to Title III are contained in chapter V, Title 20, and subtitle A, Title 29, Code of Federal Regulations. Regulations of the Secretary of Health and Human Services (formerly Secretary of Health, Education, and Welfare) relating to Title III are contained in subtitle A, Title 45, Code of Federal Regulations.

See Vol. II, P.L. 95–521, §102(i), with respect to reporting of benefits received under the Social Security Act.

See Vol. II, P.L. 97–248, §604(c), with respect to an appropriation of funds to assist States in meeting administrative costs.

See Vol. II, P.L. 100–628, §904(c)(2) and (3), with respect to access to State employment records.

[2] This table of contents does not appear in the law.

[3] The "Federal Unemployment Tax Act" is in §§3301–3311 of P.L. 83–591 (this volume).

tors as the Secretary of Labor finds relevant. The Secretary of Labor shall not certify for payment under this section in any fiscal year a total amount in excess of the amount appropriated therefor for such fiscal year.

(b) Out of the sums appropriated therefor, the Secretary of the Treasury shall, upon receiving a certification under subsection (a), pay, through the Fiscal Service of the Department of the Treasury and prior to audit or settlement by the General Accounting Office[4], to the State agency charged with the administration of such law the amount so certified.

(c) No portion of the cost of mailing a statement under section 6050B(b) of the Internal Revenue Code of 1986 (relating to unemployment compensation) shall be treated as not being a cost for the proper and efficient administration of the State unemployment compensation law by reason of including with such statement information about the earned income credit provided by section 32 of the Internal Revenue Code of 1986. The preceding sentence shall not apply if the inclusion of such information increases the postage required to mail such statement.

PROVISIONS OF STATE LAWS

SEC. 303. [42 U.S.C. 503] (a) The Secretary of Labor shall make no certification for payment to any State unless he finds that the law of such State, approved by the Secretary of Labor under the Federal Unemployment Tax Act[5], includes provision for—

(1) Such methods of administration (including after January 1, 1940, methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary of Labor shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Secretary of Labor to be reasonably calculated to insure full payment of unemployment compensation when due[6]; and[7]

(2) Payment of unemployment compensation solely through public employment offices or such other agencies as the Secretary of Labor may approve; and

(3) Opportunity for a fair hearing, before an impartial tribunal, for all individuals whose claims for unemployment compensation are denied; and

(4) The payment of all money received in the unemployment fund of such State (except for refunds of sums erroneously paid into such fund and except for refunds paid in accordance with the provisions of section 3305(b) of the Federal Unemployment Tax Act[8]), immediately upon such receipt, to the Secretary of the Treasury to the credit of the unemployment trust fund[9] established by section 904; and

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[4] PL 108-271, §8(b), provided that "Any reference to the General Accounting Office in any law, rule, regulation, certificate, directive, instruction, or other official paper in force on the date of enactment to this Act, (July 7, 2004), shall be considered to refer and apply to the Government Accountability Office."

[5] See P.L. 83–591, §§3301–3311 (this volume).

[6] P.L. 91–648, §208(a)(2)(B), transferred to the U.S. Civil Service Commission, effective March 6, 1971, all functions, powers, and duties of the Secretary of Labor under paragraph (1).

[7] See Vol. II, P.L. 105–33, §5401, with respect to a clarifying provision relating to base periods.

[8] See P.L. 83–591, §3305(b) (this volume).

[9] As in original. Probably should be "Unemployment Trust Fund".

(5) Expenditure of all money withdrawn from an unemployment fund of such State, in the payment of unemployment compensation, exclusive of expenses of administration, and for refunds of sums erroneously paid into such fund and refunds paid in accordance with the provisions of section 3305(b) of the Federal Unemployment Tax Act: *Provided,* That an amount equal to the amount of employee payments in to the unemployment fund of a State may be used in the payment of cash benefits to individuals with respect to their disability, exclusive of expenses of administration: *Provided further,* That the amounts 903(c)(2) or 903(d)(4) may, subject to the conditions prescribed in such section, be used for expenses incurred by the State for administration of its unemployment compensation law and public employment offices: *Provided further,* That nothing in this paragraph shall be construed to prohibit deducting an amount from unemployment compensation otherwise payable to an individual and using the amount so deducted to pay for health insurance, or the withholding of Federal, State, or local individual income tax, if the individual elected to have such deduction made and such deduction was made under a program approved by the Secretary of Labor: *Provided further,* That amounts may be deducted from unemployment benefits and used to repay overpayments as provided in subsection (g): *Provided further,* That amounts may be withdrawn for the payment of short-time compensation under a plan approved by the Secretary of Labor: *Provided further,* That amounts may be withdrawn for the payment of allowances under a self-employment assistance program (as defined in section 3306(t) of the Internal Revenue Code of 1986); and

(6) The making of such reports, in such form and containing such information, as the Secretary of Labor may from time to time require, and compliance with such provisions as the Secretary of Labor may from time to time find necessary to assure the correctness and verification of such reports; and

(7) Making available upon request to any agency of the United States charged with the administration of public works or assistance through public employment, the name, address, ordinary occupation and employment status of each recipient of unemployment compensation, and a statement of such recipient's rights to further compensation under such law; and

(8) Effective July 1, 1941, the expenditure of all moneys received pursuant to section 302 of this title solely for the purposes and in the amounts found necessary by the Secretary of Labor for the proper and efficient administration of such State law; and

(9) Effective July 1, 1941, the replacement, within a reasonable time, of any moneys received pursuant to section 302 of this title, which, because of any action or contingency, have been lost or have been expended for purposes other than, or in amounts in excess of, those found necessary by the Secretary of Labor for the proper administration of such State law; and

(10) A requirement that, as a condition of eligibility for regular compensation for any week, any claimant who has been referred to reemployment services pursuant to the profiling system under subsection (j)(1)(B) participate in such services or in

similar services unless the State agency charged with the administration of the State law determines—

(A) such claimant has completed such services; or

(B) there is justifiable cause for such claimant's failure to participate in such services.

(b) Whenever the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency charged with the administration of the State law, finds that in the administration of the law there is—

(1) a denial, in a substantial number of cases, of unemployment compensation to individuals entitled thereto under such law; or

(2) a failure to comply substantially with any provision specified in subsection (a);

the Secretary of Labor shall notify such State agency that further payments will not be made to the State until the Secretary of Labor is satisfied that there is no longer any such denial or failure to comply. Until he is so satisfied he shall make no further certification to the Secretary of the Treasury with respect to such State: *Provided,* That there shall be no finding under clause (1) until the question of entitlement shall have been decided by the highest judicial authority given jurisdiction under such State law: *Provided further,* That any costs may be paid with respect to any claimant by a State and included as costs of administration of its law.

(c) The Secretary of Labor shall make no certification for payment to any State if he finds, after reasonable notice and opportunity for hearing to the State agency charged with the administration of the State law—

(1) that such State does not make its records available to the Railroad Retirement Board, and furnish to the Railroad Retirement Board at the expense of the Railroad Retirement Board such copies thereof as the Railroad Retirement Board deems necessary for its purposes;

(2) that such State is failing to afford reasonable cooperation with every agency of the United States charged with the administration of any unemployment insurance law; or

(3) that any interest required to be paid on advances under title XII of this Act has not been paid by the date on which such interest is required to be paid or has been paid directly or indirectly (by an equivalent reduction in State unemployment taxes or otherwise) by such State from amounts in such State's unemployment fund, until such interest is properly paid.

(d)(1) The State agency charged with the administration of the State law—

(A) shall disclose, upon request and on a reimbursable basis, to officers and employees of the Department of Agriculture and to officers or employees of any State food stamp agency any of the following information contained in the records of such State agency—

(i) wage information,

(ii) whether an individual is receiving, has received, or has made application for, unemployment compensation, and the amount of any such compensation being received (or to be received) by such individual,

(iii) the current (or most recent) home address of such individual, and

(iv) whether an individual has refused an offer of employment and, if so, a description of the employment so offered and the terms, conditions, and rate of pay therefor, and

(B) shall establish such safeguards as are necessary (as determined by the Secretary of Labor in regulations) to insure that information disclosed under subparagraph (A) is used only for purposes of determining an individual's eligibility for benefits, or the amount of benefits, under the food stamp program established under the Food Stamp Act of 1977.

(2)(A) For purposes of this paragraph, the term "unemployment compensation" means any unemployment compensation payable under the State law (including amounts payable pursuant to an agreement under a Federal unemployment compensation law).

(B) The State agency charged with the administration of the State law—

(i) may require each new applicant for unemployment compensation to disclose whether the applicant owes an uncollected overissuance (as defined in section 13(c)(1) of the Food Stamp Act of 1977) of food stamp coupons,

(ii) may notify the State food stamp agency to which the uncollected overissuance is owed that the applicant has been determined to be eligible for unemployment compensation if the applicant discloses under clause (i) that the applicant owes an uncollected overissuance and the applicant is determined to be so eligible,

(iii) may deduct and withhold from any unemployment compensation otherwise payable to an individual—

(I) the amount specified by the individual to the State agency to be deducted and withheld under this clause,

(II) the amount (if any) determined pursuant to an agreement submitted to the State food stamp agency under section 13(c)(3)(A) of the Food Stamp Act of 1977 [10], or

(III) any amount otherwise required to be deducted and withheld from the unemployment compensation pursuant to section 13(c)(3)(B) of such Act, and

(iv) shall pay any amount deducted and withheld under clause (iii) to the appropriate State food stamp agency.

(C) Any amount deducted and withheld under subparagraph (B)(iii) shall for all purposes be treated as if it were paid to the individual as unemployment compensation and paid by the individual to the State food stamp agency to

[10] See Vol. II, P.L. 88–525.

which the uncollected overissuance is owed as repayment of the individual's uncollected overissuance.

(D) A State food stamp agency to which an uncollected overissuance is owed shall reimburse the State agency charged with the administration of the State unemployment compensation law for the administrative costs incurred by the State agency under this paragraph that are attributable to repayment of uncollected overissuance to the State food stamp agency to which the uncollected overissuance is owed.

(3) Whenever the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency charged with the administration of the State law, finds that there is a failure to comply substantially with the requirements of paragraph (1), the Secretary of Labor shall notify such State agency that further payments will not be made to the State until he is satisfied that there is no longer any such failure. Until the Secretary of Labor is so satisfied, he shall make no further certification to the Secretary of the Treasury with respect to such State.

(4) For purposes of this subsection, the term "State food stamp agency" means any agency described in section 3(n)(1) of the Food Stamp Act of 1977 which administers the food stamp program established under such Act.[11]

(e)(1) The State agency charged with the administration of the State law—

(A) shall disclose, upon request and on a reimbursable basis, directly to officers or employees of any State or local child support enforcement agency any wage information contained in the records of such State agency, and

(B) shall establish such safeguards as are necessary (as determined by the Secretary of Labor in regulations) to insure that information disclosed under subparagraph (A) is used only for purposes of establishing and collecting child support obligations from, and locating, individuals owing such obligations.

For purposes of this subsection, the term "child support obligations" only includes obligations which are being enforced pursuant to a plan described in section 454 of this Act which has been approved by the Secretary of Health and Human Services under part D of title IV of this Act.

(2)(A) The State agency charged with the administration of the State law—

(i) shall require each new applicant for unemployment compensation to disclose whether or not such applicant owes child support obligations (as defined in the last sentence of paragraph (1)),

(ii) shall notify the State or local child support enforcement agency enforcing such obligations, if any applicant discloses under clause (i) that he owes child support obligations and he is determined to be eligible for unemployment compensation, that such applicant has been so determined to be eligible,

[11] See Vol. II, P.L. 88–525, §11(e)(19), with respect to requesting and exchanging information for verifying income and eligibility for food stamps.

(iii) shall deduct and withhold from any unemployment compensation otherwise payable to an individual—

(I) the amount specified by the individual to the State agency to be deducted and withheld under this clause,

(II) the amount (if any) determined pursuant to an agreement submitted to the State agency under section 454(19)(B)(i) of this Act, or

(III) any amount otherwise required to be so deducted and withheld from such unemployment compensation through legal process (as defined in section 462(e)), and

(iv) shall pay any amount deducted and withheld under clause (iii) to the appropriate State or local child support enforcement agency.

Any amount deducted and withheld under clause (iii) shall for all purposes be treated as if it were paid to the individual as unemployment compensation and paid by such individual to the State or local child support enforcement agency in satisfaction of his child support obligations.

(B) For purposes of this paragraph, the term "unemployment compensation" means any compensation payable under the State law (including amounts payable pursuant to agreements under any Federal unemployment compensation law).

(C) Each State or local child support enforcement agency shall reimburse the State agency charged with the administration of the State unemployment compensation law for the administrative costs incurred by such State agency under this paragraph which are attributable to child support obligations being enforced by the State or local child support enforcement agency.

(3) Whenever the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency charged with the administration of the State law, finds that there is a failure to comply substantially with the requirements of paragraph (1) or (2), the Secretary of Labor shall notify such State agency that further payments will not be made to the State until he is satisfied that there is no longer any such failure. Until the Secretary of Labor is so satisfied, he shall make no further certification to the Secretary of the Treasury with respect to such State.[12]

(4) For purposes of this subsection, the term "State or local child support enforcement agency" means any agency of a State or political subdivision thereof operating pursuant to a plan described in the last sentence of paragraph (1).

(5) A State or local child support enforcement agency may disclose to any agent of the agency that is under contract with the agency to carry out the purposes described in paragraph (1)(B) wage information that is disclosed to an officer or employee of the agency under paragraph (1)(A). Any agent of a State or local child support agency that receives wage informa-

[12] See Vol. II, P.L. 96–499, §1025, with respect to withholding certification of State unemployment laws.

tion under this paragraph shall comply with the safeguards established pursuant to paragraph (1)(B).

(f) The State agency charged with the administration of the State law shall provide that information shall be 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.

(g)(1) A State may deduct from unemployment benefits otherwise payable to an individual an amount equal to any overpayment made to such individual under an unemployment benefit program of the United States or of any other State, and not previously recovered. The amount so deducted shall be paid to the jurisdiction under whose program such overpayment was made. Any such deduction shall be made only in accordance with the same procedures relating to notice and opportunity for a hearing as apply to the recovery of overpayments of regular unemployment compensation paid by such State.

(2) Any State may enter into an agreement with the Secretary of Labor under which—

(A) the State agrees to recover from unemployment benefits otherwise payable to an individual by such State any overpayments made under an unemployment benefit program of the United States to such individual and not previously recovered, in accordance with paragraph (1), and to pay such amounts recovered to the United States for credit to the appropriate account, and

(B) the United States agrees to allow the State to recover from unemployment benefits otherwise payable to an individual under an unemployment benefit program of the United States any overpayments made by such State to such individual under a State unemployment benefit program and not previously recovered, in accordance with the same procedures as apply under paragraph (1).

(3) For purposes of this subsection, "unemployment benefits" means unemployment compensation, trade adjustment allowances, and other unemployment assistance.

(h)(1) The State agency charged with the administration of the State law shall, on a reimbursable basis—

(A) disclose quarterly, to the Secretary of Health and Human Services, wage and claim information, as required pursuant to section 453(i)(1), contained in the records of such agency;

(B) ensure that information provided pursuant to subparagraph (A) meets such standards relating to correctness and verification as the Secretary of Health and Human Services, with the concurrence of the Secretary of Labor, may find necessary; and

(C) establish such safeguards as the Secretary of Labor determines are necessary to insure that information disclosed under subparagraph (A) is used only for purposes of subsections (i)(1), (i)(3), and (j) of section 453.

(2) Whenever the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency charged with the administration of the State law, finds that there is a failure to comply substantially with the requirements of paragraph (1), the Secretary of Labor shall notify such State agency

that further payments will not be made to the State until the Secretary of Labor is satisfied that there is no longer any such failure. Until the Secretary of Labor is so satisfied, such Secretary shall make no future certification to the Secretary of the Treasury with respect to the State.

(3) For purposes of this subsection—

(A) the term "wage information" means information regarding wages paid to an individual, the social security account number of such individual, and the name, address, State, and the Federal employer identification number of the employer paying such wages to such individual; and

(B) the term "claim information" means information regarding whether an individual is receiving, has received, or has made application for, unemployment compensation, the amount of any such compensation being received (or to be received by such individual), and the individual's current (or most recent) home address.

(i)(1) The State agency charged with the administration of the State law—

(A) shall disclose, upon request and on a reimbursable basis, only to officers and employees of the Department of Housing and Urban Development and to representatives of a public housing agency, any of the following information contained in the records of such State agency with respect to individuals applying for or participating in any housing assistance program administered by the Department who have signed an appropriate consent form approved by the Secretary of Housing and Urban Development—

(i) wage information, and

(ii) whether an individual is receiving, has received, or has made application for, unemployment compensation, and the amount of any such compensation being received (or to be received) by such individual, and

(B) shall establish such safeguards as are necessary (as determined by the Secretary of Labor in regulations) to ensure that information disclosed under subparagraph (A) is used only for purposes of determining an individual's eligibility for benefits, or the amount of benefits, under a housing assistance program of the Department of Housing and Urban Development.

(2) The Secretary of Labor shall prescribe regulations governing how often and in what form information may be disclosed under paragraph (1)(A).

(3) Whenever the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency charged with the administration of the State law, finds that there is a failure to comply substantially with the requirements of paragraph (1), the Secretary of Labor shall notify such State agency that further payments will not be made to the State until he or she is satisfied that there is no longer any such failure. Until the Secretary of Labor is so satisfied, he or she shall make no future certification to the Secretary of the Treasury with respect to such State.

(4) For purposes of this subsection, the term "public housing agency" means any agency described in section 3(b)(6) of the United States Housing Act of 1937 [13].

(j)(1) The State agency charged with the administration of the State law shall establish and utilize a system of profiling all new claimants for regular compensation that—

(A) identifies which claimants will be likely to exhaust regular compensation and will need job search assistance services to make a successful transition to new employment;

(B) refers claimants identified pursuant to subparagraph (A) to reemployment services, such as job search assistance services, available under any State or Federal law;

(C) collects follow-up information relating to the services received by such claimants and the employment outcomes for such claimants subsequent to receiving such services and utilizes such information in making identifications pursuant to subparagraph (A); and

(D) meets such other requirements as the Secretary of Labor determines are appropriate.

(2) Whenever the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency charged with the administration of the State law, finds that there is a failure to comply substantially with the requirements of paragraph (1), the Secretary of Labor shall notify such State agency that further payments will not be made to the State until he is satisfied that there is no longer any such failure. Until the Secretary of Labor is so satisfied, he shall make no further certification to the Secretary of the Treasury with respect to such State.

(k) [14] (1) For purposes of subsection (a), the unemployment compensation law of a State must provide—

(A) that if an employer transfers its business to another employer, and both employers are (at the time of transfer) under substantially common ownership, management, or control, then the unemployment experience attributable to the transferred business shall also be transferred to (and combined with the unemployment experience attributable to) the employer to whom such business is so transferred,

(B) that unemployment experience shall not, by virtue of the transfer of a business, be transferred to the person acquiring such business if—

(i) such person is not otherwise an employer at the time of such acquisition, and

(ii) the State agency finds that such person acquired the business solely or primarily for the purpose of obtaining a lower rate of contributions,

(C) that unemployment experience shall (or shall not) be transferred in accordance with such regulations as the Secretary of Labor may prescribe to ensure that higher rates

[13] See Vol. II, P.L. 75–412.

[14] P.L. 108–295, §2(a), added subsection (k), applicable to a certifications for payments (under section 302(a) of the Social Security Act) in rate years beginning after the end of the 26-week period beginning on the first day of the first regularly scheduled session of the State legislature beginning on or after August 9, 2004.

See Vol. II, P.L. 108–295, §2(d), with respect to a study and reporting requirements and definitions for §303(k) .

of contributions are not avoided through the transfer or acquisition of a business,

(D) that meaningful civil and criminal penalties are imposed with respect to—

(i) persons that knowingly violate or attempt to violate those provisions of the State law which implement subparagraph (A) or (B) or regulations under subparagraph (C), and

(ii) persons that knowingly advise another person to violate those provisions of the State law which implement subparagraph (A) or (B) or regulations under subparagraph (C), and

(E) for the establishment of procedures to identify the transfer or acquisition of a business for purposes of this subsection.

(2) For purposes of this subsection—

(A) the term "unemployment experience", with respect to any person, refers to such person's experience with respect to unemployment or other factors bearing a direct relation to such person's unemployment risk;

(B) the term "employer" means an employer as defined under the State law;

(C) the term "business" means a trade or business (or a part thereof);

(D) the term "contributions" has the meaning given such term by section 3306(g) of the Internal Revenue Code of 1986 [15];

(E) the term "knowingly" means having actual knowledge of or acting with deliberate ignorance of or reckless disregard for the prohibition involved; and

(F) the term "person" has the meaning given such term by section 7701(a)(1) of the Internal Revenue Code of 1986 [16].

JUDICIAL REVIEW

SEC. 304. [42 U.S.C. 504] (a) Whenever the Secretary of Labor—

(1) finds that a State law does not include any provision specified in section 303(a), or

(2) makes a finding with respect to a State under subsection (b), (c), (d), (e), (h), (i), or (j) of section 303,

such State may, within 60 days after the Governor of the State has been notified of such action, file with the United States court of appeals for the circuit in which such State is located or with the United States Court of Appeals for the District of Columbia, a petition for review of such action. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary of Labor. The Secretary of Labor thereupon shall file in the court the record of the proceedings on which he based his action as provided in section 2112 of title 28, United States Code [17].

(b) The findings of fact by the Secretary of Labor, if supported by substantial evidence, shall be conclusive; but the court, for good cause shown, may remand the case to the Secretary of Labor to

[15] See P.L. 83-591, §3306(g) (this volume).
[16] See Vol. II, P.L. 83-591, §7701(a)(1).
[17] See Vol. II, 28 U.S.C. 2112.

take further evidence and the Secretary of Labor may thereupon make new or modified findings of fact and may modify his previous action, and shall certify to the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence.

(c) The court shall have jurisdiction to affirm the action of the Secretary of Labor or to set it aside, in whole or in part. The judgment of the court shall be subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28 of the United States Code [18].

(d)(1) The Secretary of Labor shall not withhold any certification for payment to any State under section 302 until the expiration of 60 days after the Governor of the State has been notified of the action referred to in paragraph (1) or (2) of subsection (a) or until the State has filed a petition for review of such action, whichever is earlier.

(2) The commencement of judicial proceedings under this section shall stay the Secretary's action for a period of 30 days, and the court may thereafter grant interim relief if warranted, including a further stay of the Secretary's action and including such other relief as may be necessary to preserve status or rights.

[18] See Vol. II, 28 U.S.C. 1254.

TITLE IV—GRANTS TO STATES FOR AID AND SERVICES TO NEEDY FAMILIES WITH CHILDREN AND FOR CHILD-WELFARE SERVICES [1]

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[1] Title IV of the Social Security Act is administered by the Department of Health and Human Services. The Office of Family Assistance administers benefit payments under Title IV, Parts A and C. The Administration for Public Services, Office of Human Development Services, administers social services under Title IV, Parts B and E. The Office of Child Support Enforcement administers the child support program under Title IV, Part D.

Title IV appears in the United States Code as §§601–687, subchapter IV, chapter 7, Title 42.

Regulations of the Secretary of Health and Human Services relating to Title IV are contained in chapters II, III, and XIII, Title 45, Code of Federal Regulations. Regulations of the Secretary of Labor relating to Title IV are contained in subtitle A, Title 29, and chapter 29, Title 41, Code of Federal Regulations.

See Vol. II, 31 U.S.C. 3720 and 3720A, with respect to collection of payments due to Federal agencies; 6504–6505, with respect to intergovernmental cooperation; 7501–7507, with respect to uniform audit requirements for State and local governments receiving Federal financial assistance.

See Vol. II, P.L. 82–183, §618, which prohibits denial of grants-in-aid under certain conditions.

See Vol. II, P.L. 88–352, §601, for prohibition against discrimination in federally assisted programs.

See Vol. II, P.L. 89–73, §213, with respect to eligibility for Federal surplus property.

See Vol. II, P.L. 89–97, §121(b), with respect to restrictions on payment to a State receiving payments under Title XIX.

See Vol. II, Appendix, P.L. 94–241, §1, for §502(a)(1) of H.J. Res. 549, with respect to participation by the Commonwealth of the Northern Mariana Islands on the same basis as Guam.

See Vol. II, P.L. 95–521, §102(i), with respect to reporting of benefits received under the Social Security Act.

See Vol. II, P.L. 100–204, §724(d), with respect to furnishing information to the United States Commission on Improving the Effectiveness of the United Nations; and §725(b), with respect to the detailing of Government personnel.

See Vol. II, P.L. 100–235, §§5–8, with respect to responsibilities of each Federal agency for computer systems security and privacy.

See Vol. II, P.L. 100–690, §5301(a)(1)(C) and (d)(1)(B), with respect to benefits of drug traffickers and possessors.

See Vol. II, P.L. 101–508, §§13301 and 13302, with respect to the OASDI Trust Funds.

[2] This table of contents does not appear in the law.

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PART A—BLOCK GRANTS TO STATES FOR TEMPORARY ASSISTANCE FOR NEEDY FAMILIES[3]

PURPOSE

SEC. 401. [42 U.S.C. 601] (a) IN GENERAL.—The purpose of this part is to increase the flexibility of States in operating a program designed to—

(1) provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives;

(2) end the dependence of needy parents on government benefits by promoting job preparation, work, and marriage;

(3) prevent and reduce the incidence of out–of–wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies; and

(4) encourage the formation and maintenance of two–parent families.

(b) NO INDIVIDUAL ENTITLEMENT.—This part shall not be interpreted to entitle any individual or family to assistance under any State program funded under this part.

[3] See Vol. II, P.L. 108-89, §101(a), P.L. 108-262, §2(a), and P.L. 108-308, §2(a) with respect to the extension of the temporary assistance for needy families block grant program.

ELIGIBLE STATES; STATE PLAN

SEC. 402. [42 U.S.C. 602] (a) IN GENERAL.—As used in this part, the term "eligible State" means, with respect to a fiscal year, a State that, during the 27–month period ending with the close of the 1st quarter of the fiscal year, has submitted to the Secretary a plan that the Secretary has found includes the following:

(1) OUTLINE OF FAMILY ASSISTANCE PROGRAM.—

(A) GENERAL PROVISIONS.—A written document that outlines how the State intends to do the following:

(i) Conduct a program, designed to serve all political subdivisions in the State (not necessarily in a uniform manner), that provides assistance to needy families with (or expecting) children and provides parents with job preparation, work and support services to enable them to leave the program and become self–sufficient.

(ii) Require a parent or caretaker receiving assistance under the program to engage in work (as defined by the State) once the State determines the parent or caretaker is ready to engage in work, or once the parent or caretaker has received assistance under the program for 24 months (whether or not consecutive), whichever is earlier, consistent with section 407(e)(2).

(iii) Ensure that parents and caretakers receiving assistance under the program engage in work activities in accordance with section 407.

(iv) Take such reasonable steps as the State deems necessary to restrict the use and disclosure of information about individuals and families receiving assistance under the program attributable to funds provided by the Federal Government.

(v) Establish goals and take action to prevent and reduce the incidence of out–of–wedlock pregnancies, with special emphasis on teenage pregnancies, and establish numerical goals for reducing the illegitimacy ratio of the State (as defined in section 403(a)(2)(C)(iii)).

(vi) Conduct a program, designed to reach State and local law enforcement officials, the education system, and relevant counseling services, that provides education and training on the problem of statutory rape so that teenage pregnancy prevention programs may be expanded in scope to include men.

(B) SPECIAL PROVISIONS.—

(i) The document shall indicate whether the State intends to treat families moving into the State from another State differently than other families under the program, and if so, how the State intends to treat such families under the program.

(ii) The document shall indicate whether the State intends to provide assistance under the program to individuals who are not citizens of the United States, and if so, shall include an overview of such assistance.

(iii) The document shall set forth objective criteria for the delivery of benefits and the determination of eligibility and for fair and equitable treatment, including an explanation of how the State will provide op-

portunities for recipients who have been adversely affected to be heard in a State administrative or appeal process.

(iv) Not later than 1 year after the date of enactment of this section, unless the chief executive officer of the State opts out of this provision by notifying the Secretary, a State shall, consistent with the exception provided in section 407(e)(2), require a parent or caretaker receiving assistance under the program who, after receiving such assistance for 2 months is not exempt from work requirements and is not engaged in work, as determined under section 407(c), to participate in community service employment, with minimum hours per week and tasks to be determined by the State.

(2) CERTIFICATION THAT THE STATE WILL OPERATE A CHILD SUPPORT ENFORCEMENT PROGRAM.—A certification by the chief executive officer of the State that, during the fiscal year, the State will operate a child support enforcement program under the State plan approved under part D.

(3) CERTIFICATION THAT THE STATE WILL OPERATE A FOSTER CARE AND ADOPTION ASSISTANCE PROGRAM.—A certification by the chief executive officer of the State that, during the fiscal year, the State will operate a foster care and adoption assistance program under the State plan approved under part E, and that the State will take such actions as are necessary to ensure that children receiving assistance under such part are eligible for medical assistance under the State plan under title XIX.

(4) CERTIFICATION OF THE ADMINISTRATION OF THE PROGRAM.—A certification by the chief executive officer of the State specifying which State agency or agencies will administer and supervise the program referred to in paragraph (1) for the fiscal year, which shall include assurances that local governments and private sector organizations—

(A) have been consulted regarding the plan and design of welfare services in the State so that services are provided in a manner appropriate to local populations; and

(B) have had at least 45 days to submit comments on the plan and the design of such services.

(5) CERTIFICATION THAT THE STATE WILL PROVIDE INDIANS WITH EQUITABLE ACCESS TO ASSISTANCE.—A certification by the chief executive officer of the State that, during the fiscal year, the State will provide each member of an Indian tribe, who is domiciled in the State and is not eligible for assistance under a tribal family assistance plan approved under section 412, with equitable access to assistance under the State program funded under this part attributable to funds provided by the Federal Government.

(6) CERTIFICATION OF STANDARDS AND PROCEDURES TO ENSURE AGAINST PROGRAM FRAUD AND ABUSE.—A certification by the chief executive officer of the State that the State has established and is enforcing standards and procedures to ensure against program fraud and abuse, including standards and procedures concerning nepotism, conflicts of interest among individuals responsible for the administration and supervision of

the State program, kickbacks, and the use of political patronage.

(7) OPTIONAL CERTIFICATION OF STANDARDS AND PROCEDURES TO ENSURE THAT THE STATE WILL SCREEN FOR AND IDENTIFY DOMESTIC VIOLENCE.—

(A) IN GENERAL.—At the option of the State, a certification by the chief executive officer of the State that the State has established and is enforcing standards and procedures to—

(i) screen and identify individuals receiving assistance under this part with a history of domestic violence while maintaining the confidentiality of such individuals;

(ii) refer such individuals to counseling and supportive services; and

(iii) waive, pursuant to a determination of good cause, other program requirements such as time limits (for so long as necessary) for individuals receiving assistance, residency requirements, child support cooperation requirements, and family cap provisions, in cases where compliance with such requirements would make it more difficult for individuals receiving assistance under this part to escape domestic violence or unfairly penalize such individuals who are or have been victimized by such violence, or individuals who are at risk of further domestic violence.

(B) DOMESTIC VIOLENCE DEFINED.—For purposes of this paragraph, the term "domestic violence" has the same meaning as the term "battered or subjected to extreme cruelty", as defined in section 408(a)(7)(C)(iii).

(b) PLAN AMENDMENTS.—Within 30 days after a State amends a plan submitted pursuant to subsection (a), the State shall notify the Secretary of the amendment.

(c) PUBLIC AVAILABILITY OF STATE PLAN SUMMARY.—The State shall make available to the public a summary of any plan or plan amendment section.

GRANTS TO STATES

SEC. 403. [42 U.S.C. 603] (a) GRANTS.—

(1) FAMILY ASSISTANCE GRANT.—

(A) IN GENERAL.—Each eligible State shall be entitled to receive from the Secretary, for each of fiscal years 1996, 1997, 1998, 1999, 2000, 2001, 2002, and 2003[4], a grant in an amount equal to the State family assistance grant.

(B) STATE FAMILY ASSISTANCE GRANT.—The State family assistance grant payable to a State for a fiscal year shall be the amount that bears the same ratio to the amount specified in subparagraph (C) of this paragraph as the amount required to be paid to the State under this paragraph for fiscal year 2002 (determined without regard to any reduction pursuant to section 409 or 412(a)(1)) bears to the total amount required to be paid under this paragraph for fiscal year 2002 (as so determined).

[4] P.L. 108-40, §3(a)(1), struck out "and 2002" and substituted "2002, and 2003", effective July 1, 2003.

(C) APPROPRIATION.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated for fiscal year 2003 $16,566, 542,000 for grants under this paragraph.[5]

(2) BONUS TO REWARD DECREASE IN ILLEGITIMACY RATIO.—

(A) IN GENERAL.—Each eligible State shall be entitled to receive from the Secretary a grant for each bonus year.

(B) AMOUNT OF GRANT.—

(i) IN GENERAL.—If, for a bonus year, none of the eligible States is Guam, the Virgin Islands, or American Samoa, then the amount of the grant shall be—

(I) $20,000,000 if there are 5 eligible States; or

(II) $25,000,000 if there are fewer than 5 eligible States.

(ii) AMOUNT IF CERTAIN TERRITORIES ARE ELIGIBLE.—If, for a bonus year, Guam, the Virgin Islands, or American Samoa is an eligible State, then the amount of the grant shall be—

(I) in the case of such a territory, 25 percent of the mandatory ceiling amount (as defined in section 1108(c)(4)) with respect to the territory; and

(II) in the case of a State that is not such a territory—

(aa) if there are 5 eligible States other than such territories, $20,000,000, minus ⅕ of the total amount of the grants payable under this paragraph to such territories for the bonus year; or

(bb) if there are fewer than 5 such eligible States, $25,000,000, or such lesser amount as may be necessary to ensure that the total amount of grants payable under this paragraph for the bonus year does not exceed $100,000,000.

(C) DEFINITIONS.—As used in this paragraph:

(i) ELIGIBLE STATE.—

(I) IN GENERAL.—The term "eligible State" means a State that the Secretary determines meets the following requirements:

(aa) The State demonstrates that the illegitimacy ratio of the State for the most recent 2–year period for which such information is available decreased as compared to the illegitimacy ratio of the State for the previous 2–year period, and the magnitude of the decrease for the State for the period is not exceeded by the magnitude of the corresponding decrease for 5 or more other States for the period. In the case of a State that is not a territory specified in subparagraph (B), the comparative magnitude of the decrease for the State shall be determined without regard to

[5] P.L. 108-40, §3(a)(2), struck out subparagraphs (B) through (E) and substituted these subparagraphs (B) and (C), effective July 1, 2003. For subparagraphs (B) through (E) as they formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L. 108-40.

the magnitude of the corresponding decrease for any such territory.

(bb) The rate of induced pregnancy terminations in the State for the calendar year for which the most recent data are available is less than the rate of induced pregnancy terminations in the State for the calendar year 1995. 104–193, §103(a).

(II) DISREGARD OF CHANGES IN DATA DUE TO CHANGED REPORTING METHODS.—In making the determination required by subclause (I), the Secretary shall disregard—

(aa) any difference between the illegitimacy ratio of a State for a calendar year and the number of out–of–wedlock births that occurred in a State for fiscal year 1995 which is attributable to a change in State methods of reporting data used to calculate the illegitimacy ratio; and

(bb) any difference between the rate of induced pregnancy terminations in a State for a calendar year and such rate for calendar year 1995 which is attributable to a change in State methods of reporting data used to calculate such rate.

(ii) BONUS YEAR.—The term "bonus year" means calendar years 1999, 2000, 2001, 2002, and 2003[6]

(iii) ILLEGITIMACY RATIO.—The term "illegitimacy ratio" means, with respect to a State and a period—

(I) the number of out–of–wedlock births to mothers residing in the State that occurred during the period; divided by

(II) the number of births to mothers residing in the State that occurred during the period.

(D) APPROPRIATION.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated for fiscal years 1999 through 2003[7], such sums as are necessary for grants under this paragraph.

(3) SUPPLEMENTAL GRANT FOR POPULATION INCREASES IN CERTAIN STATES.—

(A) IN GENERAL.—Each qualifying State shall, subject to subparagraph (F), be entitled to receive from the Secretary—

(i) for fiscal year 1998 a grant in an amount equal to 2.5 percent of the total amount required to be paid to the State under former section 403 (as in effect during fiscal year 1994) for fiscal year 1994; and

(ii) for each of fiscal years 1999, 2000, and 2001, a grant in an amount equal to the sum of—

(I) the amount (if any) required to be paid to the State under this paragraph for the immediately preceding fiscal year; and

(II) 2.5 percent of the sum of—

[6] P. L. 108-40, §3(c)(1), struck out "and 2002" and substituted "2002, and 2003", effective July 1, 2003.

[7] P.L. 108-40, §3(c)(2), struck out "2002" and substituted "2003", effective July 1, 2003.

(aa) the total amount required to be paid to the State under former section 403 (as in effect during fiscal year 1994) for fiscal year 1994; and

(bb) the amount (if any) required to be paid to the State under this paragraph for the fiscal year preceding the fiscal year for which the grant is to be made.

(B) PRESERVATION OF GRANT WITHOUT INCREASES FOR STATES FAILING TO REMAIN QUALIFYING STATES.—Each State that is not a qualifying State for a fiscal year specified in subparagraph (A)(ii) but was a qualifying State for a prior fiscal year shall, subject to subparagraph (F), be entitled to receive from the Secretary for the specified fiscal year, a grant in an amount equal to the amount required to be paid to the State under this paragraph for the most recent fiscal year for which the State was a qualifying State.

(C) QUALIFYING STATE.—

(i) IN GENERAL.—For purposes of this paragraph, a State is a qualifying State for a fiscal year if—

(I) the level of welfare spending per poor person by the State for the immediately preceding fiscal year is less than the national average level of State welfare spending per poor person for such preceding fiscal year; and

(II) the population growth rate of the State (as determined by the Bureau of the Census) for the most recent fiscal year for which information is available exceeds the average population growth rate for all States (as so determined) for such most recent fiscal year.

(ii) STATE MUST QUALIFY IN FISCAL YEAR 1998.—Notwithstanding clause (i), a State shall not be a qualifying State for any fiscal year after 1998 by reason of clause (i) if the State is not a qualifying State for fiscal year 1998 by reason of clause (i). for

(iii) CERTAIN STATES DEEMED QUALIFYING STATES.—For purposes of this paragraph, a State is deemed to be a qualifying State for fiscal years 1998, 1999, 2000, and 2001 if—

(I) the level of welfare spending per poor person by the State for fiscal year 1994 is less than 35 percent of the national average level of State welfare spending per poor person for fiscal year 1994; or

(II) the population of the State increased by more than 10 percent from April 1, 1990 to July 1, 1994, according to the population estimates in publication CB94–204 of the Bureau of the Census.

(D) DEFINITIONS.—As used in this paragraph:

(i) LEVEL OF WELFARE SPENDING PER POOR PERSON.—The term "level of State welfare spending per poor person" means, with respect to a State and a fiscal year—

(I) the sum of—

(aa) the total amount required to be paid to the State under former section 403 (as in effect during fiscal year 1994) for fiscal year 1994; and

(bb) the amount (if any) paid to the State under this paragraph for the immediately preceding fiscal year; divided by

(II) the number of individuals, according to the 1990 decennial census, who were residents of the State and whose income was below the poverty line.

(ii) NATIONAL AVERAGE LEVEL OF STATE WELFARE SPENDING PER POOR PERSON.—The term "national average level of State welfare spending per poor person" means, with respect to a fiscal year, an amount equal to—

(I) the total amount required to be paid to the States under former section 403 (as in effect during fiscal year 1994) for fiscal year 1994; divided by

(II) the number of individuals, according to the 1990 decennial census, who were residents of any State and whose income was below the poverty line.

(iii) STATE.—The term "State" means each of the 50 States of the United States and the District of Columbia.

(E) APPROPRIATION.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated for fiscal years 1998, 1999, 2000, and 2001 such sums as are necessary for grants under this paragraph, in a total amount not to exceed $800,000,000.

(F) GRANTS REDUCED PRO RATA IF INSUFFICIENT APPROPRIATIONS.—If the amount appropriated pursuant to this paragraph for a fiscal year is less than the total amount of payments otherwise required to be made under this paragraph for the fiscal year, then the amount otherwise payable to any State for the fiscal year under this paragraph shall be reduced by a percentage equal to the amount so appropriated divided by such total amount.

(G) BUDGET SCORING.—Notwithstanding section 257(b)(2) of the Balanced Budget and Emergency Deficit Control Act of 1985, the baseline shall assume that no grant shall be made under this paragraph after fiscal year 2001.

(H) REAUTHORIZATION [8].—Notwithstanding any other provision of this paragraph—

(i) any State that was a qualifying State under this paragraph for fiscal year 2001 or any prior fiscal year shall be entitled to receive from the Secretary for each of fiscal years 2002 and 2003 [9] a grant in an amount

[8] P.L. 108-40, §3(d)(1), struck out "of grants for fiscal year 2002", effective July 1, 2003.
P.L. 108-89, §101(b)(1)(A), also struck out "of grants for fiscal year 2002".

[9] P.L. 108-40, §3(d)(2), struck out "fiscal year 2002" and substituted "each of fiscal years 2002 and 2003", effective July 1, 2003.

equal to the amount required to be paid to the State under this paragraph for the most recent fiscal year in which the State was a qualifying State;

(ii) Subparagraph (G) shall be applied as if "March 31, 2005[10]" were substituted for "fiscal year 2001[11]"; and

(iii) out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated for each of fiscal years 2002 and 2003[12] such sums as are necessary for grants under this subparagraph.

(4) BONUS TO REWARD HIGH PERFORMANCE STATES.—

(A) IN GENERAL.—The Secretary shall make a grant pursuant to this paragraph to each State for each bonus year for which the State is a high performing State.

(B) AMOUNT OF GRANT.—

(i) IN GENERAL.—Subject to clause (ii) of this subparagraph, the Secretary shall determine the amount of the grant payable under this paragraph to a high performing State for a bonus year, which shall be based on the score assigned to the State under subparagraph (D)(i) for the fiscal year that immediately precedes the bonus year.

(ii) LIMITATION.—The amount payable to a State under this paragraph for a bonus year shall not exceed 5 percent of the State family assistance grant.

(C) FORMULA FOR MEASURING STATE PERFORMANCE.—Not later than 1 year after the date of the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996[13], the Secretary, in consultation with the National Governors' Association and the American Public Welfare Association, shall develop a formula for measuring State performance in operating the State program funded under this part so as to achieve the goals set forth in section 401(a).

(D) SCORING OF STATE PERFORMANCE; SETTING OF PERFORMANCE THRESHOLDS.—For each bonus year, the Secretary shall—

(i) use the formula developed under subparagraph (C) to assign a score to each eligible State for the fiscal year that immediately precedes the bonus year; and

(ii) prescribe a performance threshold in such a manner so as to ensure that—

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[10] P.L. 108-40, §3(d)(3), struck out "2002" and substituted "2003", effective July 1, 2003.

P.L. 108-89, §101(b)(1)(B)(i), struck out "2003" and substituted "March 31*, 2004", effective October 1, 2003.

*P.L. 108-210, §2(b), struck out "March 31" and substituted "June 30**", effective March 31, 2004.

**P.L. 108-262, §2(b), struck out "June 30" and substituted "September 30", effective June 30, 2004.

P.L. 108-308, §2(b)(1), struck out "September 30, 2004" and substituted "March 31, 2005", effective September 30, 2004.

[11] P.L. 108-89, §101(b)(1)(B)(ii), struck out "2001" and substituted "fiscal year 2001", effective October 1, 2003.

[12] P.L. 108-40, §3(d)(4), struck out "fiscal year 2002" and substituted "each of fiscal years 2002 and 2003", effective July 1, 2003.

[13] The date of enactment of P.L. 104-193 was August 22, 1986.

(I) the average annual total amount of grants to be made under this paragraph for each bonus year equals $200,000,000; and

(II) the total amount of grants to be made under this paragraph for all bonus years equals $1,000,000,000.

(E) DEFINITIONS.—As used in this paragraph:

(i) BONUS YEAR.—The term "bonus year" means fiscal years 1999, 2000, 2001, 2002, and 2003.

(ii) HIGH PERFORMING STATE.—The term "high performing State" means, with respect to a bonus year, an eligible State whose score assigned pursuant to subparagraph (D)(i) for the fiscal year immediately preceding the bonus year equals or exceeds the performance threshold prescribed under subparagraph (D)(ii) for such preceding fiscal year.

(F) APPROPRIATION.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated for fiscal years 1999 through 2003 $1,000,000,000 for grants under this paragraph.

(5) WELFARE–TO–WORK GRANTS.—

(A) FORMULA GRANTS.—

(i) ENTITLEMENT.—A State shall be entitled to receive from the Secretary of Labor a grant for each fiscal year specified in subparagraph (H) of this paragraph for which the State is a welfare–to–work State, in an amount that does not exceed the lesser of—

(I) 2 times the total of the expenditures by the State (excluding qualified State expenditures (as defined in section 409(a)(7)(B)(i)) and any expenditure described in subclause (I), (II), or (IV) of section 409(a)(7)(B)(iv)) during the period permitted under subparagraph (C)(vii) of this paragraph for the expenditure of funds under the grant for activities described in subparagraph (C)(i) of this paragraph; or

(II) the allotment of the State under clause (iii) of this subparagraph for the fiscal year.

(ii) WELFARE–TO–WORK STATE.—A State shall be considered a welfare–to–work State for a fiscal year for purposes of this paragraph if the Secretary of Labor determines that the State meets the following requirements:

(I) The State has submitted to the Secretary of Labor and the Secretary of Health and Human Services (in the form of an addendum to the State plan submitted under section 402) a plan which—

(aa) describes how, consistent with this subparagraph, the State will use any funds provided under this subparagraph during the fiscal year;

(bb) specifies the formula to be used pursuant to clause (vi) to distribute funds in the State, and describes the process by which the formula was developed;

(cc) contains evidence that the plan was developed in consultation and coordination with appropriate entitites in sub–State areas;

(dd) contains assurances by the Governor of the State that the private industry council (and any alternate agency designated by the Governor under item (ee)) for a service delivery area in the State will coordinate the expenditure of any funds provided under this subparagraph for the benefit of the service delivery area with the expenditure of the funds provided to the State under section 403(a)(1);

(ee) if the Governor of the State desires to have an agency other than a industry council administer the funds provided under this subparagraph for the benefit of 1 or more service delivery areas in the State, contains an application to the Secretary of Labor for a waiver of clause (vii)(I) with respect to the area or areas in order to permit an alternate agency designated by the Governor to so administer the funds; and

(ff) describes how the State will ensure that a private industry council to which information is disclosed pursuant to section 403(a)(5)(K) or 454A(f)(5) has procedures for safeguarding the information and for ensuring that the information is used solely for the purpose described in that section.

(II) The State has provided to the Secretary of Labor an estimate of the amount that the State intends to expend during the period permitted under subparagraph (C)(vii) of this paragraph for the expenditure of funds under the grant (excluding expenditures described in section 409(a)(7)(B)(iv) (other than subclause (III) thereof)) pursuant to this paragraph.

(III) The State has agreed to negotiate in good faith with the Secretary of Health and Human Services with respect to the substance and funding of any evaluation under section 413(j), and to cooperate with the conduct of any such evaluation.

(IV) The State is an eligible State for the fiscal year.

(V) The State certifies that qualified State expenditures (within the meaning of section 409(a)(7)) for the fiscal year will be not less than the applicable percentage of historic State expenditures (within the meaning of section 409(a)(7)) with respect to the fiscal year.

(iii) ALLOTMENTS TO WELFARE–TO–WORK STATES.—

(I) IN GENERAL.—Subject to this clause, the allotment of a welfare–to–work State for a fiscal year shall be the available amount for the fiscal

year, multiplied by the State percentage for the fiscal year.

(II) MINIMUM ALLOTMENT.—The allotment of a welfare–to–work State (other than Guam, the Virgin Islands, or American Samoa) for a fiscal year shall not be less than 0.25 percent of the available amount for the fiscal year.

(III) PRO RATA REDUCTION.—Subject to subclause (II), the Secretary of Labor shall make pro rata reductions in the allotments to States under this clause for a fiscal year as necessary to ensure that the total of the allotments does not exceed the available amount for the fiscal year.

(iv) AVAILABLE AMOUNT.—As used in this subparagraph, the term "available amount" means, for a fiscal year, the sum of—

(I) 75 percent of the sum of—

(aa) the amount specified in subparagraph (H) for the fiscal year, minus the total of the amounts reserved pursuant to subparagraphs (E), (F), and (G) for the fiscal year; and

(bb) any amount reserved pursuant to subparagraph (E) for the immediately preceding fiscal year that has not been obligated; and

(II) any available amount for the immediately preceding fiscal year that has not been obligated by a State, other than funds reserved by the State for distribution under clause (vi)(III) and funds distributed pursuant to clause (vi)(I) in any State in which the service delivery area is the State.

(v) STATE PERCENTAGE.—As used in clause (iii), the term "State percentage" means, with respect to a fiscal year, ½ of the sum of—

(I) the percentage represented by the number of individuals in the State whose income is less than the poverty line divided by the number of such individuals in the United States; and

(II) the percentage represented by the number of adults who are recipients of assistance under the State program funded under this part divided by the number of adults in the United States who are recipients of assistance under any State program funded under this part.

(vi) PROCEDURE FOR DISTRIBUTION OF FUNDS WITHIN STATES.—

(I) ALLOCATION FORMULA.—A State to which a grant is made under this subparagraph shall devise a formula for allocating not less than 85 percent of the amount of the grant among the service delivery areas in the State, which—

(aa) determines the amount to be allocated for the benefit of a service delivery area in proportion to the number (if any) by which the population of the area with an income that is less than the poverty line exceeds 7.5 percent of the total population of the area, rel-

ative to such number for all such areas in the State with such an excess, and accords a weight of not less than 50 percent to this factor;

(bb) may determine the amount to be allocated for the benefit of such an area in proportion to the number of adults residing in the area who have been recipients of assistance under the State program funded under this part (whether in effect before or after the amendments made by section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 first applied to the State) for at least 30 months (whether or not consecutive) relative to the number of such adults residing in the State; and

(cc) may determine the amount to be allocated for the benefit of such an area in proportion to the number of unemployed individuals residing in the area relative to the number of such individuals residing in the State.

(II) DISTRIBUTION OF FUNDS.—

(aa) IN GENERAL.—If the amount allocated by the formula to a service delivery area is at least $100,000, the State shall distribute the amount to the entity administering the grant in the area.

(bb) SPECIAL RULE.—If the amount allocated by the formula to a service delivery area is less than $100,000, the sum shall be available for distribution in the State under subclause (III) during the fiscal year.

(III) PROJECTS TO HELP LONG–TERM RECIPIENTS OF ASSISTANCE ENTER UNSUBSIDIZED JOBS.—The Governor of a State to which a grant is made under this subparagraph may distribute not more than 15 percent of the grant funds (plus any amount required to be distributed under this subclause by reason of subclause (II)(bb)) to projects that appear likely to help long–term recipients of assistance under the State program funded under this part (whether in effect before or after the amendments made by section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 first applied to the State) enter unsubsidized employment.

(vii) ADMINISTRATION.—

(I) PRIVATE INDUSTRY COUNCILS.—The private industry council for a service delivery area in a State shall have sole authority, in coordination with the chief elected official (as defined in section 101 of the Workforce Investment Act of 1998 [14]) of the area, to expend the amounts distributed under clause (vi)(II)(aa) for the benefit

[14] See Vol. II, P.L. 105-220, §101.

of the service delivery area, in accordance with the assurances described in clause (ii)(I)(dd) provided by the Governor of the State.

(II) ENFORCEMENT OF COORDINATION OF EXPENDITURES WITH OTHER EXPENDITURES UNDER THIS PART.—Notwithstanding subclause (I) of this clause, on a determination by the Governor of a State that a private industry council (or an alternate agency described in clause (ii)(I)(dd)) has used funds provided under this subparagraph in a manner inconsistent with the assurances described in clause (ii)(I)(dd)—

(aa) the private industry council (or such alternate agency) shall remit the funds to the Governor; and

(bb) the Governor shall apply to the Secretary of Labor for a waiver of subclause (I) of this clause with respect to the service delivery area or areas involved in order to permit an alternate agency designated by the Governor to administer the funds in accordance with the assurances.

(III) AUTHORITY TO PERMIT USE OF ALTERNATE ADMINISTERING AGENCY.—The Secretary of Labor shall approve an application submitted under clause (ii)(I)(ee) or subclause (II)(bb) of this clause to waive subclause (I) of this clause with respect to 1 or more service delivery areas if the Secretary determines that the alternate agency designated in the application would improve the effectiveness or efficiency of the administration of amounts distributed under clause (vi)(II)(aa) for the benefit of the area or areas.

(viii) DATA TO BE USED IN DETERMINING THE NUMBER OF ADULT TANF RECIPIENTS.—For purposes of this subparagraph, the number of adult recipients of assistance under a State program funded under this part for a fiscal year shall be determined using data for the most recent 12–month period for which such data is available before the beginning of the fiscal year.

(ix) REVERSION OF UNALLOTTED FORMULA FUNDS.—If at the end of any fiscal year any funds available under this subparagraph have not been allotted due to a determination by the Secretary that any State has not met the requirements of clause (ii), such funds shall be transferred to the General Fund of the Treasury of the United States.

(B) COMPETITIVE GRANTS.—

(i) IN GENERAL.—The Secretary of Labor shall award grants in accordance with this subparagraph, in fiscal years 1998 and 1999, for projects proposed by eligible applicants, based on the following:

(I) The effectiveness of the proposal in—

(aa) expanding the base of knowledge about programs aimed at moving recipients of assistance under State programs funded under

this part who are least job ready into unsubsidized employment.

(bb) moving recipients of assistance under State programs funded under this part who are least job ready into unsubsidized employment; and

(cc) moving recipients of assistance under State programs funded under this part who are least job ready into unsubsidized employment, even in labor markets that have a shortage of low–skill jobs.

(II) At the discretion of the Secretary of Labor, any of the following:

(aa) The history of success of the applicant in moving individuals with multiple barriers into work.

(bb) Evidence of the applicant's ability to leverage private, State, and local resources.

(cc) Use by the applicant of State and local resources beyond those required by subparagraph (A).

(dd) Plans of the applicant to coordinate with other organizations at the local and State level.

(ee) Use by the applicant of current or former recipients of assistance under a State program funded under this part as mentors, case managers, or service providers.

(ii) ELIGIBLE APPLICANTS.—As used in clause (i), the term "eligible applicant" means a private industry council for a service delivery area in a State, a political subdivision of a State, or a private entity applying in conjunction with the private industry council for such a service delivery area or with such a political subdivision, that submits a proposal developed in consultation with the Governor of the State.

(iii) DETERMINATION OF GRANT AMOUNT.—In determining the amount of a grant to be made under this subparagraph for a project proposed by an applicant, the Secretary of Labor shall provide the applicant with an amount sufficient to ensure that the project has a reasonable opportunity to be successful, taking into account the number of long–term recipients of assistance under a State program funded under this part, the level of unemployment, the job opportunities and job growth, the poverty rate, and such other factors as the Secretary of Labor deems appropriate, in the area to be served by the project.

(iv) CONSIDERATION OF NEEDS OF RURAL AREAS AND CITIES WITH LARGE CONCENTRATIONS OF POVERTY.—In making grants under this subparagraph, the Secretary of Labor shall consider the needs of rural areas and cities with large concentrations of residents with an income that is less than the poverty line.

(v) FUNDING.—For grants under this subparagraph for each fiscal year specified in subparagraph (H),

there shall be available to the Secretary of Labor an amount equal to the sum of—

(I) 25 percent of the sum of—

(aa) the amount specified in subparagraph (H) for the fiscal year, minus the total of the amounts reserved pursuant to subparagraphs (E), (F) and (G) for the fiscal year; and

(bb) any amount reserved pursuant to subparagraph (E) for the immediately preceding fiscal year that has not been obligated; and

(II) any amount available for grants under this subparagraph for the immediately preceding fiscal year that has not been obligated.

(C) LIMITATIONS ON USE OF FUNDS.—

(i) ALLOWABLE ACTIVITIES.—An entity to which funds are provided under this paragraph shall use the funds to move individuals into and keep individuals in lasting unsubsidized employment by means of any of the following:

(I) The conduct and administration of community service or work experience programs.

(II) Job creation through public or private sector employment wage subsidies.

(III) On–the–job training.

(IV) Contracts with public or private providers of readiness, placement, and post– employment services or if the entity is not a private industry council or workforce investment board, the direct provision of such services.

(V) Job vouchers for placement, readiness, and postemployment services.

(VI) Job retention or support services if such services are not otherwise available. Contracts or vouchers for job placement services supported by such funds must require that at least ½ of the payment occur after an eligible individual placed into the workforce has been in the workforce for 6 months.

(VII) Not more than 6 months of vocational educational or job training.

(ii) GENERAL ELIGIBILITY.—An entity that operates a project with funds provided under this paragraph may expend funds provided to the project for the benefit of recipients of assistance under the program funded under this part of the State in which the entity is located who—

(I) has received assistance under the State program funded under this part (whether in effect before or after the amendments made by section 103 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 first apply to the State) for at least 30 months (whether or not consecutive); or

(II) within 12 months, will become ineligible for assistance under the State program funded under this part by reason of a durational limit on such

assistance, without regard to any exemption provided pursuant to section 408(a)(7)(C) that may apply to the individual.

(iii) NONCUSTODIAL PARENTS.— An entity that operates a project with funds provided under this paragraph may use the funds to provide services in a form described in clause (i) to noncustodial parents with respect to whom the requirements of the following subclauses are met:

(I) The noncustodial parent is unemployed, underemployed, or having difficulty in paying child support obligations.

(II) At least 1 of the following applies to a minor child of the noncustodial parent (with preference in the determination of the noncustodial parents to be provided services under this paragraph to be provided by the entity to those noncustodial parents with minor children who meet, or who have custodial parents who meet, the requirements of item (aa)):

(aa) The minor child or the custodial parent of the minor child meets the requirements of subclause (I) or (II) of clause (ii).

(bb) The minor child is eligible for, or is receiving, benefits under the program funded under this part.

(cc) The minor child received benefits under the program funded under this part in the 12-month period preceding the date of the determination but no longer receives such benefits.

(dd) The minor child is eligible for, or is receiving, assistance under the Food Stamp Act of 1977 [15], benefits under the supplemental security income program under title XVI of this Act, medical assistance under title XIX of this Act, or child health assistance under title XXI of this Act.

(III) In the case of a noncustodial parent who becomes enrolled in the project on or after the date of the enactment of this clause, the noncustodial parent is in compliance with the terms of an oral or written personal responsibility contract entered into among the noncustodial parent, the entity, and (unless the entity demonstrates to the Secretary that the entity is not capable of coordinating with such agency) the agency responsible for administering the State plan under part D, which was developed taking into account the employment and child support status of the noncustodial parent, which was entered into not later than 30 (or, at the option of the entity, not later than 90) days after the noncustodial parent was enrolled in the project, and which, at a minimum, includes the following:

[15] P.L. 83-591.

(aa) A commitment by the noncustodial parent to cooperate, at the earliest opportunity, in the establishment of the paternity of the minor child, through voluntary acknowledgement or other procedures, and in the establishment of a child support order.

(bb) A commitment by the noncustodial parent to cooperate in the payment of child support for the minor child, which may include a modification of an existing support order to take into account the ability of the noncustodial parent to pay such support and the participation of such parent in the project.

(cc) A commitment by the noncustodial parent to participate in employment or related activities that will enable the noncustodial parent to make regular child support payments, and if the noncustodial parent has not attained 20 years of age, such related activities may include completion of high school, a general equivalency degree, or other education directly related to employment.

(dd) A description of the services to be provided under this paragraph, and a commitment by the noncustodial parent to participate in such services, that are designed to assist the noncustodial parent obtain and retain employment, increase earnings, and enhance the financial and emotional contributions to the well-being of the minor child.

In order to protect custodial parents and children who may be at risk of domestic violence, the preceding provisions of this subclause shall not be construed to affect any other provision of law requiring a custodial parent to cooperate in establishing the paternity of a child or establishing or enforcing a support order with respect to a child, or entitling a custodial parent to refuse, for good cause, to provide such cooperation as a condition of assistance or benefit under any program, shall not be construed to require such cooperation by the custodial parent as a condition of participation of either parent in the program authorized under this paragraph, and shall not be construed to require a custodial parent to cooperate with or participate in any activity under this clause. The entity operating a project under this clause with funds provided under this paragraph shall consult with domestic violence prevention and intervention organizations in the development of the project.

(iv) TARGETING OF HARD TO EMPLOY INDIVIDUALS WITH CHARACTERISTICS ASSOCIATED WITH LONG–TERM WELFARE DEPENDENCE.—An entity that operates a project with funds provided under this paragraph may expend not more than 30 percent of all funds provided to the project for programs that provide assistance in a form described in clause (i)—

(I) to recipients of assistance under the program funded under this part of the State in which the entity is located who have characteristics associated with long–term welfare dependence (such as school dropout, teen pregnancy, or poor work history), including, at the option of the State, by providing assistance in such form as a condition of receiving assistance under the State program funded under this part;

(II) to children—

(aa) who have attained 18 years of age but not 25 years of age; and

(bb) who, before attaining 18 years of age, were recipients of foster care maintenance payments (as defined in section 475(4)) under part E or were in foster care under the responsibility of a State;

(III) to recipients of assistance under the State program funded under this part, determined to have a significant barriers to self—sufficiency, pursuant to criteria established by the local private industry council; or

(IV) to custodial parents with incomes below 100 percent of the poverty line (as defined in section 673(2) of the Omnibus Budget Reconciliation Act of 1981 [16], including any revision required by such section, applicable to a family of the size involved).

To the extent that the entity does not expend such funds in accordance with the preceding sentence, the entity shall expend such funds in accordance with clauses (ii) and (iii) and, as appropriate, clause (v).

(v) AUTHORITY TO PROVIDE WORK–RELATED SERVICES TO INDIVIDUALS WHO HAVE REACHED THE 5 YEAR LIMIT.—An entity that operates a project with funds provided under this paragraph may use the funds to provide assistance in a form described in clause (i) of this subparagraph to, or for the benefit of, individuals who (but for section 408(a)(7)) would be eligible for assistance under the program funded under this part of the State in which the entity is located.

(vi) RELATIONSHIP TO OTHER PROVISIONS OF THIS PART.—

(I) RULES GOVERNING USE OF FUNDS.—The rules of section 404, other than subsections (b), (f), and (h) of section 404, shall not apply to a grant made under this paragraph.

(II) RULES GOVERNING PAYMENTS TO STATES.—The Secretary of Labor shall carry out the functions otherwise assigned by section 405 to the Secretary of Health and Human Services with respect to the grants payable under this paragraph.

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

(III) ADMINISTRATION.—Section 416 shall not apply to the programs under this paragraph.

(vii) PROHIBITION AGAINST USE OF GRANT FUNDS FOR ANY OTHER FUND MATCHING REQUIREMENT.—An entity to which funds are provided under this paragraph shall not use any part of the funds, nor any part of State expenditures made to match the funds, to fulfill any obligation of any State, political subdivision, or private industry council to contribute funds under section 403(b)or 418 or any other provision of this Act or other Federal law.

(viii) DEADLINE FOR EXPENDITURE.—An entity to which funds are provided under this paragraph shall remit to the Secretary of Labor any part of the funds that are not expended within 5 years after the date the funds are so provided.

(ix) REGULATIONS.—Within 90 days after the date of the enactment of this paragraph, the Secretary of Labor, after consultation with the Secretary of Health and Human Services and the Secretary of Housing and Urban Development, shall prescribe such regulations as may be necessary to implement this paragraph.

(x) REPORTING REQUIREMENTS.—The Secretary of Labor, in consultation with the Secretary of Health and Human Services, States, and organizations that represent State or local governments, shall establish requirements for the collection and maintenance of financial and participant information and the reporting of such information by entities carrying out activities under this paragraph.

(D) DEFINITIONS.—

(i) INDIVIDUALS WITH INCOME LESS THAN THE POVERTY LINE.—For purposes of this paragraph, the number of individuals with an income that is less than the poverty line shall be determined for a fiscal year—

(I) based on the methodology used by the Bureau of the Census to produce and publish intercensal poverty data for States and counties (or, in the case of Puerto Rico, the Virgin Islands, Guam, and American Samoa, other poverty data selected by the Secretary of Labor); and

(II) using data for the most recent year for which such data is available before the beginning of the fiscal year.

(ii) PRIVATE INDUSTRY COUNCIL.—As used in this paragraph, the term "private industry council" means, with respect to a service delivery area, the private industry council or local workforce investment board established for the service delivery area pursuant to title I of the Workforce Investment Area [17] of 1998 [18], as appropriate.

[17] As in original. Probably should be "Act".
[18] P.L. 105-220.

(iii) SERVICE DELIVERY AREA.—As used in this paragraph, the term "service delivery area" shall have the meaning given such term for purposes of the Job Training Partnership Act or [19].

(E) FUNDING FOR INDIAN TRIBES.—1 percent of the amount specified in subparagraph (H) for fiscal year 1998 and $15,000,000 of the amount so specified for fiscal year 1999 shall be reserved for grants to Indian tribes under section 412(a)(3).

(F) FUNDING FOR EVALUATIONS OF WELFARE–TO–WORK PROGRAMS.—0.6 percent $9,000,000 of the amount specified in subparagraph (H) for fiscal year 1998 and of the amount so specified for fiscal year 1999 shall be reserved for use by the Secretary to carry out section 413(j).

(G) FUNDING FOR EVALUATION OF ABSTINENCE EDUCATION PROGRAMS.—

(i) IN GENERAL.—0.2 percent $3,000,000 of the amount specified in subparagraph (H) for fiscal year 1998 and of the amount so specified for fiscal year 1999 shall be reserved for use by the Secretary to evaluate programs under section 510, directly or through grants, contracts, or interagency agreements.

(ii) AUTHORITY TO USE FUNDS FOR EVALUATIONS OF WELFARE–TO–WORK PROGRAMS.—Any such amount not required for such evaluations shall be available for use by the Secretary to carry out section 413(j).

(iii) DEADLINE FOR OUTLAYS.—Outlays from funds used pursuant to clause (i) for evaluation of programs under section 510 shall not be made after fiscal year 2005.

(iv) INTERIM REPORT.—Not later than January 1, 2002, the Secretary shall submit to the Congree and interim report on the evaluations referred to in clause (i).

(H) APPROPRIATIONS.—

(i) IN GENERAL.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated for grants under this paragraph– (I) $1,500,000,000 for fiscal years 1998; and (II) $1,4000,000 for fiscal year 1999.

(ii) AVAILABILITY.—The amounts made available pursuant to clause (i) shall remain available for such period as is necessary to make the grants provided for in this paragraph.

(I) WORKER PROTECTIONS.—

(i) NONDISPLACEMENT IN WORK ACTIVITIES.—

(I) GENERAL PROHIBITION.—Subject to this clause, an adult in a family receiving assistance attributable to funds provided under this paragraph may fill a vacant employment position in order to engage in a work activity.

(II) PROHIBITION AGAINST VIOLATION OF CONTRACTS.—A work activity engaged in under a program operated with funds provided under this

[19] As in original.

paragraph shall not violate an existing contract for services or a collective bargaining agreement, and such a work activity that would violate a collective bargaining agreement shall not be undertaken without the written concurrence of the labor organization and employer concerned.

(III) OTHER PROHIBITIONS.—An adult participant in a work activity engaged in under a program operated with funds provided under this paragraph shall not be employed or assigned—

(aa) when any other individual is on layoff from the same or any substantially equivalent job;

(bb) if the employer has terminated the employment of any regular employee or otherwise caused an involuntary reduction in its workforce with the intention of filling the vacancy so created with the participant; or

(cc) if the employer has caused an involuntary reduction to less than full time in hours of any employee in the same or a substantially equivalent job.

(ii) HEALTH AND SAFETY.—Health and safety standards established under Federal and State law otherwise applicable to working conditions of employees shall be equally applicable to working conditions of other participants engaged in a work activity under a program operated with funds provided under this paragraph.

(iii) NONDISCRIMINATION.—In addition to the protections provided under the provisions of law specified in section 408(c), an individual may not be discriminated against by reason of gender with respect to participation in work activities engaged in under a program operated with funds provided under this paragraph.

(iv) GRIEVANCE PROCEDURE.—

(I) IN GENERAL.—Each State to which a grant is made under this paragraph shall establish and maintain a procedure for grievances or complaints from employees alleging violations of clause (i) and participants in work activities alleging violations of clause (i), (ii), or (iii).

(II) HEARING.—The procedure shall include an opportunity for a hearing.

(III) REMEDIES.—The procedure shall include remedies for violation of clause (i), (ii), or (iii), which may continue during the pendency of the procedure, and which may include—

(aa) suspension or termination of payments from funds provided under this paragraph;

(bb) prohibition of placement of a participant with an employer that has violated clause (i), (ii), or (iii);

(cc) where applicable, reinstatement of an employee, payment of lost wages and benefits,

and reestablishment of other relevant terms, conditions and privileges of employment; and

(dd) where appropriate, other equitable relief.

(IV) APPEALS.—

(aa) FILING.—Not later than 30 days after a grievant or complainant receives an adverse decision under the procedure established pursuant to subclause (I), the grievant or complainant may appeal the decision to a State agency designated by the State which shall be independent of the State or local agency that is administering the programs operated with funds provided under this paragraph and the State agency administering, or supervising the administration of, the State program funded under this part.

(bb) FINAL DETERMINATION.—Not later than 120 days after the State agency designated under item (aa) receives a grievance or complaint made under the procedure established by a State pursuant to subclause (I), the State agency shall make a final determination on the appeal.

(v) RULE OF INTERPRETATION.—This subparagraph shall not be construed to affect the authority of a State to provide or require workers' compensation.

(vi) NONPREEMPTION OF STATE LAW.—The provisions of this subparagraph shall not be construed to preempt any provision of State law that affords greater protections to employees or to other participants engaged in work activities under a program funded under this part than is afforded by such provisions of this subparagraph.

(J) INFORMATION DISCLOSURE.—If a State to which a grant is made under section 403 establishes safeguards against the use or disclosure of information about applicants or recipients of assistance under the State program funded under this part, the safeguards shall not prevent the State agency administering the program from furnishing to a private industry council the names, addresses, telephone numbers, and identifying case number information in the State program funded under this part, of noncustodial parents residing in the service delivery area of the private industry council, for the purpose of identifying and contacting noncustodial parents regarding participation in the program under this paragraph.

(b) CONTINGENCY FUND.—

(1) ESTABLISHMENT.—There is hereby established in the Treasury of the United States a fund which shall be known as the "Contingency Fund for State Welfare Programs" (in this section referred to as the "Fund").

(2) DEPOSITS INTO FUND.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated for fiscal years 1997, 1998, 1999, 2000, 2001, 2002,

and 2003[20] such sums as are necessary for payment to the Fund in a total amount not to exceed $2,000,000,000, reduced by the sum of the dollar amounts specified in paragraph (6)(C)(ii).

(3) GRANTS.—

(A) PROVISIONAL PAYMENTS.—If an eligible State submits to the Secretary a request for funds under this paragraph during an eligible month, the Secretary shall, subject to this paragraph, pay to the State, from amounts appropriated pursuant to paragraph (2), an amount equal to the amount of funds so requested.

(B) PAYMENT PRIORITY.—The Secretary shall make payments under subparagraph (A) in the order in which the Secretary receives requests for such payments.

(C) LIMITATIONS.—

(i) MONTHLY PAYMENT TO A STATE.—The total amount paid to a single State under subparagraph (A) during a month shall not exceed 1/12 of 20 percent of the State family assistance grant.

(ii) PAYMENTS TO ALL STATES.—The total amount paid to all States under subparagraph (A) during fiscal years 1997 through 2005[21] shall not exceed the total amount appropriated pursuant to paragraph (2).

(4) ELIGIBLE MONTH.—As used in paragraph (3)(A), the term "eligible month" means, with respect to a State, a month in the 2–month period that begins with any month for which the State is a needy State.

(5) NEEDY STATE.—For purposes of paragraph (4), a State is a needy State for a month if—

(A) the average rate of—

(i) total unemployment in such State (seasonally adjusted) for the period consisting of the most recent 3 months for which data for all States are published equals or exceeds 6.5 percent; and

(ii) total unemployment in such State (seasonally adjusted) for the 3–month period equals or exceeds 110 percent of such average rate for either (or both) of the corresponding 3–month periods ending in the 2 preceding calendar years; or

(B) as determined by the Secretary of Agriculture (in the discretion of the Secretary of Agriculture), the monthly average number of individuals (as of the last day of each month) participating in the food stamp program in the State in the then most recently concluded 3–month period for which data are available exceeds by not less than 10 percent the less or of—

(i) the monthly average number of individuals (as of the last day of each month) in the State that would have participated in the food stamp program in the corresponding 3–month period in fiscal year 1994 if the amendments made by titles IV and VIII of the

[20] P.L. 108-40, §3(e)(1), struck out "and 2002" and substituted "2002, and 2003", effective July 1, 2003.

[21] P.L. 108-40, §3(e)(2), struck out "2002" and substituted "2003", effective July 1, 2003.
P.L. 108-89, §101(b)(2), struck out "2003" and substituted "2004", effective October 1, 2003.
P.L. 108-308, §2(b)(2), struck out "2004" and substituted "2005", effective September 30, 2004.

Personal Responsibility and Work Opportunity Reconciliation Act of 1996 had been in effect throughout fiscal year 1994; or

(ii) the monthly average number of individuals (as of the last day of each month) in the State that would have participated in the food stamp program in the corresponding 3–month period in fiscal year 1995 if the amendments made by titles IV and VIII of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 had been in effect throughout fiscal year 1995.

(6) ANNUAL RECONCILIATION.—

(A) IN GENERAL.—Notwithstanding paragraph (3), if the Secretary makes a payment to a State under this subsection in a fiscal year, then the State shall remit to the Secretary, within 1 year after the end of the first subsequent period of 3 consecutive months for which the State is not a needy State, an amount equal to the amount (if any) by which—

(i) the total amount paid to the State under paragraph (3) of this subsection in the fiscal year; exceeds

(ii) the product of—

(I) the Federal medical assistance percentage for the State (as defined in section 1905(b), as such section was in effect on September 30, 1995);

(II) the State's reimbursable expenditures for the fiscal year; and

(III) 1/12 times the number of months during the fiscal year for which the Secretary made a payment to the State under such paragraph (3).

(B) DEFINITIONS.—As used in subparagraph (A);

(i) REIMBURSABLE EXPENDITURES.—The term "reimbursable expenditures" means, with respect to a State and a fiscal year, the amount (if any) by which—

(I) countable State expenditures for the fiscal year; exceeds

(II) historic State expenditures (as defined in section 409(a)(7)(B)(iii)), excluding any amount expended by the State for child care under subsection (g) or (i) of section 402 (as in effect during fiscal year 1994) for fiscal year 1994.

(ii) COUNTABLE STATE EXPENDITURES.—The term "countable expenditures" means, with respect to a State and a fiscal year—

(I) the qualified State expenditures (as defined in section 409(a)(7)(B)(i) (other than the expenditures described in subclause (I)(bb) of such section)) under the State program funded under this part for the fiscal year; plus

(II) any amount paid to the State under paragraph (3) during the fiscal year that is expended by the State under the State program funded under this part.

(C) ADJUSTMENT OF STATE REMITTANCES.—

(i) IN GENERAL.—The amount otherwise required by subparagraph (A) to be remitted by a State for a fiscal year shall be increased by the lesser of—

(I) the total adjustment for the fiscal year, multiplied by the adjustment percentage for the State for the fiscal year; or

(II) the unadjusted net payment to the State for the fiscal year.

(ii) TOTAL ADJUSTMENT.—As used in clause (i), the term "total adjustment" means—

(I) in the case of fiscal year 1998, $2,000,000;

(II) in the case of fiscal year 1999, $9,000,000;

(III) in the case of fiscal year 2001, $13,000,000.

(iii) ADJUSTMENT PERCENTAGE.—As used in clause (i), the term "adjustment percentage" means, with respect to a State and a fiscal year—

(I) the unadjusted net payment to the State for the fiscal year; divided by

(II) the sum of the unadjusted net payments to all States for the fiscal year.

(iv) UNADJUSTED NET PAYMENT.—As used in this subparagraph, the term, "unadjusted net payment" means with respect to a State and a fiscal year—

(I) the total amount paid to the State under paragraph (3) in the fiscal year; minus

(II) the amount that, in the absence of this subparagraph, would be required by subparagraph (A) or by section 409(a)(10) to be remitted by the State in respect of the payment.

(7) OTHER TERMS DEFINED.—As used in this subsection:

(A) STATE.—The term "State" means each of the 50 States of the United States and the District of Columbia.

(B) SECRETARY.—The term "Secretary" means the Secretary of the Treasury.

(8) ANNUAL REPORTS.—The Secretary shall annually report to the Congress on the status of the Fund.

USE OF GRANTS

SEC. 404. [42 U.S.C. 604] (a) GENERAL RULES.—Subject to this part, a State to which a grant is made under section 403 may use the grant—

(1) in any manner that is reasonably calculated to accomplish the purpose of this part, including to provide low income households with assistance in meeting home heating and cooling costs; or

(2) in any manner that the State was authorized to use amounts received under part A or F, as such parts were in effect on September 30, 1995, or (as the option of the State) August 21, 1996.

(b) LIMITATION ON USE OF GRANT FOR ADMINISTRATIVE PURPOSES.—

(1) LIMITATION.—A State to which a grant is made under section 403 shall not expend more than 15 percent of the grant for administrative purposes.

(2) EXCEPTION.—Paragraph (1) shall not apply to the use of a grant for information technology and computerization needed for tracking or monitoring required by or under this part.

(c) AUTHORITY TO TREAT INTERSTATE IMMIGRANTS UNDER RULES OF FORMER STATE.—A State operating a program funded under this part may apply to a family the rules (including benefit amounts) of the program funded under this part of another State if the family has moved to the State from the other State and has resided in the State for less than 12 months.

(d) AUTHORITY TO USE PORTION OF GRANT FOR OTHER PURPOSES.—

(1) IN GENERAL.—Subject to paragraph (2), a State may use not more than 30 percent of the amount of any grant made to the State under section 403(a) for a fiscal year to carry out a State program pursuant to any or all of the following provisions of law:

(A) Title XX of this Act.

(B) The Child Care and Development Block Grant Act of 1990[22].

(2) LIMITATION ON AMOUNT TRANSFERABLE TO TITLE XX PROGRAMS.—

(A) IN GENERAL.—A State may use not more than the applicable percent of the amount of any grant made to the State under section 403(a) for a fiscal year to carry out State programs pursuant to title XX.

(B) APPLICABLE PERCENT.—For purposes of subparagraph (A), the applicable percent is 4.25 percent in the case of fiscal year 2001 and each succeeding fiscal year.

(3) APPLICABLE RULES.—

(A) IN GENERAL.—Except as provided in subparagraph (B) of this paragraph, any amount paid to a State under this part that is used to carry out a State program pursuant to a provision of law specified in paragraph (1) shall not be subject to the requirements of this part, but shall be subject to the requirements that apply to Federal funds provided directly under the provision of law to carry out the program, and the expenditure of any amount so used shall not be considered to be an expenditure under this part.

(B) EXCEPTION RELATING TO TITLE XX PROGRAMS.—All amounts paid to a State under this part that are used to carry out State programs pursuant to title XX shall be used only for programs and services to children or their families whose income is less than 200 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[23]) applicable to a family of the size involved.

(e) AUTHORITY TO RESERVE CERTAIN AMOUNTS FOR ASSISTANCE.—A State or tribe may reserve amounts paid to the State or tribe under this part for any fiscal year for the purpose of provid-

[22] P.L. 101-508, §5082; 42 U.S.C. 9858-9858(q).
[23] See Vol. II, P.L. 97-35 §673(2).

ing, without fiscal year limitation, assistance under the State or tribal program funded under this part.

(f) AUTHORITY TO OPERATE EMPLOYMENT PLACEMENT PROGRAM.—A State to which a grant is made under section 403 may use the grant to make payments (or provide job placement vouchers) to State–approved public and private job placement agencies that provide employment placement services to individuals who receive assistance under the State program funded under this part.

(g) IMPLEMENTATION OF ELECTRONIC BENEFIT TRANSFER SYSTEM.—A State to which a grant is made under section 403 is encouraged to implement an electronic benefit transfer system for providing assistance under the State program funded under this part, and may use the grant for such purpose.

(h) USE OF FUNDS FOR INDIVIDUAL DEVELOPMENT ACCOUNTS.—

(1) IN GENERAL.—A State to which a grant is made under section 403 may use the grant to carry out a program to fund individual development accounts (as defined in paragraph (2)) established by individuals eligible for assistance under the State program funded under this part.

(2) INDIVIDUAL DEVELOPMENT ACCOUNTS.—

(A) ESTABLISHMENT.—Under a State program carried out under paragraph (1), an individual development account may be established by or on behalf of an individual eligible for assistance under the State program operated under this part for the purpose of enabling the individual to accumulate funds for a qualified purpose described in subparagraph (B).

(B) QUALIFIED PURPOSE.—A qualified purpose described in this subparagraph is 1 or more of the following, as provided by the qualified entity providing assistance to the individual under this subsection:

(i) POSTSECONDARY EDUCATIONAL EXPENSES.—Postsecondary educational expenses paid from an individual development account directly to an eligible educational institution.

(ii) FIRST HOME PURCHASE.—Qualified acquisition costs with respect to a qualified principal residence for a qualified first–time homebred, if paid from an individual development account directly to the persons to whom the amounts are due.

(iii) BUSINESS CAPITALIZATION.—Amounts paid from an individual development account directly to a business capitalization account which is established in a federally insured financial institution and is restricted to use solely for qualified business capitalization expenses.

(C) CONTRIBUTIONS TO BE FROM EARNED INCOME.—An individual may only contribute to an individual development account such amounts as are derived from earned income, as defined in section 911(d)(2) of the Internal Revenue Code of 1986[24].

(D) WITHDRAWAL OF FUNDS.—The Secretary shall establish such regulations as may be necessary to ensure that funds held in an individual development account are not

[24] See Vol. II, P.L. 83-591.

withdrawn except for 1 or more of the qualified purposes described in subparagraph (B).

(3) REQUIREMENTS.—

(A) IN GENERAL.—An individual development account established under this subsection shall be a trust created or organized in the United States and funded through periodic contributions by the establishing individual and matched by or through a qualified entity for a qualified purpose (as described in paragraph (2)(B)).

(B) QUALIFIED ENTITY.—As used in this subsection, the term "qualified entity" means—

(i) a not–for–profit organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from taxation under section 501(a) of such Code; or

(ii) a State or local government agency acting in cooperation with an organization described in clause (i).

(4) NO REDUCTION IN BENEFITS.—Notwithstanding any other provision of Federal law (other than the Internal Revenue Code of 1986) that requires consideration of 1 or more financial circumstances of an individual, for the purpose of determining eligibility to receive, or the amount of, any assistance or benefit authorized by such law to be provided to or for the benefit of such individual, funds (including interest accruing) in an individual development account under this subsection shall be disregarded for such purpose with respect to any period during which such individual maintains or makes contributions into such an account.

(5) DEFINITIONS.—As used in this subsection—

(A) ELIGIBLE EDUCATIONAL INSTITUTION.—The term "eligible educational institution" means the following:

(i) An institution described in section 481(a)(1) or 1201(a) of the Higher Education Act of 1965[25] (20 U.S.C. 1088(a)(1) or 1141(a)), as such sections are in effect on the date of the enactment of this subsection.

(ii) An area vocational education school (as defined in subparagraph (C) or (D) of section 521(4) of the Carl D. Perkins Vocational and Applied Technology Education Act[26] (20 U.S.C. 2471(4))) which is in any State (as defined in section 521(33) of such Act), as such sections are in effect on the date of the enactment of this subsection.

(B) POST–SECONDARY EDUCATIONAL EXPENSES.—The term "post–secondary educational expenses" means—

(i) tuition and fees required for the enrollment or attendance of a student at an eligible educational institution, and

(ii) fees, books, supplies, and equipment required for courses of instruction at an eligible educational institution.

(C) QUALIFIED ACQUISITION COSTS.—The term "qualified acquisition costs" means the costs of acquiring, constructing, or reconstructing a residence. The term includes any

[25] See Vol. II., P.L. 89-329, §481(a) and §1201(a).
[26] See Vol. II., P.L. 88-210, §521(4).

usual or reasonable settlement, financing, or other closing costs.

(D) QUALIFIED BUSINESS.—The term "qualified business" means any business that does not contravene any law or public policy (as determined by the Secretary).

(E) QUALIFIED BUSINESS CAPITALIZATION EXPENSES.—The term "qualified business capitalization expenses" means qualified expenditures for the capitalization of a qualified business pursuant to a qualified plan.

(F) QUALIFIED EXPENDITURES.—The term "qualified expenditures" means expenditures included in a qualified plan, including capital, plant, equipment, working capital, and inventory expenses.

(G) QUALIFIED FIRST–TIME HOMEBUYER.—

(i) IN GENERAL.—The term "qualified first–time homebuyer" means a taxpayer (and, if married, the taxpayer's spouse) who has no present ownership interest in a principal residence during the 3–year period ending on the date of acquisition of the principal residence to which this subsection applies.

(ii) DATE OF ACQUISITION.—The term "date of acquisition" means the date on which a binding contract to acquire, construct, or reconstruct the principal residence to which this subparagraph applies is entered into.

(H) QUALIFIED PLAN.—The term "qualified plan" means a business plan which—

(i) is approved by a financial institution, or by a nonprofit loan fund having demonstrated fiduciary integrity,

(ii) includes a description of services or goods to be sold, a marketing plan, and projected financial statements, and

(iii) may require the eligible individual to obtain the assistance of an experienced entrepreneurial advisor.

(I) QUALIFIED PRINCIPAL RESIDENCE.—The term "qualified principal residence" means a principal residence (within the meaning of section 1034 of the Internal Revenue Code of 1986 [27]), the qualified acquisition costs of which do not exceed 100 percent of the average area purchase price applicable to such residence (determined in accordance with paragraphs (2) and (3) of section 143(e) of such Code [28]).

(i) SANCTION WELFARE RECIPIENTS FOR FAILING TO ENSURE THAT MINOR DEPENDENT CHILDREN ATTEND SCHOOL.—A State to which a grant is made under section 403 shall not be prohibited from sanctioning a family that includes an adult who has received assistance under any State program funded under this part attributable to funds provided by the Federal Government or under the food stamp program, as defined in section 3(h) of the Food Stamp Act of 1977 [29], if such adult fails to ensure that the minor depend-

[27] See Vol. II, P.L. 83-591, §1034.
[28] See Vol. II, P.L. 83-591, §§143(e)(2) and (3).
[29] See Vol. II, P.L. 88-525, §3(h).

ent children of such adult attend school as required by the law of the State in which the minor children reside.

(j) REQUIREMENT FOR HIGH SCHOOL DIPLOMA OR EQUIVALENT.—A State to which a grant is made under section 403 shall not be prohibited from sanctioning a family that includes an adult who is older than age 20 and younger than age 51 and who has received assistance under any State program funded under this part attributable to funds provided by the Federal Government or under the food stamp program, as defined in section 3(h) of the Food Stamp Act of 1977, if such adult does not have, or is not working toward attaining, a secondary school diploma or its recognized equivalent unless such adult has been determined in the judgment of medical, psychiatric, or other appropriate professionals to lack the requisite capacity to complete successfully a course of study that would lead to a secondary school diploma or its recognized equivalent.

(k) LIMITATIONS ON USE OF GRANT FOR MATCHING UNDER CERTAIN FEDERAL TRANSPORTATION PROGRAM.—

(1) USE LIMITATIONS.—A State to which a grant is made under section 403 may not use any part of the grant to match funds made available under section 3037 of the Transportation Equity Act for the 21st Century, unless—

(A) the grant is used for new or expanded transportation services (and not for construction) that benefit individuals described in subparagraph (C), and not to subsidize current operating costs;

(B) the grant is used to supplement and not supplant other State expenditures on transportation;

(C) the preponderance of the benefits derived from such use of the grant accrues to individuals who are—

(i) recipients of assistance under the State program funded under this part;

(ii) former recipients of such assistance;

(iii) noncustodial parents who are described in section 403(a)(5)(C)(iii); and

(iv) low–income individuals who are at risk of qualifying for such assistance; and

(D) the services provided through such use of the grant promote the ability of such recipients to engage in work activities (as defined in section 407(d)).

(2) AMOUNT LIMITATION.—From a grant made to a State under section 403(a), the amount that a State uses to match funds described in paragraph (1) of this subsection shall not exceed the amount (if any) by which 30 percent of the total amount of the grant exceeds the amount (if any) of the grant that is used by the State to carry out any State program described in subsection (d)(1) of this section.

(3) RULE OF INTERPRETATION.—The provision by a State of a transportation benefit under a program conducted under section 3037 of the Transportation Equity Act for the 21st Century, to an individual who is not otherwise a recipient of assistance under the State program funded under this part, using funds from a grant made under section 403(a) of this Act, shall not be considered to be the provision of assistance to the individual under the State program funded under this part.

ADMINISTRATIVE PROVISIONS

SEC. 405. [42 U.S.C. 605] (a) QUARTERLY.—The Secretary shall pay each grant payable to a State under section 403 in quarterly installments, subject to this section.

(b) NOTIFICATION.—Not later than 3 months before the payment of any such quarterly installment to a State, the Secretary shall notify the State of the amount of any reduction determined under section 412(a)(1)(B) with respect to the State.

(c) COMPUTATION AND CERTIFICATION OF PAYMENTS TO STATES.—

(1) COMPUTATION.—The Secretary shall estimate the amount to be paid to each eligible State for each quarter under this part, such estimate to be based on a report filed by the State containing an estimate by the State of the total sum to be expended by the State in the quarter under the State program funded under this part and such other information as the Secretary may find necessary.

(2) CERTIFICATION.—The Secretary of Health and Human Services shall certify to the Secretary of the Treasury the amount estimated under paragraph (1) with respect to a State, reduced or increased to the extent of any overpayment or underpayment which the Secretary of Health and Human Services determines was made under this part to the State for any prior quarter and with respect to which adjustment has not been made under this paragraph.

(d) PAYMENT METHOD.—Upon receipt of a certification under subsection (c)(2) with respect to a State, the Secretary of the Treasury shall, through the Fiscal Service of the Department of the Treasury and before audit or settlement by the General Accounting Office[30], pay to the State, at the time or times fixed by the Secretary of Health and Human Services, the amount so certified.

FEDERAL LOANS FOR STATE WELFARE PROGRAMS

SEC. 406. [42 U.S.C. 606] (a) LOAN AUTHORITY.—

(1) IN GENERAL.—The Secretary shall make loans to any loan–eligible State, for a period to maturity of not more than 3 years.

(2) LOAN–ELIGIBLE STATE.—As used in paragraph (1), the term "loan–eligible State" means a State against which a penalty has not been imposed under section 409(a)(1).

(b) RATE OF INTEREST.—The Secretary shall charge and collect interest on any loan made under this section at a rate equal to the current average market yield on outstanding marketable obligations of the United States with remaining periods to maturity comparable to the period to maturity of the loan.

(c) USE OF LOAN.—A State shall use a loan made to the State under this section only for any purpose for which grant amounts received by the State under section 403(a) may be used, including—

(1) welfare anti–fraud activities, and

(2) the provision of assistance under the State program to Indian families that have moved from the service area of an In-

[30] P.L. 108-271, §8(b), provided that "Any reference to the General Accouting office in any law, rule, regulation, certificate, directive, instruction, or other official paper in force on the date of enactment of this Act [July 7, 2004] shall be considered to refer and apply to the Government Accountability Office.

dian tribe with a tribal family assistance plan approved under section 412.

(d) LIMITATION ON TOTAL AMOUNT OF LOANS TO A STATE.—The cumulative dollar amount of all loans made to a State under this section during fiscal years 1997 through 2003[31] shall not exceed 10 percent of the State family assistance grant.

(e) LIMITATION ON TOTAL AMOUNT OF OUTSTANDING LOANS.—The total dollar amount of loans outstanding under this section may not exceed $1,700,000,000.

(f) APPROPRIATION.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated such sums as may be necessary for the cost of loans under this section.

MANDATORY WORK REQUIREMENTS

SEC. 407. [42 U.S.C. 607] (a) PARTICIPATION RATE REQUIREMENTS.—

(1) ALL FAMILIES.—A State to which a grant is made under section 403 for a fiscal year shall achieve the minimum participation rate specified in the following table for the fiscal year with respect to all families receiving assistance under the State program funded under this part:

If the fiscal year is:	**The minimum participation rate is:**
1997	25
1998	30
1999	35
2000	40
2001	45
2002 or thereafter	50.

(2) 2–PARENT FAMILIES.—A State to which a grant is made under section 403 for a fiscal year shall achieve the minimum participation rate specified in the following table for the fiscal year with respect to 2–parent families receiving assistance under the State program funded under this part:

If the fiscal year is:	**The minimum participation rate is:**
1997	75
1998	75
1999 or thereafter	90.

(b) CALCULATION OF PARTICIPATION RATES.—

(1) ALL FAMILIES.—

(A) AVERAGE MONTHLY RATE.—For purposes of subsection (a)(1), the participation rate for all families of a State for a fiscal year is the average of the participation

[31] P.L. 108-40, §3(f), struck out "2002" and substituted "2003", effective July 1, 2003.

rates for all families of the State for each month in the fiscal year.

(B) MONTHLY PARTICIPATION RATES.—The participation rate of a State for all families of the State for a month, expressed as a percentage, is—

(i) the number of families receiving assistance under the State program funded under this part that include an adult or a minor child head of household who is engaged in work for the month; divided by

(ii) the amount by which—

(I) the number of families receiving such assistance during the month that include an adult or a minor child head of household receiving such assistance; exceeds

(II) the number of families receiving such assistance that are subject in such month to a penalty described in subsection (e)(1) but have not been subject to such penalty for more than 3 months within the preceding 12–month period (whether or not consecutive).

(2) 2–PARENT FAMILIES.—

(A) AVERAGE MONTHLY RATE.—For purposes of subsection (a)(2), the participation rate for 2–parent families of a State for a fiscal year is the average of the participation rates for 2–parent families of the State for each month in the fiscal year.

(B) MONTHLY PARTICIPATION RATES.—The participation rate of a State for 2–parent families of the State for a month shall be calculated by use of the formula set forth in paragraph (1)(B), except that in the formula the term "number of 2–parent families" shall be substituted for the term "number of families" each place such latter term appears.

(C) FAMILY WITH A DISABLED PARENT NOT TREATED AS A 2–PARENT FAMILY.—A family that includes a disabled parent shall not be considered a 2–parent family for purposes of subsections (a) and (b) of this section.

(3) PRO RATA REDUCTION OF PARTICIPATION RATE DUE TO CASELOAD REDUCTIONS NOT REQUIRED BY FEDERAL LAW AND NOT RESULTING FROM CHANGES IN STATE ELIGIBILITY CRITERIA.—

(A) IN GENERAL.—The Secretary shall prescribe regulations for reducing the minimum participation rate otherwise required by this section for a fiscal year by the number of percentage points equal to the number of percentage points (if any) by which—

(i) the average monthly number of families receiving assistance during the immediately preceding fiscal year under the State program funded under this part is less than

(ii) the average monthly number of families that received aid under the State plan approved under part A (as in effect on September 30, 1995) during fiscal year 1995.

The minimum participation rate shall not be reduced to the extent that the Secretary determines that the reduc-

tion in the number of families receiving such assistance is required by Federal law.

(B) ELIGIBILITY CHANGES NOT COUNTED.—The regulations required by subparagraph (A) shall not take into account families that are diverted from a State program funded under this part as a result of differences in eligibility criteria under a State program funded under this part and eligibility criteria under the State program operated under the State plan approved under part A (as such plan and such part were in effect on September 30, 1995). Such regulations shall place the burden on the Secretary to prove that such families were diverted as a direct result of differences in such eligibility criteria.

(4) STATE OPTION TO INCLUDE INDIVIDUALS RECEIVING ASSISTANCE UNDER A TRIBAL FAMILY ASSISTANCE PLAN OR TRIBAL WORK PROGRAM.—For purposes of paragraph (1)(B) and (2)(B), a State may, at its option, include families in the State that are receiving assistance under a tribal family assistance plan approved under section 412 or under a tribal work program to which funds are provided under this part.

(5) STATE OPTION FOR PARTICIPATION REQUIREMENT EXEMPTIONS.—For any fiscal year, a State may, at its option, not require an individual who is single custodial parent caring for a child who has not attained 12 months of age to engage in work, and may disregard such an individual in determining the participation rates under subsection (a) for not more than 12 months.

(c) ENGAGED IN WORK.—

(1) GENERAL RULES.—

(A) ALL FAMILIES.—For purposes of subsection (b)(1)(B)(i), a recipient is engaged in work for a month in a fiscal year if the recipient is participating in work activities for at least the minimum average number of hours per week specified in the following table during the month, not fewer than 20 hours per week of which are attributable to an activity described in paragraph (1), (2), (3), (4), (5), (6), (7), (8), or (12) of subsection (d), subject to this subsection:

If the month is in fiscal year:	**The minimum average number of hours per week is:**
1997	20
1998	20
1999	25
2000 or thereafter	30.

(B) 2–PARENT FAMILIES.—For purposes of subsection (b)(2)(B), an individual is engaged in work for a month in a fiscal year if—

(i) the individual and the other parent in the family are participating in work activities for a total of at least 35 hours per week during the month, not fewer than 30 hours per week of which are attributable to an activity described in paragraph (1), (2), (3), (4), (5),

(6), (7), (8), or (12) of subsection (d), subject to this subsection; and

(ii) if the family of the individual receives federally-funded child care assistance and an adult in the family is not disabled or caring for a severely disabled child, the individual and the other parent in the family are participating in work activities for a total of at least 55 hours per week during the month, not fewer than 50 hours per week of which are attributable to an activity described in paragraph (1), (2), (3), (4), (5), (6), (7), (8), or (12) of subsection (d).

(2) LIMITATIONS AND SPECIAL RULES.—

(A) NUMBER OF WEEKS FOR WHICH JOB SEARCH COUNTS AS WORK.—

(i) LIMITATION.—Notwithstanding paragraph (1) of this subsection, an individual shall not be considered to be engaged in work by virtue of participation in an activity described in subsection (d)(6) of a State program funded under this part, after the individual has participated in such an activity for 6 weeks (or, if the unemployment rate of the State is at least 50 percent greater than the unemployment rate of the United States or the State is a needy State within the meaning of section 403(b)(6)), 12 weeks), or if the participation is for a week that immediately follows 4 consecutive weeks of such participation.

(ii) LIMITED AUTHORITY TO COUNT LESS THAN FULL WEEK OF PARTICIPATION.—For purposes of clause (i) of this subparagraph, on not more than 1 occasion per individual, the State shall consider participation of the individual in an activity described in subsection (d)(6) for 3 or 4 days during a week as a week of participation in the activity by the individual.

(B) SINGLE PARENT OR RELATIVE WITH CHILD UNDER AGE 6 DEEMED TO BE MEETING WORK PARTICIPATION REQUIREMENTS IF PARENT OR RELATIVE IS ENGAGED IN WORK FOR 20 HOURS PER WEEK.—For purposes of determining monthly participation rates under subsection (b)(1)(B)(i), a recipient who is the only parent or caretaker relative in the family of a child who has not attained 6 years of age is deemed to be engaged in work for a month if the recipient is engaged in work for an average of at least 20 hours per week during the month.

(C) SINGLE TEEN HEAD OF HOUSEHOLD OR MARRIED TEEN WHO MAINTAINS SATISFACTORY SCHOOL ATTENDANCE DEEMED TO BE MEETING WORK PARTICIPATION REQUIREMENTS.—For purposes of determining monthly participation rates under subsection (b)(1)(B)(i), a recipient who is married or a head of household and has not attained 20 years of age is deemed to be engaged in work for a month in a fiscal year if the recipient—

(i) maintains satisfactory attendance at secondary school or the equivalent during the month; or

(ii) participates in education directly related to employment for an average of at least 20 hours per week during the month.

(D) LIMITATION ON NUMBER OF PERSONS WHO MAY BE TREATED AS ENGAGED IN WORK BY REASON OF PARTICIPATION IN EDUCATIONAL ACTIVITIES.—For purposes of determining monthly participation rates under paragraphs (1)(B)(i) and (2)(B) of subsection (b), not more than 30 percent of the number of individuals in all families and in 2–parent families, respectively, in a State who are treated as engaged in work for a month may consist of individuals who are determined to be engaged in work for the month by reason of participation in vocational educational training, or (if the month is in fiscal year 2000 or thereafter) deemed to be engaged in work for the month by reason of subparagraph (C) of this paragraph.

(d) WORK ACTIVITIES DEFINED.—As used in this section, the term "work activities" means—

(1) unsubsidized employment;

(2) subsidized private sector employment;

(3) subsidized public sector employment;

(4) work experience (including work associated with the refurbishing of publicly assisted housing) if sufficient private sector employment is not available;

(5) on–the–job training;

(6) job search and job readiness assistance;

(7) community service programs;

(8) vocational educational training (not to exceed 12 months with respect to any individual);

(9) job skills training directly related to employment;

(10) education directly related to employment, in the case of a recipient who has not received a high school diploma or a certificate of high school equivalency;

(11) satisfactory attendance at secondary school or in a course of study leading to a certificate of general equivalence, in the case of a recipient who has not completed secondary school or received such a certificate; and

(12) the provision of child care services to an individual who is participating in a community service program.

(e) PENALTIES AGAINST INDIVIDUALS.—

(1) IN GENERAL.—Except as provided in paragraph (2), if an individual in a family receiving assistance under the State program funded under this part refuses to engage in work required in accordance with this section, the State shall—

(A) reduce the amount of assistance otherwise payable to the family pro rata (or more, at the option of the State) with respect to any period during a month in which the individual so refuses; or

(B) terminate such assistance,

subject to such good cause and other exceptions as the State may establish.

(2) EXCEPTION.—Notwithstanding paragraph (1), a State may not reduce or terminate assistance under the State program funded under this part based on a refusal of an individual to engage in work required in accordance with this section if the individual is a single custodial parent caring for a child who has not attained 6 years of age, and the individual proves that the individual has a demonstrated inability (as determined by

the State) to obtain needed child care, for 1 or more of the following reasons:

(A) Unavailability of appropriate child care within a reasonable distance from the individual's home or work site.

(B) Unavailability or unsuitability of informal child care by a relative or under other arrangements.

(C) Unavailability of appropriate and affordable formal child care arrangements.

(f) NONDISPLACEMENT IN WORK ACTIVITIES.—

(1) IN GENERAL.—Subject to paragraph (2), an adult in a family receiving assistance under a State program funded under this part attributable to funds provided by the Federal Government may fill a vacant employment position in order to engage in a work activity described in subsection (d).

(2) NO FILLING OF CERTAIN VACANCIES.—No adult in a work activity described in subsection (d) which is funded, in whole or in part, by funds provided by the Federal Government shall be employed or assigned—

(A) when any other individual is on layoff from the same or any substantially equivalent job; or

(B) if the employer has terminated the employment of any regular employee or otherwise caused an involuntary reduction of its workforce in order to fill the vacancy so created with an adult described in paragraph (1).

(3) GRIEVANCE PROCEDURE.—A State with a program funded under this part shall establish and maintain a grievance procedure for resolving complaints of alleged violations of paragraph (2).

(4) NO PREEMPTION.—Nothing in this subsection shall preempt or supersede any provision of State or local law that provides greater protection for employees from displacement.

(g) SENSE OF THE CONGRESS.—It is the sense of the Congress that in complying with this section, each State that operates a program funded under this part is encouraged to assign the highest priority to requiring adults in 2–parent families and adults in single–parent families that include older preschool or school–age children to be engaged in work activities.

(h) SENSE OF THE CONGRESS THAT STATES SHOULD IMPOSE CERTAIN REQUIREMENTS ON NONCUSTODIAL, NONSUPPORTING MINOR PARENTS.—It is the sense of the Congress that the States should require noncustodial, nonsupporting parents who have not attained 18 years of age to fulfill community work obligations and attend appropriate parenting or money management classes after school.

(i) REVIEW OF IMPLEMENTATION OF STATE WORK PROGRAMS.—During fiscal year 1999, the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate shall hold hearings and engage in other appropriate activities to review the implementation of this section by the States, and shall invite the Governors of the States to testify before them regarding such implementation. Based on such hearings, such Committees may introduce such legislation as may be appropriate to remedy any problems with the State programs operated pursuant to this section.

PROHIBITIONS; REQUIREMENTS

SEC. 408. [42 U.S.C. 608] (a) IN GENERAL.—

(1) NO ASSISTANCE FOR FAMILIES WITHOUT A MINOR CHILD.—A State to which a grant is made under section 403 shall not use any part of the grant to provide assistance to a family unless the family includes a minor child who resides with the family (consistent with paragraph (10)) or a pregnant individual.

(2) REDUCTION OR ELIMINATION OF ASSISTANCE FOR NONCOOPERATION IN ESTABLISHING PATERNITY OR OBTAINING CHILD SUPPORT.—If the agency responsible for administering the State plan approved under part D determines that an individual is not cooperating with the State in establishing paternity or in establishing, modifying, or enforcing a support order with respect to a child of the individual, and the individual does not qualify for any good cause or other exception established by the State pursuant to section 454(29), then the State—

(A) shall deduct from the assistance that would otherwise be provided to the family of the individual under the State program funded under this part an amount equal to not less than 25 percent of the amount of such assistance; and

(B) may deny the family any assistance under the State program.

(3) NO ASSISTANCE FOR FAMILIES NOT ASSIGNING CERTAIN SUPPORT RIGHTS TO THE STATE.—

(A) GENERAL.—A State to which a grant is made under section 403 shall require, as a condition of providing assistance to a family under the State program funded under this part, that a member of the family assign to the State any rights the family member may have (on behalf of the family member or of any other person for whom the family member has applied for or is receiving such assistance) to support from any other person, not exceeding the total amount of assistance so provided to the family, which accrue (or have accrued) before the date the family ceases to receive assistance under the program, which assignment, on and after such date, shall not apply with respect to any support (other than support collected pursuant to section 464) which accrued before the family received such assistance and which the State has not collected by—

(i)(I) September 30, 2000, if the assignment is executed on or after October 1, 1997, and before October 1, 2000; or

(II) the date the family ceases to receive assistance under the program, if the assignment is executed on or after October 1, 2000; or

(ii) If the State elects to distribute collections under section 457(a)(6), the date the family ceases to receive assistance under the program, if the assignment is executed on or after October 1, 1998.

(B) LIMITATION.—A State to which a grant is made under section 403 shall not require, as a condition of providing assistance to any family under the State program funded under this part, that a member of the family assign to the State any rights to support described in subpara-

graph (A) which accrue after the date the family ceases to receive assistance under the program.

(4) NO ASSISTANCE FOR TEENAGE PARENTS WHO DO NOT ATTEND HIGH SCHOOL OR OTHER EQUIVALENT TRAINING PROGRAM.—A State to which a grant is made under section 403 shall not use any part of the grant to provide assistance to an individual who has not attained 18 years of age, is not married, has a minor child at least 12 weeks of age in his or her care, and has not successfully completed a high–school education (or its equivalent), if the individual does not participate in—

(A) educational activities directed toward the attainment of a high school diploma or its equivalent; or

(B) an alternative educational or training program that has been approved by the State.

(5) NO ASSISTANCE FOR TEENAGE PARENTS NOT LIVING IN ADULT–SUPERVISED SETTINGS.—

(A) IN GENERAL.—

(i) REQUIREMENT.—Except as provided in subparagraph (B), a State to which a grant is made under section 403 shall not use any part of the grant to provide assistance to an individual described in the minor child referred to in clause (ii) of this subparagraph if the individual and the minor child referred to in clause (ii)(II) do not reside in a place of residence maintained by a parent, legal guardian, or other adult relative of the individual as such parent's, guardian's, or adult relative's own home.

(ii) INDIVIDUAL DESCRIBED.—For purposes of clause (i), an individual described in this clause is an individual who—

(I) has not attained 18 years of age; and

(II) is not married, and has a minor child in his or her care.

(B) EXCEPTION.—

(i) PROVISION OF, OR ASSISTANCE IN LOCATING, ADULT–SUPERVISED LIVING ARRANGEMENT.—In the case of an individual who is described in clause (ii), the State agency referred to in section 402(a)(4) shall provide, or assist the individual in locating, a second chance home, maternity home, or other appropriate adult–supervised supportive living arrangement, taking into consideration the needs and concerns of the individual, unless the State agency determines that the individual's current living arrangement is appropriate, and thereafter shall require that the individual and the minor child referred to in subparagraph (A)(ii)(II) reside in such living arrangement as a condition of the continued receipt of assistance under the State program funded under this part attributable to funds provided by the Federal Government (or in an alternative appropriate arrangement, should circumstances change and the current arrangement cease to be appropriate).

(ii) INDIVIDUAL DESCRIBED.—For purposes of clause (i), an individual is described in this clause if the individual is described in subparagraph (A)(ii), and—

(I) the individual has no parent, legal guardian, or other appropriate adult relative described in subclause (II) of his or her own who is living or whose whereabouts are known;

(II) no living parent, legal guardian, or other appropriate adult relative, who would otherwise meet applicable State criteria to act as the individual's legal guardian, of such individual allows the individual to live in the home of such parent, guardian, or relative;

(III) the State agency determines that—

(aa) the individual or the minor child referred to in subparagraph (A)(ii)(II) is being or has been subjected to serious physical or emotional harm, sexual abuse, or exploitation in the residence of the individual's own parent or legal guardian; or

(bb) substantial evidence exists of an act or failure to act that presents an imminent or serious harm if the individual and the minor child lived in the same residence with the individual's own parent or legal guardian; or

(IV) the State agency otherwise determines that it is in the best interest of the minor child to waive the requirement of subparagraph (A) with respect to the individual or the minor child.

(iii) SECOND–CHANCE HOME.—For purposes of this subparagraph, the term "second–chance home" means an entity that provides individuals described in clause (ii) with a supportive and supervised living arrangement in which such individuals are required to learn parenting skills, including child development, family budgeting, health and nutrition, and other skills to promote their long–term economic independence and the well–being of their children.

(6) NO MEDICAL SERVICES.—

(A) IN GENERAL.—A State to which a grant is made under section 403 shall not use any part of the grant to provide medical services.

(B) EXCEPTION FOR PREPREGNANCY FAMILY PLANNING SERVICES.—As used in subparagraph (A), the term "medical services" does not include prepregnancy family planning services.

(7) NO ASSISTANCE FOR MORE THAN 5 YEARS.—

(A) IN GENERAL.—A State to which a grant is made under section 403 shall not use any part of the grant to provide assistance to a family that includes an adult who has received assistance under any State program funded under this part attributable to funds provided by the Federal Government, for 60 months (whether or not consecutive) after the date the State program funded under this part commences, subject to this paragraph.

(B) MINOR CHILD EXCEPTION.—In determining the number of months for which an individual who is a parent or pregnant has received assistance under the State program funded under this part, the State shall disregard any month for which such assistance was provided with respect to the individual and during which the individual was—

(i) a minor child; and

(ii) not the head of a household or married to the head of a household.

(C) HARDSHIP EXCEPTION.—

(i) IN GENERAL.—The State may exempt a family from the application of subparagraph (A) by reason of hardship or if the family includes an individual who has been battered or subjected to extreme cruelty.

(ii) LIMITATION.—The average monthly number of families with respect to which an exemption made by a State under clause (i) is in effect for a fiscal year shall not exceed 20 percent of the average monthly number of families to which assistance is provided under the State program funded under this part during the fiscal year or the immediately preceding fiscal year (but not both), as the State may elect.

(iii) BATTERED OR SUBJECT TO EXTREME CRUELTY DEFINED.—For purposes of clause (i), an individual has been battered or subjected to extreme cruelty if the individual has been subjected to—

(I) physical acts that resulted in, or threatened to result in, physical injury to the individual;

(II) sexual abuse;

(III) sexual activity involving a dependent child;

(IV) being forced as the caretaker relative of a dependent child to engage in nonconsensual sexual acts or activities;

(V) threats of, or attempts at, physical or sexual abuse;

(VI) mental abuse; or

(VII) neglect or deprivation of medical care.

(D) DISREGARD OF MONTHS OF ASSISTANCE RECEIVED BY ADULT WHILE LIVING IN INDIAN COUNTRY OR AN ALASKAN NATIVE VILLAGE WITH 50 PERCENT UNEMPLOYMENT.—

(i) IN GENERAL.—In determining the number of months for which an adult has received assistance under a State or tribal program funded under this part, the State or tribe shall disregard any month during which the adult lived in Indian country or an Alaskan Native village if the most reliable data available with respect to the month (or a period including the month) indicate that at least 50 percent of the adults living in Indian country or in the village were not employed.

(ii) INDIAN COUNTRY DEFINED.—As used in clause (i), the term "Indian country" has the meaning given such term in section 1151 of title 18, United States Code [32].

[32] See Vol. II., 18 U.S.C. 1151.

(E) RULE OF INTERPRETATION.—Subparagraph (A) shall not be interpreted to require any State to provide assistance to any individual for any period of time under the State program funded under this part.

(F) RULE OF INTERPRETATION.—This part shall not be interpreted to prohibit any State from expending State funds not originating with the Federal Government on benefits for children or families that have become ineligible for assistance under the State program funded under this part by reason of subparagraph (A).

(G) INAPPLICABILITY TO WELFARE–TO–WORK GRANTS AND ASSISTANCE.—For purposes of subparagraph (A) of this paragraph, a grant made under section 403(a)(5) shall not be considered a grant made under section 403, and noncash assistance from funds provided under section 403(a)(5) shall not be considered assistance.

(8) DENIAL OF ASSISTANCE FOR 10 YEARS TO A PERSON FOUND TO HAVE FRAUDULENTLY MISREPRESENTED RESIDENCE IN ORDER TO OBTAIN ASSISTANCE IN 2 OR MORE STATES.—A State to which a grant is made under section 403 shall not use any part of the grant to provide cash assistance to an individual during the 10–year period that begins on the date the individual is convicted in Federal or State court of having made a fraudulent statement or representation with respect to the place of residence of the individual in order to receive assistance simultaneously from 2 or more States under programs that are funded under this title, title XIX, or the Food Stamp Act of 1977, or benefits in 2 or more States under the supplemental security income program under title XVI. The preceding sentence shall not apply with respect to a conviction of an individual, for any month beginning after the President of the United States grants a pardon with respect to the conduct which was the subject of the conviction.

(9) DENIAL OF ASSISTANCE FOR FUGITIVE FELONS AND PROBATION AND PAROLE VIOLATORS.—

(A) IN GENERAL.—A State to which a grant is made under section 403 shall not use any part of the grant to provide assistance to any individual who is—

(i) fleeing to avoid prosecution, or custody or confinement after conviction, under the laws of the place from which the individual flees, for a crime, or an attempt to commit a crime, which is a felony under the laws of the place from which the individual flees, or which, in the case of the State of New Jersey, is a high misdemeanor under the laws of such State; or

(ii) violating a condition of probation or parole imposed under Federal or State law.

The preceding sentence shall not apply with respect to conduct of an individual, for any month beginning after the President of the United States grants a pardon with respect to the conduct.

(B) EXCHANGE OF INFORMATION WITH LAW ENFORCEMENT AGENCIES.—If a State to which a grant is made under section 403 establishes safeguards against the use or disclosure of information about applicants or recipients of assistance under the State program funded under this part, the

safeguards shall not prevent the State agency administering the program from furnishing a Federal, State, or local law enforcement officer, upon the request of the officer, with the current address of any recipient if the officer furnishes the agency with the name of the recipient and notifies the agency that—

(i) the recipient—

(I) is described in subparagraph (A); or

(II) has information that is necessary for the officer to conduct the official duties of the officer; and

(ii) the location or apprehension of the recipient is within such official duties.

(10) DENIAL OF ASSISTANCE FOR MINOR CHILDREN WHO ARE ABSENT FROM THE HOME FOR A SIGNIFICANT PERIOD.—

(A) IN GENERAL.—A State to which a grant is made under section 403 shall not use any part of the grant to provide assistance for a minor child who has been, or is expected by a parent (or other caretaker relative) of the child to be, absent from the home for a period of 45 consecutive days or, at the option of the State, such period of not less than 30 and not more than 180 consecutive days as the State may provide for in the State plan submitted pursuant to section 402.

(B) STATE AUTHORITY TO ESTABLISH GOOD CAUSE EXCEPTIONS.—The State may establish such good cause exceptions to subparagraph (A) as the State considers appropriate if such exceptions are provided for in the State plan submitted pursuant to section 402.

(C) DENIAL OF ASSISTANCE FOR RELATIVE WHO FAILS TO NOTIFY STATE AGENCY OF ABSENCE OF CHILD.—A State to which a grant is made under section 403 shall not use any part of the grant to provide assistance for an individual who is a parent (or other caretaker relative) of a minor child and who fails to notify the agency administering the State program funded under this part of the absence of the minor child from the home for the period specified in or provided for pursuant to subparagraph (A), by the end of the 5–day period that begins with the date that it becomes clear to the parent (or relative) that the minor child will be absent for such period so specified or provided for.

(11) MEDICAL ASSISTANCE REQUIRED TO BE PROVIDED FOR CERTAIN FAMILIES HAVING EARNINGS FROM EMPLOYMENT OR CHILD SUPPORT.—

(A) EARNINGS FROM EMPLOYMENT.—A State to which a grant is made under section 403 and which has a State plan approved under title XIX shall provide that in the case of a family that is treated (under section 1931(b)(1)(A) for purposes of title XIX) as receiving aid under a State plan approved under this part (as in effect on July 16, 1996), that would become ineligible for such aid because of hours of or income from employment of the caretaker relative (as defined under this part as in effect on such date) or because of section 402(a)(8)(B)(ii)(II) (as so in effect), and that was so treated as receiving such aid in at least 3 of the 6 months immediately preceding the month in

which such ineligibility begins, the family shall remain eligible for medical assistance under the State's plan approved under title XIX for an extended period or periods as provided in section 1925 or 1902(e)(1) (as applicable), and that the family will be appropriately notified of such extension as required by section 1925(a)(2).

(B) CHILD SUPPORT.—A State to which a grant is made under section 403 and which has a State plan approved under title XIX shall provide that in the case of a family that is treated (under section 1931(b)(1)(A) for purposes of title XIX) as receiving aid under a State plan approved under this part (as in effect on July 16, 1996), that would become ineligible for such aid as a result (wholly or partly) of the collection of child or spousal support under part D and that was so treated as receiving such aid in at least 3 of the 6 months immediately preceding the month in which such ineligibility begins, the family shall remain eligible for medical assistance under the State's plan approved under title XIX for an extended period or periods as provided in section 1931(c)(1).

(b) INDIVIDUAL RESPONSIBILITY PLANS.—

(1) ASSESSMENT.—The State agency responsible for administering the State program funded under this part shall make an initial assessment of the skills, prior work experience, and employability of each recipient of assistance under the program who—

(A) has attained 18 years of age; or

(B) has not completed high school or obtained a certificate of high school equivalency, and is not attending secondary school.

(2) CONTENTS OF PLANS.—

(A) IN GENERAL.—On the basis of the assessment made under subsection (a) with respect to an individual, the State agency, in consultation with the individual, may develop an individual responsibility plan for the individual, which—

(i) sets forth an employment goal for the individual and a plan for moving the individual immediately into private sector employment;

(ii) sets forth the obligations of the individual, which may include a requirement that the individual attend school, maintain certain grades and attendance, keep school age children of the individual in school, immunize children, attend parenting and money management classes, or do other things that will help the individual become and remain employed in the private sector;

(iii) to the greatest extent possible is designed to move the individual into whatever private sector employment the individual is capable of handling as quickly as possible, and to increase the responsibility and amount of work the individual is to handle over time;

(iv) describes the services the State will provide the individual so that the individual will be able to obtain and keep employment in the private sector, and de-

scribe the job counseling and other services that will be provided by the State; and

(v) may require the individual to undergo appropriate substance abuse treatment.

(B) TIMING.—The State agency may comply with paragraph (1) with respect to an individual—

(i) within 90 days (or, at the option of the State, 180 days) after the effective date of this part, in the case of an individual who, as of such effective date, is a recipient of aid under the State plan approved under part A (as in effect immediately before such effective date); or

(ii) within 30 days (or, at the option of the State, 90 days) after the individual is determined to be eligible for such assistance, in the case of any other individual.

(3) PENALTY FOR NONCOMPLIANCE BY INDIVIDUAL.—In addition to any other penalties required under the State program funded under this part, the State may reduce, by such amount as the State considers appropriate, the amount of assistance otherwise payable under the State program to a family that includes an individual who fails without good cause to comply with a responsibility plan signed by the individual.

(4) STATE DISCRETION.—The exercise of the authority of this subsection shall be within the sole discretion of the State.

(c) SANCTIONS AGAINST RECIPIENTS NOT CONSIDERED WAGE REDUCTIONS.—A penalty imposed by a State against the family of an individual by reason of the failure of the individual to comply with a requirement under the State program funded under this part shall not be construed to be a reduction in any wage paid to the individual.

(d) NONDISCRIMINATION PROVISIONS.—The following provisions of law shall apply to any program or activity which receives funds provided under this part:

(1) The Age Discrimination Act of 1975[33] (42 U.S.C. 6101 et seq.).

(2) Section 504 of the Rehabilitation Act of 1973[34] (29 U.S.C. 794).

(3) The Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.).

(4) Title VI of the Civil Rights Act of 1964[35] (42 U.S.C. 2000d et seq.).

(e) SPECIAL RULES RELATING TO TREATMENT OF CERTAIN ALIENS.-For special rules relating to the treatment of certain aliens, see title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

(f) SPECIAL RULES RELATING TO THE TREATMENT OF NON–213A ALIENS.—The following rules shall apply if a State elects to take the income or resources of any sponsor of a non–213A alien into account in determining whether the alien is eligible for assistance under the State program funded under this part, or in determining the amount or types of such assistance to be provided to the alien:

[33] See Vol. II, P.L. 94-135.
[34] See Vol. II, P.L. 93-112.
[35] See Vol. II, P.L. 88-352.

(1) DEEMING OF SPONSOR'S INCOME AND RESOURCES.—For a period of 3 years after a non–213A alien enters the United States:

(A) INCOME DEEMING RULE.—The income of any sponsor of the alien and of any spouse of the sponsor is deemed to be income of the alien, to the extent that the total amount of the income exceeds the sum of—

(i) the lesser of—

(I) 20 percent of the total of any amounts received by the sponsor or any such spouse in the month as wages or salary or as net earnings from self–employment, plus the full amount of any costs incurred by the sponsor and any such spouse in producing self–employment income in such month; or

(II) $175;

(ii) the cash needs standard established by the State for purposes of determining eligibility for assistance under the State program funded under this part for a family of the same size and composition as the sponsor and any other individuals living in the same household as the sponsor who are claimed by the sponsor as dependents for purposes of determining the sponsor's Federal personal income tax liability but whose needs are not taken into account in determining whether the sponsor's family has met the cash needs standard;

(iii) any amounts paid by the sponsor or any such spouse to individuals not living in the household who are claimed by the sponsor as dependents for purposes of determining the sponsor's Federal personal income tax liability; and

(iv) any payments of alimony or child support with respect to individuals not living in the household.

(B) RESOURCE DEEMING RULE.—The resources of a sponsor of the alien and of any spouse of the sponsor are deemed to be resources of the alien to the extent that the aggregate value of the resources exceeds $1,500.

(C) SPONSORS OF MULTIPLE NON–213A ALIENS.—If a person is a sponsor of 2 or more non–213A aliens who are living in the same home, the income and resources of the sponsor and any spouse of the sponsor that would be deemed income and resources of any such alien under subparagraph (A) shall be divided into a number of equal shares equal to the number of such aliens, and the State shall deem the income and resources of each such alien to include 1 such share.

(2) INELIGIBILITY OF NON–213A ALIENS SPONSORED BY AGENCIES; EXCEPTION.—A non–213A alien whose sponsor is or was a public or private agency shall be ineligible for assistance under a State program funded under this part, during a period of 3 years after the alien enters the United States, unless the State agency administering the program determines that the sponsor either no longer exists or has become unable to meet the alien's needs.

(3) INFORMATION PROVISIONS.—

(A) DUTIES OF NON–213A ALIENS.—A non–213A alien, as a condition of eligibility for assistance under a State program funded under this part during the period of 3 years after the alien enters the United States, shall be required to provide to the State agency administering the program—

(i) such information and documentation with respect to the alien's sponsor as may be necessary in order for the State agency to make any determination required under this subsection, and to obtain any cooperation from the sponsor necessary for any such determination; and

(ii) such information and documentation as the State agency may request and which the alien or the alien's sponsor provided in support of the alien's immigration application.

(B) DUTIES OF FEDERAL AGENCIES.—The Secretary shall enter into agreements with the Secretary of State and the Attorney General under which any information available to them and required in order to make any determination under this subsection will be provided by them to the Secretary (who may, in turn, make the information available, upon request, to a concerned State agency).

(4) NON–213A ALIEN DEFINED.—An alien is a non–213A alien for purposes of this subsection if the affidavit of support or similar agreement with respect to the alien that was executed by the sponsor of the alien's entry into the United States was executed other than pursuant to section 213A of the Immigration and Nationality Act.

(5) INAPPLICABILITY TO ALIEN MINOR SPONSORED BY A PARENT.—This subsection shall not apply to an alien who is a minor child if the sponsor of the alien or any spouse of the sponsor is a parent of the alien.

(6) INAPPLICABILITY TO CERTAIN CATEGORIES OF ALIENS.—This subsection shall not apply to an alien who is—

(A) admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act[36];

(B) paroled into the United States under section 212(d)(5) of such Act for a period of at least 1 year; or

(C) granted political asylum by the Attorney General under section 208 of such Act.

(g) STATE REQUIRED TO PROVIDE CERTAIN INFORMATION.—Each State to which a grant is made under section 403 shall, at least 4 times annually and upon request of the Immigration and Naturalization Service, furnish the Immigration and Naturalization Service with the name and address of, and other identifying information on, any individual who the State knows is not lawfully present in the United States.

PENALTIES

SEC. 409. [42 U.S.C. 609] (a) IN GENERAL.—Subject to this section:

(1) USE OF GRANT IN VIOLATION OF THIS PART.—

[36] See Vol. II., P.L. 84-414, §§207, 208 and 212(d)(5).

(A) GENERAL PENALTY.—If an audit conducted under chapter 75 of title 31, United States Code, finds that an amount paid to a State under section 403 for a fiscal year has been used in violation of this part, the Secretary shall reduce the grant payable to the State under section 403(a)(1) for the immediately succeeding fiscal year quarter by the amount so used.

(B) ENHANCED PENALTY FOR INTENTIONAL VIOLATIONS.—If the State does not prove to the satisfaction of the Secretary that the State did not intend to use the amount in violation of this part, the Secretary shall further reduce the grant payable to the State under section 403(a)(1) for the immediately succeeding fiscal year quarter by an amount equal to 5 percent of the State family assistance grant.

(C) PENALTY FOR MISUSE OF COMPETITIVE WELFARE–TO–WORK FUNDS.—If the Secretary of Labor finds that an amount paid to an entity under section 403(a)(5)(B) has been used in violation of subparagraph (B) or (C) of section 403(a)(5), the entity shall remit to the Secretary of Labor an amount equal to the amount so used.

(2) FAILURE TO SUBMIT REQUIRED REPORT.—

(A) IN GENERAL.—If the Secretary determines that a State has not, within 45 days after the end of a fiscal quarter, submitted the report required by section 411(a) for the quarter, the Secretary shall reduce the grant payable to the State under section 403(a)(1) for the immediately succeeding fiscal year by an amount equal to 4 percent of the State family assistance grant.

(B) RESCISSION OF PENALTY.—The Secretary shall rescind a penalty imposed on a State under subparagraph (A) with respect to a report if the State submits the report before the end of the fiscal quarter that immediately succeeds the fiscal quarter for which the report was required.

(3) FAILURE TO SATISFY MINIMUM PARTICIPATION RATES.—

(A) IN GENERAL.—If the Secretary determines that a State to which a grant is made under section 403 for a fiscal year has failed to comply with section 407(a) for the fiscal year, the Secretary shall reduce the grant payable to the State under section 403(a)(1) for the immediately succeeding fiscal year by an amount equal to the applicable percentage of the State family assistance grant.

(B) APPLICABLE PERCENTAGE DEFINED.—As used in subparagraph (A), the term "applicable percentage" means, with respect to a State—

(i) if a penalty was not imposed on the State under subparagraph (A) for the immediately preceding fiscal year, 5 percent; or

(ii) if a penalty was imposed on the State under subparagraph (A) for the immediately preceding fiscal year, the lesser of—

(I) the percentage by which the grant payable to the State under section 403(a)(1) was reduced for such preceding fiscal year, increased by 2 percentage points; or

(II) 21 percent.

(C) PENALTY BASED ON SEVERITY OF FAILURE.—The Secretary shall impose reductions under subparagraph (A) with respect to a fiscal year based on the degree of noncompliance, and may reduce the penalty if the noncompliance is due to circumstances that caused the State to become a needy State (as defined in section 403(b)(6)) during the fiscal year or if the noncompliance is due to extraordinary circumstances such as a natural disaster or regional recession. The Secretary shall provide a written report to Congress to justify any waiver or penalty reduction due to such extraordinary circumstances.

(4) FAILURE TO PARTICIPATE IN THE INCOME AND ELIGIBILITY VERIFICATION SYSTEM.—If the Secretary determines that a State program funded under this part is not participating during a fiscal year in the income and eligibility verification system required by section 1137, the Secretary shall reduce the grant payable to the State under section 403(a)(1) for the immediately succeeding fiscal year by an amount equal to not more than 2 percent of the State family assistance grant.

(5) FAILURE TO COMPLY WITH PATERNITY ESTABLISHMENT AND CHILD SUPPORT ENFORCEMENT REQUIREMENTS UNDER PART D.—Notwithstanding any other provision of this Act, if the Secretary determines that the State agency that administers a program funded under this part does not enforce the penalties requested by the agency administering part D against recipients of assistance under the State program who fail to cooperate in establishing paternity or in establishing, modifying, or enforcing a child support order in accordance with such part and who do not qualify for any good cause or other exception established by the State under section 454(29), the Secretary shall reduce the grant payable to the State under section 403(a)(1) for the immediately succeeding fiscal year (without regard to this section) by not more than 5 percent.

(6) FAILURE TO TIMELY REPAY A FEDERAL LOAN FUND FOR STATE WELFARE PROGRAMS.—If the Secretary determines that a State has failed to repay any amount borrowed from the Federal Loan Fund for State Welfare Programs established under section 406 within the period of maturity applicable to the loan, plus any interest owed on the loan, the Secretary shall reduce the grant payable to the State under section 403(a)(1) for the immediately succeeding fiscal year quarter (without regard to this section) by the outstanding loan amount, plus the interest owed on the outstanding amount. The Secretary shall not forgive any outstanding loan amount or interest owed on the outstanding amount.

(7) FAILURE OF ANY STATE TO MAINTAIN CERTAIN LEVEL OF HISTORIC EFFORT.—

(A) IN GENERAL.—The Secretary shall reduce the grant payable to the State under section 403(a)(1) for fiscal year 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, or 2006[37] by the amount (if any) by which qualified State expendi-

[37] P.L. 108-308, §2(b)(3)(A), struck out "or 2005" and substituted "2005, or 2006", effective September 30, 2004.
P.L. 108-40, §3(g)(1), struck out "or 2003" and substituted "2003, or 2004", effective July 1, 2003.
P.L. 108-89, §101(b)(3)(A), struck out "or 2004" and substituted "2004, or 2005", effective October 1, 2003.

tures for the then immediately preceding fiscal year are less that the applicable percentage of historic State expenditures with respect to such preceding fiscal year.

(B) DEFINITIONS.—As used in this paragraph:

(i) QUALIFIED STATE EXPENDITURES.—

(I) IN GENERAL.—The term "qualified State expenditures" means, with respect to a State and a fiscal year, the total expenditures by the State during the fiscal year, under all State programs, for any of the following with respect to eligible families:

(aa) Cash assistance, including any amount collected by the State as support pursuant to a plan approved under part D, on behalf of a family receiving assistance under the State program funded under this part, that is distributed to the family under section 457(a)(1)(B) and disregarded in determining the eligibility of the family for, and the amount of, such assistance.

(bb) Child care assistance.

(cc) Educational activities designed to increase self–sufficiency, job training, and work, excluding any expenditure for public education in the State except expenditures which involve the provision of services or assistance to a member of an eligible family which is not generally available to persons who are not members of an eligible family.

(dd) Administrative costs in connection with the matters described in items (aa), (bb), (cc), and (ee), but only to the extent that such costs do not exceed 15 percent of the total amount of qualified State expenditures for the fiscal year.

(ee) Any other use of funds allowable under section 404(a)(1).

(II) EXCLUSION OF TRANSFERS FROM OTHER STATE AND LOCAL PROGRAMS.—Such term does not include expenditures under any State or local program during a fiscal year, except to the extent that—

(aa) the expenditures exceed the amount expended under the State or local program in the fiscal year most recently ending before the date of the enactment of this section [38];or

(bb) the State is entitled to a payment under former section 403 (as in effect immediately before such date of enactment) with respect to the expenditures.

(III) EXCLUSION OF AMOUNTS EXPENDED TO REPLACE PENALTY GRANT REDUCTIONS.—Such term does not include any amount expended in order to comply with paragraph (12).

[38] July 1, 1997.

(IV) ELIGIBLE FAMILIES.—As used in subclause (I), the term "eligible families" means families eligible for assistance under the State program funded under this part, families that would be eligible for such assistance but for the application of section 408(a)(7) of this Act, and families of aliens lawfully present in the United States that would be eligible for such assistance but for the application of title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

(ii) APPLICABLE PERCENTAGE.—The term "applicable percentage" means for fiscal years 1997 through 2005[39], 80 percent (or, if the State meets the requirements of section 407(a) for the fiscal year, 75 percent).

(iii) HISTORIC STATE EXPENDITURES.—The term "historic State expenditures" means, with respect to a State, the lesser of—

(I) the expenditures by the State under parts A and F (as in effect during fiscal year 1994) for fiscal year 1994; or

(II) the amount which bears the same ratio to the amount described in subclause (I) as—

(aa) the State family assistance grant, plus the total amount required to by paid to the State under former section 403 for fiscal year 1994 with respect to amounts expended by the State for child care under subsection (g) or (i) of section 402 (as in effect during fiscal year 1994); bears to

(bb) the total amount required to be paid to the State under former section 403 (as in effect during fiscal year 1994) for fiscal year 1994.

Such term does not include any expenditures under the State plan approved under part A (as so in effect) on behalf of individuals covered by a tribal family assistance plan approved under section 412, as determined by the Secretary.

(iv) EXPENDITURES BY THE STATE.—The term "expenditures by the State" does not include—

(I) any expenditure from amounts made available by the Federal Government;

(II) any State funds expended for the medicaid program under title XIX;

(III) any State funds which are used to match Federal funds provided under section 403(a)(5); or

(IV) any State funds which are expended as a condition of receiving Federal funds other than under this part.

Notwithstanding subclause (IV) of the preceding sentence, such term includes expenditures by a State for

[39] P.L. 108-40, §3(g)(2), struck out "2002" and substituted "2003", effective July 1, 2003.
P.L. 108-89, §101(b)(3)(B), struck out "2003" and substituted "2004", effective October 1, 2003.
P.L. 108-308, §2(b)(3)(B), struck out "2004" and substituted "2005", effective September 30, 2004.

child care in a fiscal year to the extent that the total amount of the expenditures does not exceed the amount of State expenditures in fiscal year 1994 or 1995 (whichever is the greater) that equal the non–Federal share for the programs described in section 418(a)(1)(A).

(v) SOURCE OF DATA.—In determining expenditures by a State for fiscal years 1994 and 1995, the Secretary shall use information which was reported by the State on ACF Form 231 or (in the case of expenditures under part F) ACF Form 331, available as of the dates specified in clauses (ii) and (iii) of section 403(a)(1)(D).

(8) NONCOMPLIANCE OF STATE CHILD SUPPORT ENFORCEMENT PROGRAM WITH REQUIREMENTS OF PART D.—

(A) IN GENERAL.—If the Secretary finds, with respect to a State's program under part D, in a fiscal year beginning on or after October 1, 1997—

(i)(I) on the basis of data submitted by a State pursuant to section 454(15)(B), or on the basis of the results of a review conducted under section 452(a)(4), that the State program failed to achieve the paternity establishment percentages (as defined in section 452(g)(2)), or to meet other performance measures that may be established by the Secretary;

(II) on the basis of the results of an audit or audits conducted under section 452(a)(4)(C)(i) that the State data submitted pursuant to section 454(15)(B) is incomplete or unreliable; or

(III) on the basis of the results of an audit or audits conducted under section 452(a)(4)(C) that a State failed to substantially comply with 1 or more of the requirements of part D (other than paragraph (24) or subparagraph (A) or (B)(i) of paragraph (27), of section 454 and

(ii) that, with respect to the succeeding fiscal year—

(I) the State failed to take sufficient corrective action to achieve the appropriate performance levels or compliance as described in subparagraph (A)(i); or

(II) the data submitted by the State pursuant to section 454(15)(B) is incomplete or unreliable; the amounts otherwise payable to the State under this part for quarters following the end of such succeeding fiscal year, prior to quarters following the end of the first quarter throughout which the State program has achieved the paternity establishment percentages or other performance measures as described in subparagraph (A)(i)(I), or is in substantial compliance with 1 or more of the requirements of part D as described in subparagraph (A)(i)(III), as appropriate, shall be reduced by the percentage specified in subparagraph (B).

(B) AMOUNT OF REDUCTIONS.—The reductions required under subparagraph (A) shall be—

(i) not less than 1 nor more than 2 percent;

(ii) not less than 2 nor more than 3 percent, if the finding is the 2nd consecutive finding made pursuant to subparagraph (A); or

(iii) not less than 3 nor more than 5 percent, if the finding is the 3rd or a subsequent consecutive such finding.

(C) DISREGARD OF NONCOMPLIANCE WHICH IS OF A TECHNICAL NATURE.—For purposes of this section and section 452(a)(4), a State determined as a result of an audit—

(i) to have failed to have substantially complied with 1 or more of the requirements of part D shall be determined to have achieved substantial compliance only if the Secretary determines that the extent of the noncompliance is of a technical nature which does not adversely affect the performance of the State's program under part D; or

(ii) to have submitted incomplete or unreliable data pursuant to section 454(15)(B) shall be determined to have submitted adequate data only if the Secretary determines that the extent of the incompleteness or unreliability of the data is of a technical nature which does not adversely affect the determination of the level of the State's paternity establishment percentages (as defined under section 452(g)(2)) or other performance measures that may be established by the Secretary.

(9) FAILURE TO COMPLY WITH 5–YEAR LIMIT ON ASSISTANCE.—If the Secretary determines that a State has not complied with section 408(a)(7) during a fiscal year, the Secretary shall reduce the grant payable to the State under section 403(a)(1) for the immediately succeeding fiscal year by an amount equal to 5 percent of the State family assistance grant.

(10) FAILURE OF STATE RECEIVING AMOUNTS FROM CONTINGENCY FUND TO MAINTAIN 100 PERCENT OF HISTORIC EFFORT.—If, at the end of any fiscal year during which amounts from the Contingency Fund for State Welfare Programs have been paid to a State, the Secretary finds that the qualified State expenditures (as defined in paragraph (7)(B)(i) (other than the expenditures described in subclause (I)(bb) of that paragraph)) under the State program funded under this part for the fiscal year are less than 100 percent of historic State expenditures (as defined in paragraph (7)(B)(iii) of this subsection), excluding any amount expended by the State for child care under subsection (g) or (i) of section 402 (as in effect during fiscal year 1994) for fiscal year 1994, the Secretary shall reduce the grant payable to the State under section 403(a)(1) for the immediately succeeding fiscal year by the total of the amounts so paid to the State that the State has not remitted under section 403(b)(6).

(11) FAILURE TO MAINTAIN ASSISTANCE TO ADULT SINGLE CUSTODIAL PARENT WHO CANNOT OBTAIN CHILD CARE FOR CHILD UNDER AGE 6.—

(A) IN GENERAL.—If the Secretary determines that a State to which a grant is made under section 403 for a fiscal year has violated section 407(e)(2) during the fiscal year, the Secretary shall reduce the grant payable to the State under section 403(a)(1) for the immediately succeed-

ing fiscal year by an amount equal to not more than 5 percent of the State family assistance grant.

(B) PENALTY BASED ON SEVERITY OF FAILURE.—The Secretary shall impose reductions under subparagraph (A) with respect to a fiscal year based on the degree of noncompliance.

(12) REQUIREMENT TO EXPEND ADDITIONAL STATE FUNDS TO REPLACE GRANT REDUCTIONS; PENALTY FOR FAILURE TO DO SO.—If the grant payable to a State under section 403(a)(1) for a fiscal year is reduced by reason of this subsection, the State shall, during the immediately succeeding fiscal year, expend under the State program funded under this part an amount equal to the total amount of such reductions. If the State fails during such succeeding fiscal year to make the expenditure required by the preceding sentence from its own funds, the Secretary may reduce the grant payable to the State under section 403(a)(1) for the fiscal year that follows such succeeding fiscal year by an amount equal to the sum of—

(A) not more than 2 percent of the State family assistance grant; and

(B) the amount of the expenditure required by the preceding sentence.

(13) PENALTY FOR FAILURE OF STATE TO MAINTAIN HISTORIC EFFORT DURING YEAR IN WHICH WELFARE–TO–WORK GRANT IS RECEIVED. - If a grant is made to a State under section 403(a)(5)(A) for a fiscal year and paragraph (7) of this subsection requires the grant payable to the State under section 403(a)(1) to be reduced for the immediately succeeding fiscal year, then the Secretary shall reduce the grant payable to the State under section 403(a)(1) for such succeeding fiscal year by the amount of the grant made to the State under section 403(a)(5)(A) for the fiscal year.

(14) PENALTY FOR FAILURE TO REDUCE ASSISTANCE FOR RECIPIENTS REFUSING WITHOUT GOOD CAUSE TO WORK.—

(A) IN GENERAL.—If the Secretary determines that a State to which a grant is made under section 403 in a fiscal year has violated section 407(e) during the fiscal year, the Secretary shall reduce the grant payable to the State under section 403(a)(1) for the immediately succeeding fiscal year by an amount equal to not less than 1 percent and not more than 5 percent of the State family assistance grant.

(B) PENALTY BASED ON SEVERITY OF FAILURE.—The Secretary shall impose reductions under subparagraph (A) with respect to a fiscal year based on the degree of noncompliance.

(b) REASONABLE CAUSE EXCEPTION.—

(1) IN GENERAL.—The Secretary may not impose a penalty on a State under subsection (a) with respect to a requirement if the Secretary determines that the State has reasonable cause for failing to comply with the requirement.

(2) EXCEPTION.—Paragraph (1) of this subsection shall not apply to any penalty under paragraph (6), (7), (8), (10), (12), or (13) of subsection (a).

(c) CORRECTIVE COMPLIANCE PLAN.—

(1) IN GENERAL.—

(A) NOTIFICATION OF VIOLATION.—Before imposing a penalty against a State under subsection (a) with respect to a violation of this part, the Secretary shall notify the State of the violation and allow the State the opportunity to enter into a corrective compliance plan in accordance with this subsection which outlines how the State will correct or discontinue, as appropriate the violation and how the State will insure continuing compliance with this part.

(B) 60–DAY PERIOD TO PROPOSE A CORRECTIVE COMPLIANCE PLAN.—During the 60–day period that begins on the date the State receives a notice provided under subparagraph (A) with respect to a violation, the State may submit to the Federal Government a corrective compliance plan to correct or discontinue, as appropriate the violation.

(C) CONSULTATION ABOUT MODIFICATIONS.—During the 60–day period that begins with the date the Secretary receives a corrective compliance plan submitted by a State in accordance with subparagraph (B), the Secretary may consult with the State on modifications to the plan.

(D) ACCEPTANCE OF PLAN.—A corrective compliance plan submitted by a State in accordance with subparagraph (B) is deemed to be accepted by the Secretary if the Secretary does not accept or reject the plan during 60–day period that begins on the date the plan is submitted.

(2) EFFECT OF CORRECTING OR DISCONTINUING VIOLATION .—The Secretary may not impose any penalty under subsection (a) with respect to any violation covered by a State corrective compliance plan accepted by the Secretary if the State corrects or discontinues, as appropriate the violation pursuant to the plan.

(3) EFFECT OF FAILING TO CORRECT OR DISCONTINUE VIOLATION .—The Secretary shall assess some or all of a penalty imposed on a State under subsection (a) with respect to a violation if the State does not, in a timely manner, correct or discontinue, as appropriate, the violation pursuant to a State corrective compliance plan accepted by the Secretary.

(4) INAPPLICABILITY TO CERTAIN PENALTIES.—This subsection shall not apply to the imposition of a penalty against a State under paragraph (6), (7), (8), (10), (12), or (13) of subsection (a).

(d) LIMITATION ON AMOUNT OF PENALTIES.—

(1) IN GENERAL.—In imposing the penalties described in subsection (a), the Secretary shall not reduce any quarterly payment to a State by more than 25 percent.

(2) CARRYFORWARD OF UNRECOVERED PENALTIES.—To the extent that paragraph (1) of this subsection prevents the Secretary from recovering during a fiscal year the full amount of penalties imposed on a State under subsection (a) of this section for a prior fiscal year, the Secretary shall apply any remaining amount of such penalties to the grant payable to the State under section 403(a)(1) for the immediately succeeding fiscal year.

APPEAL OF ADVERSE DECISION

SEC. 410. [42 U.S.C. 610] (a) IN GENERAL.—Within 5 days after the date the Secretary takes any adverse action under this part

with respect to a State, the Secretary shall notify the chief executive officer of the State of the adverse action, including any action with respect to the State plan submitted under section 402 or the imposition of a penalty under section 409.

(b) ADMINISTRATIVE REVIEW.—

(1) IN GENERAL.—Within 60 days after the date a State receives notice under subsection (a) of an adverse action, the State may appeal the action, in whole or in part, to the Departmental Appeals Board established in the Department of Health and Human Services (in this section referred to as the "Board") by filing an appeal with the Board.

(2) PROCEDURAL RULES.—The Board shall consider an appeal filed by a State under paragraph (1) on the basis of such documentation as the State may submit and as the Board may require to support the final decision of the Board. In deciding whether to uphold an adverse action or any portion of such an action, the Board shall conduct a thorough review of the issues and take into account all relevant evidence. The Board shall make a final determination with respect to an appeal filed under paragraph (1) not less than 60 days after the date the appeal is filed.

(c) JUDICIAL REVIEW OF ADVERSE DECISION.—

(1) IN GENERAL.—Within 90 days after the date of a final decision by the Board under this section with respect to an adverse action taken against a State, the State may obtain judicial review of the final decision (and the findings incorporated into the final decision) by filing an action in—

(A) the district court of the United States for the judicial district in which the principal or headquarters office of the State agency is located; or

(B) the United States District Court for the District of Columbia.

(2) PROCEDURAL RULES.—The district court in which an action is filed under paragraph (1) shall review the final decision of the Board on the record established in the administrative proceeding, in accordance with the standards of review prescribed by subparagraphs (A) through (E) of section 706(2) of title 5, United States Code[40]. The review shall be on the basis of the documents and supporting data submitted to the Board.

DATA COLLECTION AND REPORTING

SEC. 411. [42 U.S.C. 611] (a) QUARTERLY REPORTS BY STATES.—

(1) GENERAL REPORTING REQUIREMENT.—

(A) CONTENTS OF REPORT.—Each eligible State shall collect on a monthly basis, and report to the Secretary on a quarterly basis, the following disaggregated case record information on the families receiving assistance under the State program funded under this part (except for information relating to activities carried out under section 403(a)(5)) :

(i) The county of residence of the family.

(ii) Whether a child receiving such assistance or an adult in the family is receiving—

[40] See Vol. II, 5 U.S.C. 706(2) A - E.

(I) Federal disability insurance benefits;

(II) benefits based on Federal disability status;

(III) aid under a State plan approved under title XIV (as in effect without regard to the amendment made by section 301 of the Social Security Amendments of 1972));

(IV) aid or assistance under a State plan approved under title XVI (as in effect without regard to such amendment) by reason of being permanently and totally disabled; or

(V) supplemental security income benefits under title XVI (as in effect pursuant to such amendment) by reason of disability.

(iii) The ages of the members of such families.

(iv) The number of individuals in the family, and the relation of each family member to the head of the family.

(v) The employment status and earnings of the employed adult in the family.

(vi) The marital status of the adults in the family, including whether such adults have never married, are widowed, or are divorced.

(vii) The race and educational level of each adult in the family.

(viii) The race and educational level of each child in the family.

(ix) Whether the family received subsidized housing, medical assistance under the State plan approved under title XIX, food stamps, or subsidized child care, and if the latter 2, the amount received.

(x) The number of months that the family has received each type of assistance under the program.

(xi) If the adults participated in, and the number of hours per week of participation in, the following activities:

(I) Education.

(II) Subsidized private sector employment.

(III) Unsubsidized employment.

(IV) Public sector employment, work experience, or community service.

(V) Job search.

(VI) Job skills training or on–the–job training.

(VII) Vocational education.

(xii) Information necessary to calculate participation rates under section 407.

(xiii) The type and amount of assistance received under the program, including the amount of and reason for any reduction of assistance (including sanctions).

(xiv) Any amount of unearned income received by any member of the family.

(xv) The citizenship of the members of the family.

(xvi) From a sample of closed cases, whether the family left the program, and if so, whether the family left due to—

(I) employment;

(II) marriage;

(III) the prohibition set forth in section 408(a)(7);

(IV) sanction; or

(V) State policy.

(xvii) With respect to each individual in the family who has not attained 20 years of age, whether the individual is a parent of a child in the family.

(B) USE OF SAMPLES.—

(i) AUTHORITY.—A State may comply with subparagraph (A) by submitting disaggregated case record information on a sample of families selected through the use of scientifically acceptable sampling methods approved by the Secretary.

(ii) SAMPLING AND OTHER METHODS.—The Secretary shall provide the States with such case sampling plans and data collection procedures as the Secretary deems necessary to produce statistically valid estimates of the performance of State programs funded under this part. The Secretary may develop and implement procedures for verifying the quality of data submitted by the States.

(2) REPORT ON USE OF FEDERAL FUNDS TO COVER ADMINISTRATIVE COSTS AND OVERHEAD.—The report required by paragraph (1) for a fiscal quarter shall include a statement of the percentage of the funds paid to the State under this part for the quarter that are used to cover administrative costs or overhead, with a separate statement of the percentage of such funds that are used to cover administrative costs or overhead incurred for programs operated with funds provided under section 403(a)(5).

(3) REPORT ON STATE EXPENDITURES ON PROGRAMS FOR NEEDY FAMILIES.—The report required by paragraph (1) for a fiscal quarter shall include a statement of the total amount expended by the State during the quarter on programs for needy families, with a separate statement of the total amount expended by the State during the quarter on programs operated with funds provided under section 403(a)(5).

(4) REPORT ON NONCUSTODIAL PARENTS PARTICIPATING IN WORK ACTIVITIES.—The report required by paragraph (1) for a fiscal quarter shall include the number of noncustodial parents in the State who participated in work activities (as defined in section 407(d)) during the quarter, with a separate statement of the number of such parents who participated in programs operated with funds provided under section 403(a)(5).

(5) REPORT ON TRANSITIONAL SERVICES.—The report required by paragraph (1) for a fiscal quarter shall include the total amount expended by the State during the quarter to provide transitional services to a family that has ceased to receive assistance under this part because of employment, along with a description of such services.

(6) REPORT ON FAMILIES RECEIVING ASSISTANCE.—The report required by paragraph (1) for a fiscal quarter shall include for each month in the quarter—

(A) the number of families and individuals receiving assistance under the State program funded under this part (including the number of 2–parent and 1–parent families);

(B) the total dollar value of such assistance received by all families; and

(C) with respect to families and individuals participating in a program operated with funds provided under section 403(a)(5)—

(i) the total number of such families and individuals; and

(ii) the number of such families and individuals whose participation in such a program was terminated during a month.

(7) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to define the data elements with respect to which reports are required by this subsection, and shall consult with the Secretary of Labor in defining the data elements with respect to programs operated with funds provided under section 403(a)(5).

(b) ANNUAL REPORTS TO THE CONGRESS BY THE SECRETARY.—Not later than 6 months after the end of fiscal year 1997, and each fiscal year thereafter, the Secretary shall transmit to the Congress a report describing—

(1) whether the States are meeting—

(A) the participation rates described in section 407(a); and

(B) the objectives of—

(i) increasing employment and earnings of needy families, and child support collections; and

(ii) decreasing out–of–wedlock pregnancies and child poverty;

(2) the demographic and financial characteristics of families applying for assistance, families receiving assistance, and families that become ineligible to receive assistance;

(3) the characteristics of each State program funded under this part; and

(4) the trends in employment and earnings of needy families with minor children living at home.

STATE REQUIRED TO PROVIDE CERTAIN INFORMATION

SEC. 411A. [42 U.S.C. 611a] Each State to which a grant is made under section 403 shall, at lease 4 times annually and upon request of the Immigration and Naturalization Service, furnish the Immigration and Naturalization Service with the name and address of, and other identifying information on, any individual who the State knows is unlawfully in the United States.

DIRECT FUNDING AND ADMINISTRATION BY INDIAN TRIBES

SEC. 412. [42 U.S.C. 612] (a) GRANTS FOR INDIAN TRIBES.—

(1) TRIBAL FAMILY ASSISTANCE GRANT.—

(A) IN GENERAL.—For each of fiscal years 1997, 1998, 1999, 2000, 2001, 2002 and 2003[41], the Secretary shall pay

[41] P.L. 108-40, §3(h), struck out "and 2002" and substituted "2002, and 2003", effective July 1, 2003.

to each Indian tribe that has an approved tribal family assistance plan a tribal family assistance grant for the fiscal year in an amount equal to the amount determined under subparagraph (B), which shall be reduced for a fiscal year, on a pro rata basis for each quarter, in the case of a tribal family assistance plan approved during a fiscal year for which the plan is to be in effect, and shall reduce the grant payable under section 403(a)(1) to any State in which lies the service area or areas of the Indian tribe by that portion of the amount so determined that is attributable to expenditures by the State.

(B) AMOUNT DETERMINED.—

(i) IN GENERAL.—The amount determined under this subparagraph is an amount equal to the total amount of the Federal payments to a State or States under section 403 (as in effect during such fiscal year) for fiscal year 1994 attributable to expenditures (other than child care expenditures) by the State or States under parts A and F (as so in effect) for fiscal year 1994 for Indian families residing in the service area or areas identified by the Indian tribe pursuant to subsection (b)(1)(C) of this section.

(ii) USE OF STATE SUBMITTED DATA.—

(I) IN GENERAL.—The Secretary shall use State submitted data to make each determination under clause (i).

(II) DISAGREEMENT WITH DETERMINATION.—If an Indian tribe or tribal organization disagrees with State submitted data described under subclause (I), the Indian tribe or tribal organization may submit to the Secretary such additional information as may be relevant to making the determination under clause (i) and the Secretary may consider such information before making such determination.

(2) GRANTS FOR INDIAN TRIBES THAT RECEIVED JOBS FUNDS.—

(A) IN GENERAL.—For each of fiscal years 1997, 1998, 1999, 2000, 2001, 2002, and 2003[42] the Secretary shall pay to each eligible Indian tribe that proposes to operate a program described in subparagraph (C) a grant in an amount equal to the amount received by the Indian tribe in fiscal year 1994 under section 482(i) (as in effect during fiscal year 1994).

(B) ELIGIBLE INDIAN TRIBE.—For purposes of subparagraph (A), the term "eligible Indian tribe" means an Indian tribe or Alaska Native organization that conducted a job opportunities and basic skills training program in fiscal year 1995 under section 482(i) (as in effect during fiscal year 1995).

(C) USE OF GRANT.—Each Indian tribe to which a grant is made under this paragraph shall use the grant for the purpose of operating a program to make work activities

[42] P.L. 108-40, §3(h), struck out "and 2002" and substituted "2002, and 2003", effective July 1, 2003.

available to such population and such service areas or areas as the tribe specifies.

(D) APPROPRIATION.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated $7,633,287 for each fiscal year specified in subparagraph (A) for grants under subparagraph (A).

(3) WELFARE–TO–WORK GRANTS.—

(A) IN GENERAL.—The Secretary of Labor shall award a grant in accordance with this paragraph to an Indian tribe for each fiscal year specified in section 403(a)(5)(H) for which the Indian tribe is a welfare–to–work tribe, in such amount as the Secretary of Labor deems appropriate, subject to subparagraph (B) of this paragraph.

(B) WELFARE–TO–WORK TRIBE.—An Indian tribe shall be considered a welfare–to–work tribe for a fiscal year for purposes of this paragraph if the Indian tribe meets the following requirements:

(i) The Indian tribe has submitted to the Secretary of Labor a plan which describes how, consistent with section 403(a)(5), the Indian tribe will use any funds provided under this paragraph during the fiscal year. If the Indian tribe has a tribal family assistance plan, the plan referred to in the preceding sentence shall be in the form of an addendum to the tribal family assistance plan.

(ii) The Indian tribe is operating a program under a tribal family assistance plan approved by the Secretary of Health and Human Services, a program described in paragraph (2)(C), or an employment program funded through other sources under which substantial services are provided to recipients of assistance under a program funded under this part.

(iii) The Indian tribe has provided the Secretary of Labor with an estimate of the amount that the Indian tribe intends to expend during the fiscal year (excluding tribal expenditures described in section 409(a)(7)(B)(iv) (other than subclause (III) thereof)) pursuant to this paragraph.

(iv) The Indian tribe has agreed to negotiate in good faith with the Secretary of Health and Human Services with respect to the substance and funding of any evaluation under section 413(j), and to cooperate with the conduct of any such evaluation.

(C) LIMITATIONS ON USE OF FUNDS.—

(i) IN GENERAL.—Section 403(a)(5)(C) shall apply to funds provided to Indian tribes under this paragraph in the same manner in which such section applies to funds provided under section 403(a)(5).

(ii) WAIVER AUTHORITY.—The Secretary of Labor may waive or modify the application of a provision of section 403(a)(5)(C) (other than clause (viii) thereof) with respect to an Indian tribe to the extent necessary to enable the Indian tribe to operate a more efficient or effective program with the funds provided under this paragraph.

(iii) REGULATIONS.—Within 90 days after the date of the enactment of this paragraph, the Secretary of Labor, after consultation with the Secretary of Health and Human Services and the Secretary of Housing and Urban Development, shall prescribe such regulations as may be necessary to implement this paragraph.

(b) 3–YEAR TRIBAL FAMILY ASSISTANCE PLAN.—

(1) IN GENERAL.—Any Indian tribe that desires to receive a tribal family assistance grant shall submit to the Secretary a 3–year tribal family assistance plan that—

(A) outlines the Indian tribe's approach to providing welfare–related services for the 3–year period, consistent with this section;

(B) specifies whether the welfare–related services provided under the plan will be provided by the Indian tribe or through agreements, contracts, or compacts with intertribal consortia, States, or other entities;

(C) identifies the population and service area or areas to be served by such plan;

(D) provides that a family receiving assistance under the plan may not receive duplicative assistance from other State or tribal programs funded under this part;

(E) identifies the employment opportunities in or near the service area or areas of the Indian tribe and the manner in which the Indian tribe will cooperate and participate in enhancing such opportunities for recipients of assistance under the plan consistent with any applicable State standards; and

(F) applies the fiscal accountability provisions of section 5(f)(1) of the Indian Self–Determination and Education Assistance Act[43] (25 U.S.C. 450c(f)(1)), relating to the submission of a single–agency audit report required by chapter 75 of title 31, United States Code[44].

(2) APPROVAL.—The Secretary shall approve each tribal family assistance plan submitted in accordance with paragraph (1).

(3) CONSORTIUM OF TRIBES.—Nothing in this section shall preclude the development and submission of a single tribal family assistance plan by the participating Indian tribes of an intertribal consortium.

(c) MINIMUM WORK PARTICIPATION REQUIREMENTS AND TIME LIMITS.—The Secretary, with the participation of Indian tribes, shall establish for each Indian tribe receiving a grant under this section minimum work participation requirements, appropriate time limits for receipt of welfare–related services under the grant, and penalties against individuals—

(1) consistent with the purposes of this section;

(2) consistent with the economic conditions and resources available to each tribe; and

(3) similar to comparable provisions in section 407(e).

(d) EMERGENCY ASSISTANCE.—Nothing in this section shall preclude an Indian tribe from seeking emergency assistance from any Federal loan program or emergency fund.

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[43] See Vol. II, P.L. 93-638.

[44] See Vol. II, 31 U.S.C. chapter 75.

(e) ACCOUNTABILITY.—Nothing in this section shall be construed to limit the ability of the Secretary to maintain program funding accountability consistent with—

(1) generally accepted accounting principles; and

(2) the requirements of the Indian Self–Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

(f) ELIGIBILITY FOR FEDERAL LOANS.—Section 406 shall apply to an Indian tribe with an approved tribal assistance plan in the same manner as such section applies to a State, except that section 406(c) shall be applied by substituting "section 412(a)" for "section 403(a)".

(g) PENALTIES.—

(1) Subsections (a)(1), (a)(6), (b), and (c) of section 409, shall apply to an Indian tribe with an approved tribal assistance plan in the same manner as such subsections apply to a State.

(2) Section 409(a)(3) shall apply to an Indian tribe with an approved tribal assistance plan by substituting "meet minimum work participation requirements established under section 412(c)" for "comply with section 407(a)".

(h) DATA COLLECTION AND REPORTING.—Section 411 shall apply to an Indian tribe with an approved tribal family assistance plan.

(i) SPECIAL RULE FOR INDIAN TRIBES IN ALASKA.—

(1) IN GENERAL.—Notwithstanding any other provision of this section, and except as provided in paragraph (2), an Indian tribe in the State of Alaska that receives a tribal family assistance grant under this section shall use the grant to operate a program in accordance with requirements comparable to the requirements applicable to the program of the State of Alaska funded under this part. Comparability of programs shall be established on the basis of program criteria developed by the Secretary in consultation with the State of Alaska and such Indian tribes.

(2) WAIVER.—An Indian tribe described in paragraph (1) may apply to the appropriate State authority to receive a waiver of the requirement of paragraph (1).

RESEARCH, EVALUATIONS, AND NATIONAL STUDIES

SEC. 413. [42 U.S.C. 613] (a) RESEARCH.—The Secretary, directly or through grants, contracts, or interagency agreements, shall conduct research on the benefits, effects, and costs of operating different State programs funded under this part, including time limits relating to eligibility for assistance. The research shall include studies on the effects of different programs and the operation of such programs on welfare dependency, illegitimacy, teen pregnancy, employment rates, child well–being, and any other area the Secretary deems appropriate. The Secretary shall also conduct research on the costs and benefits of State activities under section 407.

(b) DEVELOPMENT AND EVALUATION OF INNOVATIVE APPROACHES TO REDUCING WELFARE DEPENDENCY AND INCREASING CHILD WELL–BEING.—

(1) IN GENERAL.—The Secretary may assist States in developing, and shall evaluate, innovative approaches for reducing welfare dependency and increasing the well–being of minor children living at home with respect to recipients of assistance

under programs funded under this part. The Secretary may provide funds for training and technical assistance to carry out the approaches developed pursuant to this paragraph.

(2) EVALUATIONS.—In performing the evaluations under paragraph (1), the Secretary shall, to the maximum extent feasible, use random assignment as an evaluation methodology.

(c) DISSEMINATION OF INFORMATION.—The Secretary shall develop innovative methods of disseminating information on any research, evaluations, and studies conducted under this section, including the facilitation of the sharing of information and best practices among States and localities through the use of computers and other technologies.

(d) ANNUAL RANKING OF STATES AND REVIEW OF MOST AND LEAST SUCCESSFUL WORK PROGRAMS.—

(1) ANNUAL RANKING OF STATES.—The Secretary shall rank annually the States to which grants are paid under section 403 in the order of their success in placing recipients of assistance under the State program funded under this part into long–term private sector jobs, reducing the overall welfare caseload, and, when a practicable method for calculating this information becomes available, diverting individuals from formally applying to the State program and receiving assistance. In ranking States under this subsection, the Secretary shall take into account the average number of minor children living at home in families in the State that have incomes below the poverty line and the amount of funding provided each State for such families.

(2) ANNUAL REVIEW OF MOST AND LEAST SUCCESSFUL WORK PROGRAMS.—The Secretary shall review the programs of the 3 States most recently ranked highest under paragraph (1) and the 3 States most recently ranked lowest under paragraph (1) that provide parents with work experience, assistance in finding employment, and other work preparation activities and support services to enable the families of such parents to leave the program and become self–sufficient.

(e) ANNUAL RANKING OF STATES AND REVIEW OF ISSUES RELATING TO OUT–OF–WEDLOCK BIRTHS.—

(1) IN GENERAL.—The Secretary shall annually rank States to which grants are made under section 403 based on the following ranking factors:

(A) ABSOLUTE OUT–OF–WEDLOCK RATIOS.—The ratio represented by—

(i) the total number of out–of–wedlock births in families receiving assistance under the State program under this part in the State for the most recent year for which information is available; over

(ii) the total number of births in families receiving assistance under the State program under this part in the State for the year.

(B) NET CHANGES IN THE OUT–OF–WEDLOCK RATIO.—The difference between the ratio described in subparagraph (A) with respect to a State for the most recent year for which such information is available and the ratio with respect to the State for the immediately preceding year.

(2) ANNUAL REVIEW.—The Secretary shall review the programs of the 5 States most recently ranked highest under

paragraph (1) and the 5 States most recently ranked the lowest under paragraph (1).

(f) STATE–INITIATED EVALUATIONS.—A State shall be eligible to receive funding to evaluate the State program funded under this part if—

(1) the State submits a proposal to the Secretary for the evaluation;

(2) the Secretary determines that the design and approach of the evaluation is rigorous and is likely to yield information that is credible and will be useful to other States; and

(3) unless otherwise waived by the Secretary, the State contributes to the cost of the evaluation, from non–Federal sources, an amount equal to at least 10 percent of the cost of the evaluation.

(g) REPORT ON CIRCUMSTANCES OF CERTAIN CHILDREN AND FAMILIES.—

(1) IN GENERAL.—Beginning 3 years after the date of the enactment of this section[45], the Secretary of Health and Human Services shall prepare and submit to the Committees on Ways and Means and on Education and the Workforce of the House of Representatives and to the Committees on Finance and on Labor and Resources of the Senate annual reports that examine in detail the matters described in paragraph (2) with respect to each of the following groups for the period after such enactment:

(A) Individuals who were children in families that have become ineligible for assistance under a State program funded under this part by reason of having reached a time limit on the provision of such assistance.

(B) Children born after such date of enactment to parents who, at the time of such birth, had not attained 20 years of age.

(C) Individuals who, after such date of enactment, became parents before attaining 20 years of age.

(2) MATTERS DESCRIBED.—The matters described in this paragraph are the following:

(A) The percentage of each group that has dropped out of secondary school (or the equivalent), and the percentage of each group at each level of educational attainment.

(B) The percentage of each group that is employed.

(C) The percentage of each group that has been convicted of a crime or has been adjudicated as a delinquent.

(D) The rate at which the members of each group are born, or have children, out–of–wedlock, and the percentage of each group that is married.

(E) The percentage of each group that continues to participate in State programs funded under this part.

(F) The percentage of each group that has health insurance provided by a private entity (broken down by whether the insurance is provided through an employer or otherwise), the percentage that has health insurance provided by an agency of government, and the percentage that does not have health insurance.

[45] The date of enactment of this section was August 22, 1996.

(G) The average income of the families of the members of each group.

(H) Such other matters as the Secretary deems appropriate.

(h) FUNDING OF STUDIES AND DEMONSTRATIONS.—

(1) IN GENERAL.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated $15,000,000 for each of fiscal years 1997 through 2002 for the purpose for paying–

(A) the cost of conducting the research described in subsection (a);

(B) the cost of developing and evaluating innovative approaches for reducing welfare dependency and increasing the well–being of minor children under subsection (b);

(C) the Federal share of any State–initiated study approved under subsection (f); and

(D) an amount determined by the Secretary to be necessary to operate and evaluate demonstration projects, relating to this part, that are in effect or approved under section 1115 as of August 22, 1996, and are continued after such date.

(2) ALLOCATION.—Of the amount appropriated under paragraph (1) for a fiscal year—

(A) 50 percent shall be allocated for the purposes described in subparagraphs (A) and (B) of paragraph (1), and

(B) 50 percent shall be allocated for the purposes described in subparagraphs (C) and (D) of paragraph (1).

(3) DEMONSTRATIONS OF INNOVATIVE STRATEGIES.—The Secretary may implement and evaluate demonstrations of innovative and promising strategies which—

(A) provide one–time capital funds to establish, expand, or replicate programs;

(B) test performance–based grant–to–loan financing in which programs meeting performance targets receive grants while programs not meeting such targets repay funding on a prorated basis; and

(C) test strategies in multiple States and types of communities.

(i) CHILD POVERTY RATES.—

(1) IN GENERAL.—Not later than May 31, 1998, and annually thereafter, the chief executive officer of each State shall submit to the Secretary a statement of the child poverty rate in the State as of such date of enactment or the date of the most recent prior statement under this paragraph.

(2) SUBMISSION OF CORRECTIVE ACTION PLAN.—Not later than 90 days after the date a State submits a statement under paragraph (1) which indicates that, as a result of the amendments made by section 103 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996[46], the child poverty rate of the State has increased by 5 percent or more since the most recent prior statement under paragraph (1), the State shall prepare and submit to the Secretary a corrective action plan in accordance with paragraph (3).

[46] P.L. 104-193.

(3) CONTENTS OF PLAN.—A corrective action plan submitted under paragraph (2) shall outline the manner in which the State will reduce the child poverty rate in the State. The plan shall include a description of the actions to be taken by the State under such plan.

(4) COMPLIANCE WITH PLAN.—A State that submits a corrective action plan that the Secretary has found contains the information required by this subsection shall implement the corrective action plan until the State determines that the child poverty rate in the State is less than the lowest child poverty rate on the basis of which the State was required to submit the corrective action plan.

(5) METHODOLOGY.—The Secretary shall prescribe regulations establishing the methodology by which a State shall determine the child poverty rate in the State. The methodology shall take into account factors including the number of children who receive free or reduced–price lunches, the number of food stamp households, and, to the extent available, county–by–county estimates of children in poverty as determined by the Census Bureau.

(j) EVALUATION OF WELFARE–TO–WORK PROGRAMS.—

(1) EVALUATION.—The Secretary, in consultation with the Secretary of Labor and the Secretary of Housing and Urban Development—

(A) shall develop a plan to evaluate how grants made under sections 403(a)(5) and 412(a)(3) have been used;

(B) may evaluate the use of such grants by such grantees as the Secretary deems appropriate, in accordance with an agreement entered into with the grantees after good–faith negotiations; and

(C) is urged to include the following outcome measures in the plan developed under subparagraph (A):

(i) Placements in unsubsidized employment, and placements in unsubsidized employment that last for at least 6 months.

(ii) Placements in the private and public sectors.

(iii) Earnings of individuals who obtain employment.

(iv) Average expenditures per placement.

(2) REPORTS TO THE CONGRESS.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the Secretary, in consultation with the Secretary of Labor and the Secretary of Housing and Urban Development, shall submit to the Congress reports on the projects funded under section 403(a)(5) and 412(a)(3) and on the evaluations of the projects.

(B) INTERIM REPORT.—Not later than January 1, 1999, the Secretary shall submit an interim report on the matter described in subparagraph (A).

(C) FINAL REPORT.—Not later than January 1, 2001, (or at a later date, if the Secretary informs the Committees of the Congress with jurisdiction over the subject matter of the report) the Secretary shall submit a final report on the matter described in subparagraph (A).

STUDY BY THE CENSUS BUREAU

SEC. 414. [42 U.S.C. 614] (a) IN GENERAL.—The Bureau of the Census shall continue to collect data on the 1992 and 1993 panels of the Survey of Income and Program Participation as necessary to obtain such information as will enable interested persons to evaluate the impact of the amendments made by title I of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996[47] on a random national sample of recipients of assistance under State programs funded under this part and (as appropriate) other low–income families, and in doing so, shall pay particular attention to the issues of out–of–wedlock birth, welfare dependency, the beginning and end of welfare spells, and the causes of repeat welfare spells, and shall obtain information about the status of children participating in such panels.

(b) APPROPRIATION.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated $10,000,000 for each of fiscal years 1996, 1997, 1998, 1999, 2000, 2001, 2002, and 2003[48] for payment to the Bureau of the Census to carry out subsection (a).

WAIVERS

SEC. 415. [42 U.S.C. 615] (a) CONTINUATION OF WAIVERS.—

(1) WAIVERS IN EFFECT ON DATE OF ENACTMENT OF WELFARE REFORM.—

(A) IN GENERAL.—Except as provided in subparagraph (B), if any waiver granted to a State under section 1115 of this Act or otherwise which relates to the provision of assistance under a State plan under this part (as in effect on September 30, 1996) is in effect as of the date of the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, the amendments made by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (other than by section 103(c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996) shall not apply with respect to the State before the expiration (determined without regard to any extensions) of the waiver to the extent such amendments are inconsistent with the waiver.

(B) FINANCING LIMITATION.—Notwithstanding any other provision of law, beginning with fiscal year 1996, a State operating under a waiver described in subparagraph (A) shall be entitled to payment under section 403 for the fiscal year, in lieu of any other payment provided for in the waiver.

(2) WAIVERS GRANTED SUBSEQUENTLY.—

(A) IN GENERAL.—Except as provided in subparagraph (B), if any waiver granted to a State under section 1115 of this Act or otherwise which relates to the provision of assistance under a State plan under this part (as in effect on September 30, 1996) is submitted to the Secretary before the date of the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and ap-

[47] P.L. 104-193.

[48] P.L. 108-40, §3(i), struck out "and 2002" and substituted "2002, and 2003", effective July 1, 2003.

proved by the Secretary on or before July 1, 1997, and the State demonstrates to the satisfaction of the Secretary that the waiver will not result in Federal expenditures under title IV of this Act (as in effect without regard to the amendments made by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996) that are greater than would occur in the absence of the waiver, the amendments made by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (other than by section 103(c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996) shall not apply with respect to the State before the expiration (determined without regard to any extensions) of the waiver to the extent the amendments made by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 are inconsistent with the waiver.

(B) NO EFFECT ON NEW WORK REQUIREMENTS.—Notwithstanding subparagraph (A), a waiver granted under section 1115 or otherwise which relates to the provision of assistance under a State program funded under this part (as in effect on September 30, 1996) shall not affect the applicability of section 407 to the State.

(b) STATE OPTION TO TERMINATE WAIVER.—

(1) IN GENERAL.—A State may terminate a waiver described in subsection (a) before the expiration of the waiver.

(2) REPORT.—A State which terminates a waiver under paragraph (1) shall submit a report to the Secretary summarizing the waiver and any available information concerning the result or effect of the waiver.

(3) HOLD HARMLESS PROVISION.—

(A) IN GENERAL.—Notwithstanding any other provision of law, a State that, not later than the date described in subparagraph (B) of this paragraph, submits a written request to terminate a waiver described in subsection (a) shall be held harmless for accrued cost neutrality liabilities incurred under the waiver.

(B) DATE DESCRIBED.—The date described in this subparagraph is 90 days following the adjournment of the first regular session of the State legislature that begins after the date of the enactment[49] of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

(c) SECRETARIAL ENCOURAGEMENT OF CURRENT WAIVERS.—The Secretary shall encourage any State operating a waiver described in subsection (a) to continue the waiver and to evaluate, using random sampling and other characteristics of accepted scientific evaluations, the result or effect of the waiver.

(d) CONTINUATION OF INDIVIDUAL WAIVERS.—A State may elect to continue 1 or more individual waivers described in subsection (a).

ADMINISTRATION

SEC. 416. [42 U.S.C. 616] The programs under this part and part D shall be administered by an Assistant Secretary for Family

[49] August 22, 1996.

Support within the Department of Health and Human Services, who shall be appointed by the President, by and with the advice and consent of the Senate, and who shall be in addition to any other Assistant Secretary of Health and Human Services provided for by law, and the Secretary shall reduce the Federal workforce within the Department of Health and Human services by an amount equal to the sum of 75 percent of the full–time equivalent positions at such Department that relate to any direct spending program, or any program funded through discretionary spending, that has been converted into a block grant program under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and the amendments made by such Act, and by an amount equal to 75 percent of that portion of the total full–time equivalent departmental management positions at such Department that bears the same relationship to the amount appropriated for any direct spending program, or any program funded through discretionary spending, that has been converted into a block grant program under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and the amendments made by such Act, as such amount relates to the total amount appropriated for use by such Department, and notwithstanding any other provision of law, the Secretary shall take such actions as may be necessary, including reductions in force actions, consistent with sections 3502 and 3595 of title 5, United States Code[50], to reduce the full–time equivalent positions within the Department of Health and Human Services by 245 full–time equivalent positions related to the program converted into a block grant under the amendments made by section 103 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, and by 60 full–time equivalent managerial positions in the Department.

LIMITATION ON FEDERAL AUTHORITY

SEC. 417. [42 U.S.C. 617] No officer or employee of the Federal Government may regulate the conduct of States under this part or enforce any provision of this part, except to the extent expressly provided in this part.

FUNDING FOR CHILD CARE

SEC. 418. [42 U.S.C. 618] (a) GENERAL CHILD CARE ENTITLEMENT.—

(1) GENERAL ENTITLEMENT.—Subject to the amount appropriated under paragraph (3), each State shall, for the purpose of providing child care assistance, be entitled to payments under a grant under this subsection for a fiscal year in an amount equal to the greater of—

(A) the total amount required to be paid to the State under section 403 for fiscal year 1994 or 1995 (whichever is greater) with respect to expenditures for child care under subsections (g) and (i) of section 402 (as in effect before October 1, 1995); or

(B) the average of the total amounts required to be paid to the State for fiscal years 1992 through 1994 under the subsections referred to in subparagraph (A).

[50] See Vol. II, 5 U.S.C. 3502 and 3595.

(2) REMAINDER.—

(A) GRANTS.—The Secretary shall use any amounts appropriated for a fiscal year under paragraph (3), and remaining after the reservation described in paragraph (4) and after grants are awarded under paragraph (1), to make grants to States under this paragraph.

(B) ALLOTMENTS TO STATES.—The total amount available for payments to States under this paragraph, as determined under subparagraph (A), shall be allotted among the States based on the formula used for determining the amount of Federal payments to each State under section 403(n) (as in effect before October 1, 1995).

(C) FEDERAL MATCHING OF STATE EXPENDITURES EXCEEDING HISTORICAL EXPENDITURES.—The Secretary shall pay to each eligible State for a fiscal year an amount equal to the lesser of the State's allotment under subparagraph (B) or the Federal medical assistance percentage for the State for the fiscal year (as defined in section 1905(b), as such section was in effect on September 30, 1995) of so much of the State's expenditures for child care in that fiscal year as exceed the total amount of expenditures by the State (including expenditures from amounts made available from Federal funds) in fiscal year 1994 or 1995 (whichever is greater) for the programs described in paragraph (1)(A).

(D) REDISTRIBUTION.—

(i) IN GENERAL.—With respect to any fiscal year, if the Secretary determines (in accordance with clause (ii)) any amounts allotted to a State under this paragraph for such fiscal year will not be used by such State during such fiscal year for carrying out the purpose for which such amounts are allotted, the Secretary shall make such amounts available in the subsequent fiscal year for carrying out such purpose to one or more States which apply for such funds to the extent the Secretary determines that such States will be able to use such additional amounts for carrying out such purpose. Such available amounts shall be redistributed to a State pursuant to section 403(n) (as such section was in effect before October 1 1995) by substituting "the number of children residing in all States applying for such funds" for "the number of children residing in the United States in the second preceding fiscal year".

(ii) TIME OF DETERMINATION AND DISTRIBUTION.—The determination of the Secretary under clause (i) for a fiscal year shall be made not later than the end of the first quarter of the subsequent fiscal year. The redistribution of amounts under clause (i) shall be made as close as practicable to the date on which such determination is made. Any amount made available to a State from an appropriation for a fiscal year in accordance with this subparagraph shall, for purposes of this part, be regarded as part of such State's payment (as determined under this subsection) for the fiscal year in which the redistribution is made.

(3) APPROPRIATION.—For grants under this section, there are appropriated—

(A) $1,967,000,000 for fiscal year 1997;
(B) $2,067,000,000 for fiscal year 1998;
(C) $2,167,000,000 for fiscal year 1999;
(D) $2,367,000,000 for fiscal year 2000;
(E) $2,567,000,000 for fiscal year 2001; and
(F) $2,717,000,000 each of fiscal years 2002 and 2003[51].

(4) INDIAN TRIBES.—The Secretary shall reserve not less than 1 percent, and not more than 2 percent, of the aggregate amount appropriated to carry out this section in each fiscal year for payments to Indian tribes and tribal organizations.

(5) DATA USED TO DETERMINE STATE AND FEDERAL SHARES OF EXPENDITURES.—In making the determinations concerning expenditures required under paragraphs (1) and (2)(C), the Secretary shall use information that was reported by the State on ACF Form 231 and available as of the applicable dates specified in clauses (i)(I), (ii), and (iii)(III) of section 403(a)(1)(D).

(b) USE OF FUNDS.—

(1) IN GENERAL.—Amounts received by a State under this section shall only be used to provide child care assistance. Amounts received by a State under a grant under subsection (a)(1) shall be available for use by the State without fiscal year limitation.

(2) USE FOR CERTAIN POPULATIONS.—A State shall ensure that not less than 70 percent of the total amount of funds received by the State in a fiscal year under this section are used to provide child care assistance to families who are receiving assistance under a State program under this part, families who are attempting through work activities to transition off of such assistance program, and families who are at risk of becoming dependent on such assistance program.

(c) APPLICATION OF CHILD CARE AND DEVELOPMENT BLOCK GRANT ACT OF 1990.—Notwithstanding any other provision of law, amounts provided to a State under this section shall be transferred to the lead agency under the Child Care and Development Block Grant Act of 1990, integrated by the State into the programs established by the State under such Act, and be subject to requirements and limitations of such Act.

(d) DEFINITION.—As used in this section, the term "State" means each of the 50 States and the District of Columbia.

DEFINITIONS

SEC. 419. [42 U.S.C. 619] As used in this part:

(1) ADULT.—The term "adult" means an individual who is not a minor child.

(2) MINOR CHILD.—The term "minor child" means an individual who—

(A) has not attained 18 years of age; or

(B) has not attained 19 years of age and is a full–time student in a secondary school (or in the equivalent level of vocational or technical training).

[51] P.L. 108-40, §4, struck out "fiscal year 2002" and substituted "each of fiscal years 2002 and 2003", effective July 1, 2003.

(3) FISCAL YEAR.—The term "fiscal year" means any 12–month period ending on September 30 of a calendar year.

(4) INDIAN, INDIAN TRIBE, AND TRIBAL ORGANIZATION.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the terms "Indian", "Indian tribe", and "tribal organization" have the meaning given such terms by section 4 of the Indian Self–Determination and Education Assistance Act (25 U.S.C. 450b)[52].

(B) SPECIAL RULE FOR INDIAN TRIBES IN ALASKA.—The term "Indian tribe" means, with respect to the State of Alaska, only the Metlakatla Indian Community of the Annette Islands Reserve and the following Alaska Native regional nonprofit corporations:

(i) Arctic Slope Native Association.
(ii) Kawerak, Inc.
(iii) Maniilaq Association.
(iv) Association of Village Council Presidents.
(v) Tanana Chiefs Conference.
(vi) Cook Inlet Tribal Council.
(vii) Bristol Bay Native Association.
(viii) Aleutian and Pribilof Island Association.
(ix) Chugachmuit.
(x) Tlingit Haida Central Council.
(xi) Kodiak Area Native Association.
(xii) Cooper River Native Association.

(5) STATE.—Except as otherwise specifically provided, the term "State" means the 50 States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, and American Samoa.

PART B—CHILD AND FAMILY SERVICES[53]

Subpart 1—Child Welfare Services[54]

APPROPRIATION

SEC. 420. [42 U.S.C. 620] (a) For the purpose of enabling the United States, through the Secretary, to cooperate with State public welfare agencies in establishing, extending, and strengthening child welfare services, there is authorized to be appropriated for each fiscal year the sum of $325,000,000.

(b) Funds appropriated for any fiscal year pursuant to the authorization contained in subsection (a) shall be included in the appropriation Act (or supplemental appropriation Act) for the fiscal year preceding the fiscal year for which such funds are available

[52] See Vol. II, P.L. 94–437, §4.

[53] See Vol. II, P.L. 105-89, §203(b), with respect to the development of a performance - based incentive system and §501(b), with respect to the delay permitted if State legislation is required in order for a State plan to meet the additional requirements imposed by the amendments to part B made by P.L. 105-89

[54] See Vol. II, P.L. 93–288, §312(d), with respect to exclusion from income and resources of certain Federal major disaster and emergency assistance; P.L. 95–608, §201(b), with respect to Indian child welfare; P.L. 100–139, §4(h)(6), with respect to exclusion of benefits as basis for denial of eligibility; P.L. 100–407, §105(c), with respect to the effect of financial assistance under that Act; P.L. 100–409, §5, with respect to the effect of this Act on P.L. 92–203 or P.L. 96–487; P.L. 100–411, §2(d)(3)(B), with respect to the effect of per capita payments; and P.L. 100–581, §§501, 502(b)(1), and 503, with respect to exclusion from income and resources of certain judgment funds.

for obligation. In order to effect a transition to this method of timing appropriation action, the preceding sentence shall apply notwithstanding the fact that its initial application will result in the enactment in the same year (whether in the same appropriation Act or otherwise) of two separate appropriations, one for the then current fiscal year and one for the succeeding fiscal year.

ALLOTMENTS TO STATES

SEC. 421. [42 U.S.C. 621] (a) The sum appropriated pursuant to section 420 for each fiscal year shall be allotted by the Secretary for use by cooperating State public welfare agencies which have plans developed jointly by the State agency and the Secretary as follows: He shall first allot $70,000 to each State, and shall then allot to each State an amount which bears the same ratio to the remainder of such sum as the product of (1) the population of the State under the age of twenty-one and (2) the allotment percentage of the State (as determined under this section) bears to the sum of the corresponding products of all the States.

(b) The "allotment percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be the percentage which bears the same ratio to 50 per centum as the per capita income of such State bears to the per capita income of the United States; except that (1) the allotment percentage shall in no case be less than 30 per centum or more than 70 per centum, and (2) the allotment percentage shall be 70 per centum in the case of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

(c) The allotment percentage for each State shall be promulgated by the Secretary between October 1 and November 30 of each even-numbered year, on the basis of the average per capita income of each State and of the United States for the three most recent calendar years for which satisfactory data are available from the Department of Commerce. Such promulgation shall be conclusive for each of the two fiscal years in the period beginning October 1 next succeeding such promulgation.

(d) For purposes of this section, the term "United States" means the fifty States and the District of Columbia.

STATE PLANS FOR CHILD WELFARE SERVICES

SEC. 422. [42 U.S.C. 622] (a) In order to be eligible for payment under this subpart, a State must have a plan for child welfare services which has been developed jointly by the Secretary and the State agency designated pursuant to subsection (b)(1), and which meets the requirements of subsection (b).

(b) Each plan for child welfare services under this subpart shall—

(1)[55] provide that (A) the individual or agency that administers or supervises the administration of the State's services

[55] P.L. 96–272, §103(a), amended §422 in its entirety effective June 17, 1980, except that in the case of Guam, Puerto Rico, the Virgin Islands, and the Commonwealth of the Northern Mariana Islands, §422(b)(1) shall be deemed to read as follows:

"(1) provide that (A) the State agency designated pursuant to section 402(a)(3) to administer or supervise the administration of the plan of the State approved under part A of this title will administer or supervise the administration of such plan for child welfare services, and (B) to the extent that child welfare services are furnished by the staff of the State agency or local agency administering such plan for child welfare

Continued

program under title XX will administer or supervise the administration of the plan (except as otherwise provided in section 103(d) of the Adoption Assistance and Child Welfare Act of 1980[56]), and (B) to the extent that child welfare services are furnished by the staff of the State agency or local agency administering the plan, a single organizational unit in such State or local agency, as the case may be, will be responsible for furnishing such child welfare services;

(2) provide for coordination between the services provided for children under the plan and the services and assistance provided under title XX, under the State program funded under part A , under the State plan approved under subpart 2 of this part, under the State plan approved under the State plan approved[57] under part E, and under other State programs having a relationship to the program under this subpart, with a view to provision of welfare and related services which will best promote the welfare of such children and their families;

(3) provide that the standards and requirements imposed with respect to child day care under title XX shall apply with respect to day care services under this subpart, except insofar as eligibility for such services is involved;

(4) provide for the training and effective use of paid paraprofessional staff, with particular emphasis on the full-time or part-time employment of 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 providing services and in assisting any advisory committees established by the State agency;

(5) contain a description of the services to be provided and specify the geographic areas where such services will be available;

(6) contain a description of the steps which the State will take to provide child welfare services and to make progress in—

(A) covering additional political subdivisions,

(B) reaching additional children in need of services, and

(C) expanding and strengthening the range of existing services and developing new types of services,

along with a description of the State's child welfare services staff development and training plans;

(7) provide, in the development of services for children, for utilization of the facilities and experience of voluntary agencies in accordance with State and local programs and arrangements, as authorized by the State;

(8) provide that the agency administering or supervising the administration of the plan will furnish such reports, containing such information, and participate in such evaluations, as the Secretary may require;

(9) provide for the diligent recruitment of potential foster and adoptive families that reflect the ethnic and racial diversity of children in the State for whom foster and adoptive homes are needed;

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services, the organizational unit in such State or local agency established pursuant to section 402(a)(15) will be responsible for furnishing such child welfare services;".

[56] See Vol. II, P.L. 96–272.

[57] As in original. Second "under the State plan approved" should be stricken.

(10) provide assurances that the State—

(A) since June 17, 1980, has completed an inventory of all children who, before the inventory, had been in foster care under the responsibility of the State for 6 months or more, which determined—

(i) the appropriateness of, and necessity for, the foster care placement;

(ii) whether the child could or should be returned to the parents of the child or should be freed for adoption or other permanent placement; and

(iii) the services necessary to facilitate the return of the child or the placement of the child for adoption or legal guardianship;

(B) is operating, to the satisfaction of the Secretary—

(i) a statewide information system from which can be readily determined the status, demographic characteristics, location, and goals for the placement of every child who is (or, within the immediately preceding 12 months, has been) in foster care;

(ii) a case review system (as defined in section 475(5)) for each child receiving foster care under the supervision of the State;

(iii) a service program designed to help children—

(I) where safe and appropriate, return to families from which they have been removed; or

(II) be placed for adoption, with a legal guardian, or, if adoption or legal guardianship is determined not to be appropriate for a child, in some other planned, permanent living arrangement; and

(iv) a preplacement preventive services program designed to help children at risk of foster care placement remain safely with their families; and

(C)(i) has reviewed (or within 12 months after the date of the enactment of this paragraph will review) State policies and administrative and judicial procedures in effect for children abandoned at or shortly after birth (including policies and procedures providing for legal representation of such children); and

(ii) is implementing (or within 24 months after the date of the enactment of this paragraph will implement) such policies and procedures as the State determines, on the basis of the review described in clause (i), to be necessary to enable permanent decisions to be made expeditiously with respect to the placement of such children;

(11) contain a description, developed after consultation with tribal organizations (as defined in section 4 of the Indian Self-Determination and Education Assistance Act[58]) in the State, of the specific measures taken by the State to comply with the Indian Child Welfare Act;

(12) contain assurances that the State shall develop plans for the effective use of cross–jurisdictional resources to facilitate timely adoptive or permanent placements for waiting children;

[58] See Vol. II, P.L. 94-437, §4.

(13) contain a description of the activities that the State has undertaken for children adopted from other countries, including the provision of adoption and post–adoption services; and

(14) provide that the State shall collect and report information on children who are adopted from other countries and who enter into State custody as a result of the disruption of a placement for adoption or the dissolution of an adoption, including the number of children, the agencies who handled the placement or adoption, the plans for the child, and the reasons for the disruption or dissolution.

PAYMENT TO STATES

SEC. 423. [42 U.S.C. 623] (a) From the sums appropriated therefor and the allotment under this subpart, subject to the conditions set forth in this section, the Secretary shall from time to time pay to each State that has a plan developed in accordance with section 422 an amount equal to 75 per centum of the total sum expended under the plan (including the cost of administration of the plan) in meeting the costs of State, district, county, or other local child welfare services.

(b) The method of computing and making payments under this section shall be as follows:

(1) The Secretary shall, prior to the beginning of each period for which a payment is to be made, estimate the amount to be paid to the State for such period under the provisions of this section.

(2) From the allotment available therefor, the Secretary shall pay the amount so estimated, reduced or increased, as the case may be, by any sum (not previously adjusted under this section) by which he finds that his estimate of the amount to be paid the State for any prior period under this section was greater or less than the amount which should have been paid to the State for such prior period under this section.

(c)(1) No payment may be made to a State under this part, for any fiscal year beginning after September 30, 1979, with respect to State expenditures made for (A) child day care necessary solely because of the employment, or training to prepare for employment, of a parent or other relative with whom the child involved is living, (B) foster care maintenance payments, and (C) adoption assistance payments, to the extent that the Federal payment with respect to those expenditures would exceed the total amount of the Federal payment under this part for fiscal year 1979.

(2) Expenditures made by a State for any fiscal year which begins after September 30, 1979, for foster care maintenance payments shall be treated for purposes of making Federal payments under this part with respect to expenditures for child welfare services, as if such foster care maintenance payments constituted child welfare services of a type to which the limitation imposed by paragraph (1) does not apply; except that the amount payable to the State with respect to expenditures made for other child welfare services and for foster care maintenance payments during any such year shall not exceed 100 per centum of the amount of the expenditures made for child welfare services for which payment may be made under the limitation imposed by paragraph (1) as in effect without regard to this paragraph.

(d) No payment may be made to a State under this part in excess of the payment made under this part for fiscal year 1979, for any fiscal year beginning after September 30, 1979, if for the latter fiscal year the total of the State's expenditures for child welfare services under this part (excluding expenditures for activities specified in subsection (c)(1)) is less than the total of the State's expenditures under this part (excluding expenditures for such activities) for fiscal year 1979.

REALLOTMENT

SEC. 424. [42 U.S.C. 624] (a) IN GENERAL.—Subject to subsection (b), the amount of any allotment to a State under section 421 for any fiscal year which the State certifies to the Secretary will not be required for carrying out the State plan developed as provided in section 422 shall be available for reallotment from time to time, on such dates as the Secretary may fix, to other States which the Secretary determines (1) have need in carrying out their State plans so developed for sums in excess of those previously allotted to them under section 421 and (2) will be able to use such excess amounts during such fiscal year. Such reallotments shall be made on the basis of the State plans so developed, after taking into consideration the population under the age of twenty-one, and the per capita income of each such State as compared with the population under the age of twenty-one, and the per capita income of all such States with respect to which such a determination by the Secretary has been made. Any amount so reallotted to a State shall be deemed part of its allotment under section 421.

(b) EXCEPTION RELATING TO FOSTER CHILD PROTECTIONS.—The Secretary shall not reallot under subsection (a) of this section any amount that is withheld or recovered from a State due to the failure of the State to meet the requirements of section 422(b)(10).

DEFINITIONS

SEC. 425. [42 U.S.C. 625] (a)(1) For purposes of this title, the term "child welfare services" means public social services which are directed toward the accomplishment of the following purposes:(A) protecting and promoting the welfare of all children, including handicapped, homeless, dependent, or neglected children; (B) preventing or remedying, or assisting in the solution of problems which may result in, the neglect, abuse, exploitation, or delinquency of children; (C) preventing the unnecessary separation of children from their families by identifying family problems, assisting families in resolving their problems, and preventing breakup of the family where the prevention of child removal is desirable and possible; (D) restoring to their families children who have been removed, by the provision of services to the child and the families; (E) placing children in suitable adoptive homes, in cases where restoration to the biological family is not possible or appropriate; and (F) assuring adequate care of children away from their homes, in cases where the child cannot be returned home or cannot be placed for adoption.

(2) Funds expended by a State for any calendar quarter to comply with section 422(b)(10) or 476(b), and funds expended with respect to nonrecurring costs of adoption proceedings in the case of children placed for adoption with respect to whom assistance is

provided under a State plan for adoption assistance approved under part E of this title, shall be deemed to have been expended for child welfare services.

(b) For other definitions relating to this part and to part E of this title, see section 475 of this Act.

RESEARCH, TRAINING, OR DEMONSTRATION PROJECTS

SEC. 426. [42 U.S.C. 626] (a) There are hereby authorized to be appropriated for each fiscal year such sums as the Congress may determine—

(1) for grants by the Secretary—

(A) to public or other nonprofit institutions of higher learning, and to public or other nonprofit agencies and organizations engaged in research or child-welfare activities, for special research or demonstration projects in the field of child welfare which are of regional or national significance and for special projects for the demonstration of new methods or facilities which show promise of substantial contribution to the advancement of child welfare;

(B) to State or local public agencies responsible for admin- istering, or supervising the administration of, the plan under this part, for projects for the demonstration of the utilization of research (including findings resulting there- from) in the field of child welfare in order to encourage experimental and special types of welfare services; and

(C) to public or other nonprofit institutions of higher learning for special projects for training personnel for work in the field of child welfare, including traineeships described in section 429 with such stipends and allowances as may be permitted by the Secretary; and

(2) for contracts or jointly financed cooperative arrangements with States and public and other organizations and agencies for the conduct of research, special projects, or demonstration projects relating to such matters.

(b)(1) There are authorized to be appropriated $4,000,000 for each of the fiscal years 1988, 1989, and 1990 for grants by the Secretary to public or private nonprofit entities submitting applications under this subsection for the purpose of conducting demonstration projects under this subsection to develop alternative care arrangements for infants who do not have health conditions that require hospitalization and who would otherwise remain in inappropriate hospital settings.

(2) The demonstration projects conducted under this section may include—

(A) multidisciplinary projects designed to prevent the inappropriate hospitalization of infants and to allow infants described in paragraph (1) to remain with or return to a parent in a residential setting, where appropriate care for the infant and suitable treatment for the parent (including treatment for drug or alcohol addiction) may be assured, with the goal (where possible) of rehabilitating the parent and eliminating the need for such care for the infant;

(B) multidisciplinary projects that assure appropriate, individualized care for such infants in a foster home or other nonmedical residential setting in cases where such infant does not

require hospitalization and would otherwise remain in inappropriate hospital settings, including projects to demonstrate methods to recruit, train, and retain foster care families; and

(C) such other projects as the Secretary determines will best serve the interests of such infants and will serve as models for projects that agencies or organizations in other communities may wish to develop.

(3) In the case of any project which includes the use of funds authorized under this subsection for the care of infants in foster homes or other non-medical residential settings away from their parents, there shall be developed for each such infant a case plan of the type described in section 475(1) (to the extent that such infant is not otherwise covered by such a plan), and each such project shall include a case review system of the type described in section 475(5) (covering each such infant who is not otherwise subject to such a system).

(4) In evaluating applications from entities proposing to conduct demonstration projects under this subsection, the Secretary shall give priority to those projects that serve areas most in need of alternative care arrangements for infants described in paragraph (1).

(5) No project may be funded unless the application therefor contains assurances that it will—

(A) provide for adequate evaluation;

(B) provide for coordination with local governments;

(C) provide for community education regarding the inappropriate hospitalization of infants;

(D) use, to the extent practical, other available private, local, State, and Federal sources for the provision of direct services; and

(E) meet such other criteria as the Secretary may prescribe.

(6) Grants may be used to pay the costs of maintenance and of necessary medical and social services (to the extent that these costs are not otherwise paid for under other titles of this Act), and for such other purposes as the Secretary may allow.

(7) The Secretary shall provide training and technical assistance to grantees, as requested.

(c) Payments of grants or under contracts or cooperative arrangements under this section may be made in advance or by way of reimbursement, and in such installments, as the Secretary may determine; and shall be made on such conditions as the Secretary finds necessary to carry out the purposes of the grants, contracts, or other arrangements.

SEC. 427. [Repealed.[59]]

PAYMENTS TO INDIAN TRIBAL ORGANIZATIONS[60]

SEC. 428. [42 U.S.C. 628] (a) The Secretary may, in appropriate cases (as determined by the Secretary) make payments under this subpart directly to an Indian tribal organization within any State

[59] P.L. 103–432, §202(c), repealed §427, effective with respect to fiscal years beginning on or after April 1, 1996.

[60] See Vol. II, P.L. 93–288, §312(d), with respect to exclusion from income and resources of certain Federal major disaster and emergency assistance; P.L. 100–407, §105(g), with respect to the effect of financial assistance under that Act; P.L. 100–409, §5, with respect to the effect of this Act on P.L. 92–203 or P.L. 96–487; P.L. 100–411, §2(d)(3)(B), with respect to the effect of certain per capita payments; and P.L. 100–581, §§501, 502(b)(1), and 503, with respect to exclusion from income and resources of certain judgment funds.

which has a plan for child welfare services approved under this subpart. Such payments shall be made in such manner and in such amounts as the Secretary determines to be appropriate.

(b) Amounts paid under subsection (a) shall be deemed to be a part of the allotment (as determined under section 421) for the State in which such Indian tribal organization is located.

(c) For purposes of this section, the terms "Indian tribe" and "tribal organization" shall have the meanings given such terms by subsections (e) and (l) of section 4 of the Indian Self–Determination and Education Assistance Act (25 U.S.C. 450b), respectively.

CHILD WELFARE TRAINEESHIPS

SEC. 429. [42 U.S.C. 628a] The Secretary may approve an application for a grant to a public or nonprofit institution for higher learning to provide traineeships with stipends under section 426(a)(1)(C) only if the application—

(1) provides assurances that each individual who receives a stipend with such traineeship (in this section referred to as a "recipient") will enter into an agreement with the institution under which the recipient agrees—

(A) to participate in training at a public or private nonprofit child welfare agency on a regular basis (as determined by the Secretary) for the period of the traineeship;

(B) to be employed for a period of years equivalent to the period of the traineeship, in a public or private nonprofit child welfare agency in any State, within a period of time (determined by the Secretary in accordance with regulations) after completing the postsecondary education for which the traineeship was awarded;

(C) to furnish to the institution and the Secretary evidence of compliance with subparagraphs (A) and (B); and

(D) if the recipient fails to comply with subparagraph (A) or (B) and does not qualify for any exception to this subparagraph which the Secretary may prescribe in regulations, to repay to the Secretary all (or an appropriately prorated part) of the amount of the stipend, plus interest, and, if applicable, reasonable collection fees (in accordance with regulations promulgated by the Secretary);

(2) provides assurances that the institution will—

(A) enter into agreements with child welfare agencies for onsite training of recipients;

(B) permit an individual who is employed in the field of child welfare services to apply for a traineeship with a stipend if the traineeship furthers the progress of the individual toward the completion of degree requirements; and

(C) develop and implement a system that, for the 3-year period that begins on the date any recipient completes a child welfare services program of study, tracks the employment record of the recipient, for the purpose of determining the percentage of recipients who secure employment in the field of child welfare services and remain employed in the field.

NATIONAL RANDOM SAMPLE STUDY OF CHILD WELFARE[61]

SEC. 429A. [42 U.S.C. 628b] (a) IN GENERAL.—The Secretary shall conduct (directly, or by grant, contract, or interagency agreement) a national study based on random samples of children who are at risk of child abuse or neglect, or are determined by States to have been abused or neglected.

(b) REQUIREMENTS.—The study required by subsection (a) shall—

(1) have a longitudinal component; and

(2) yield data reliable at the State level for as many States as the Secretary determines is feasible.

(c) PREFERRED CONTENTS.—In conducting the study required by subsection (a), the Secretary should—

(1) carefully consider selecting the sample from cases of confirmed abuse or neglect; and

(2) follow each case for several years while obtaining information on, among other things—

(A) the type of abuse or neglect involved;

(B) the frequency of contact with State or local agencies;

(C) whether the child involved has been separated from the family, and, if so, under what circumstances;

(D) the number, type, and characteristics of out–of–home placements of the child; and

(E) the average duration of each placement.

(d) REPORTS.—

(1) IN GENERAL.—From time to time, the Secretary shall prepare reports summarizing the results of the study required by subsection (a).

(2) AVAILABILITY.—The Secretary shall make available to the public any report prepared under paragraph (1), in writing or in the form of an electronic data tape.

(3) AUTHORITY TO CHARGE FEE.—The Secretary may charge and collect a fee for the furnishing of reports under paragraph (2).

(e) APPROPRIATION.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to the Secretary for each of fiscal years 1996 through 2002 $6,000,000 to carry out this section.

Subpart 2—Promoting Safe and Stable Families

FINDINGS AND PURPOSE

SEC. 430. [42 U.S.C. 629] (a) FINDINGS.—The Congress finds that there is a continuing urgent need to protect children and to strengthen families as demonstrated by the following:

(1) Family support programs directed at specific vulnerable populations have had positive effects on parents, children, or both. The vulnerable populations for which programs have been shown to be effective include teenage mothers with very young children and families that have children with special needs.

[61] See Vol. II, P.L. 108-89, §102, P.L. 108-262, §3, and P.L. 108-308, §3, with respect to the extension of National Random Sample Study of Child Welfare and child welfare waiver authority.

(2) Family preservation programs have been shown to provide extensive and intensive services to families in crisis.

(3) The time lines established by the Adoption and Safe Families Act of 1997 have made the prompt availability of services to address family problems (and in particular the prompt availability of appropriate services and treatment addressing substance abuse) an important factor in successful family reunification.

(4) The rapid increases in the annual number of adoptions since the enactment of the Adoption and Safe Families Act of 1997 have created a growing need for postadoption services and for service providers with the particular knowledge and skills required to address the unique issues adoptive families and children may face.

(b) PURPOSE.—The purpose of this program is to enable States to develop and establish, or expand, and to operate coordinated programs of community–based family support services, family preservation services, time–limited family reunification services, and adoption promotion and support services to accomplish the following objectives:

(1) To prevent child maltreatment among families at risk through the provision of supportive family services.

(2) To assure children's safety within the home and preserve intact families in which children have been maltreated, when the family's problems can be addressed effectively.

(3) To address the problems of families whose children have been placed in foster care so that reunification may occur in a safe and stable manner in accordance with the Adoption and Safe Families Act of 1997.

(4) To support adoptive families by providing support services as necessary so that they can make a lifetime commitment to their children.

DEFINITIONS

SEC. 431. [42 U.S.C. 629a] (a) IN GENERAL.—As used in this subpart:

(1) FAMILY PRESERVATION SERVICES.—The term "family preservation services" means services for children and families designed to help families (including adoptive and extended families) at risk or in crisis, including—

(A) service programs designed to help children—

(i) where safe and appropriate, return to families from which they have been removed; or

(ii) be placed for adoption, with a legal guardian, or, if adoption or legal guardianship is determined not to be safe and appropriate for a child, in some other planned, permanent living arrangement;

(B) preplacement preventive services programs, such as intensive family preservation programs, designed to help children at risk of foster care placement remain safely with their families;

(C) service programs designed to provide followup care to families to whom a child has been returned after a foster care placement;

(D) respite care of children to provide temporary relief for parents and other caregivers (including foster parents);

(E) services designed to improve parenting skills (by reinforcing parents' confidence in their strengths, and helping them to identify where improvement is needed and to obtain assistance in improving those skills) with respect to matters such as child development, family budgeting, coping with stress, health, and nutrition; and

(F) infant safe haven programs to provide a way for a parent to safely relinquish a newborn infant at a safe haven designated pursuant to a State law.

(2) FAMILY SUPPORT SERVICES.—The term "family support services" means community-based services to promote the safety and well-being of children and families designed to increase the strength and stability of families (including adoptive, foster, and extended families), to increase parents' confidence and competence in their parenting abilities, to afford children a safe, stable, and supportive family environment, to strengthen parental relationships and promote healthy marriages, and otherwise to enhance child development.

(3) STATE AGENCY.—The term "State agency" means the State agency responsible for administering the program under subpart 1.

(4) STATE.—The term "State" includes an Indian tribe or tribal organization, in addition to the meaning given such term for purposes of subpart 1.

(5) TRIBAL ORGANIZATION.—The term "tribal organization" means the recognized governing body of any Indian tribe.

(6) INDIAN TRIBE.—The term "Indian tribe" means any Indian tribe (as defined in section 482 (i)(5), as in effect before August 22, 1986) and any Alaska Native organization (as defined in section 482(i)(7)(A), as so in effect).

(7) TIME–LIMITED FAMILY REUNIFICATION SERVICES.—

(A) IN GENERAL.—The term "time–limited family reunification services" means the services and activities described in subparagraph (B) that are provided to a child that is removed from the child's home and placed in a foster family home or a child care institution and to the parents or primary caregiver of such a child, in order to facilitate the reunification of the child safely and appropriately within a timely fashion, but only during the 15–month period that begins on the date that the child, pursuant to section 475(5)(F), is considered to have entered foster care.

(B) SERVICES AND ACTIVITIES DESCRIBED.—The services and activities described in this subparagraph are the following:

(i) Individual, group, and family counseling.

(ii) Inpatient, residential, or outpatient substance abuse treatment services.

(iii) Mental health services.

(iv) Assistance to address domestic violence.

(v) Services designed to provide temporary child care and therapeutic services for families, including crisis nurseries.

(vi) Transportation to or from any of the services and activities described in this subparagraph.

(8) ADOPTION PROMOTION AND SUPPORT SERVICES.—The term "adoption promotion and support services" means services and activities designed to encourage more adoptions out of the foster care system, when adoptions promote the best interests of children, including such activities as pre– and post–adoptive services and activities designed to expedite the adoption process and support adoptive families.

(9) NON–FEDERAL FUNDS.—The term "non–Federal funds" means State funds, or at the option of a State, State and local funds.

(b) OTHER TERMS.—For other definitions of other terms used in this subpart, see section 475.

STATE PLANS

SEC. 432. [42 U.S.C. 629b] (a) PLAN REQUIREMENTS.—A State plan meets the requirements of this subsection if the plan—

(1) provides that the State agency shall administer, or supervise the administration of, the State program under this subpart;

(2)(A)(i) sets forth the goals intended to be accomplished under the plan by the end of the 5th fiscal year in which the plan is in operation in the State, and (ii) is updated periodically to set forth the goals intended to be accomplished under the plan by the end of each 5th fiscal year thereafter;

(B) describes the methods to be used in measuring progress toward accomplishment of the goals;

(C) contains assurances that the State—

(i) after the end of each of the 1st 4 fiscal years covered by a set of goals, will perform an interim review of progress toward accomplishment of the goals, and on the basis of the interim review will revise the statement of goals in the plan, if necessary, to reflect changed circumstances; and

(ii) after the end of the last fiscal year covered by a set of goals, will perform a final review of progress toward accomplishment of the goals, and on the basis of the final review (I) will prepare, transmit to the Secretary, and make available to the public a final report on progress toward accomplishment of the goals, and (II) will develop (in consultation with the entities required to be consulted pursuant to subsection (b)) and add to the plan a statement of the goals intended to be accomplished by the end of the 5th succeeding fiscal year;

(3) provides for coordination, to the extent feasible and appropriate, of the provision of services under the plan and the provision of services or benefits under other Federal or federally assisted programs serving the same populations;

(4) contains assurances that not more than 10 percent of expenditures under the plan for any fiscal year with respect to which the State is eligible for payment under section 434 for the fiscal year shall be for administrative costs, and that the remaining expenditures shall be for programs of family preservation services, community-based family support services, time–limited family reunification services, and adoption pro-

motion and support services, with significant portions of such expenditures for each such program;

(5) contains assurances that the State will—

(A) annually prepare, furnish to the Secretary, and make available to the public a description (including separate descriptions with respect to family preservation services, community-based family support services time–limited family reunification services, and adoption promotion and support services) of—

(i) the service programs to be made available under the plan in the immediately succeeding fiscal year;

(ii) the populations which the programs will serve; and

(iii) the geographic areas in the State in which the services will be available; and

(B) perform the activities described in subparagraph (A)—

(i) in the case of the 1st fiscal year under the plan, at the time the State submits its initial plan; and

(ii) in the case of each succeeding fiscal year, by the end of the 3rd quarter of the immediately preceding fiscal year;

(6) provides for such methods of administration as the Secretary finds to be necessary for the proper and efficient operation of the plan;

(7)(A) contains assurances that Federal funds provided to the State under this subpart will not be used to supplant Federal or non-Federal funds for existing services and activities which promote the purposes of this subpart; and

(B) provides that the State will furnish reports to the Secretary, at such times, in such format, and containing such information as the Secretary may require, that demonstrate the State's compliance with the prohibition contained in subparagraph (A);

(8) provides that the State agency will furnish such reports, containing such information, and participate in such evaluations, as the Secretary may require; and

(9) contains assurances that in administering and conducting service programs under the plan, the safety of the children to be served shall be of paramount concern.

(b) APPROVAL OF PLANS.—

(1) IN GENERAL.—The Secretary shall approve a plan that meets the requirements of subsection (a) only if the plan was developed jointly by the Secretary and the State, after consultation by the State agency with appropriate public and nonprofit private agencies and community-based organizations with experience in administering programs of services for children and families (including family preservation, family support, time–limited family reunification, and adoption promotion and support).

(2) Plans of Indian tribes.—

(A) Exemption from inappropriate requirements.—The Secretary may exempt a plan submitted by an Indian tribe from any requirement of this section that the Secretary determines would be inappropriate to apply to the Indian

tribe, taking into account the resources, needs, and other circumstances of the Indian tribe.

(B) Special Rule.—Notwithstanding subparagraph (A) of this paragraph, the Secretary may not approve a plan of an Indian tribe under this subpart to which (but for this subparagraph) an allotment of less than $10,000 would be made under section 433(a) if allotments were made under section 433(a) to all Indian tribes with plans approved under this subpart with the same or larger numbers of children.

ALLOTMENTS TO STATES

SEC. 433. [42 U.S.C. 629c] (a) Indian Tribes.—From the amount reserved pursuant to section 436(b)(3) for any fiscal year, the Secretary shall allot to each Indian tribe with a plan approved under this subpart an amount that bears the same ratio to such reserved amount as the number of children in the Indian tribe bears to the total number of children in all Indian tribes with State plans so approved, as determined by the Secretary on the basis of the most current and reliable information available to the Secretary.

(b) Territories.—From the amount described in section 436(a) for any fiscal year that remains after applying section 436(b) for the fiscal year, the Secretary shall allot to each of the jurisdictions of Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and American Samoa an amount determined in the same manner as the allotment to each of such jurisdictions is determined under section 421.

(c) Other States.—

(1) In general.—From the amount described in section 436(a) for any fiscal year that remains after applying section 436(b) and subsection (b) of this section for the fiscal year, the Secretary shall allot to each State (other than an Indian tribe) which is not specified in subsection (b) of this section an amount equal to such remaining amount multiplied by the food stamp percentage of the State for the fiscal year.

(2) Food stamp percentage defined.—

(A) IN GENERAL.—As used in paragraph (1) of this subsection, the term "food stamp percentage" means, with respect to a State and a fiscal year, the average monthly number of children receiving food stamp benefits in the State for months in the 3 fiscal years referred to in subparagraph (B) of this paragraph, as determined from sample surveys made under section 16(c) of the Food Stamp Act of 1977[62], expressed as a percentage of the average monthly number of children receiving food stamp benefits in the States described in such paragraph (1) for months in such 3 fiscal years, as so determined.

(B) FISCAL YEARS USED IN CALCULATION.—For purposes of the calculation pursuant to subparagraph (A), the Secretary shall use data for the 3 most recent fiscal years, preceding the fiscal year for which the State's allotment is calculated under this subsection, for which such data are available to the Secretary.

[62] See Vol. II, P.L. 88–525, §16(c).

(d) REALLOTMENTS.—The amount of any allotment to a State under this section for any fiscal year that the State certifies to the Secretary will not be required for carrying out the State plan under section 432 shall be available for reallotment using the allotment methodology specified in this section. Any amount so reallotted to a State is deemed part of the allotment of the State under the preceding provisions of this section.

PAYMENTS TO STATES

SEC. 434. [42 U.S.C. 629d] (a) ENTITLEMENT.—Each State that has a plan approved under section 432 shall be entitled to payment of the lesser of—

(1) 75 percent of the total expenditures by the State for activities under the plan during the fiscal year or the immediately succeeding fiscal year; or

(2) the allotment of the State under section 433 for the fiscal year.

(A) such amount, not exceeding $1,000,000, from the allotment of the State under section 433 for fiscal year 1994, as the State may require to develop and submit a plan for approval under section 432; and

(B) an amount equal to the lesser of—

(i) 75 percent of the expenditures by the State for services to children and families in accordance with the application and the expenditure rules of section 432(a)(4); or

(ii) the allotment of the State under section 433 for fiscal year 1994, reduced by any amount paid to the State pursuant to subparagraph (A) of this paragraph.

(b) PROHIBITIONS.—

(1) No Use of other federal funds for state match.—Each State receiving an amount paid under subsection (a) may not expend any Federal funds to meet the costs of services under the State plan under section 432 not covered by the amount so paid.

(2) Availability of funds.—A State may not expend any amount paid under subsection (a) for any fiscal year after the end of the immediately succeeding fiscal year.

(c) DIRECT PAYMENTS TO TRIBAL ORGANIZATIONS OF INDIAN TRIBES.—The Secretary shall pay any amount to which an Indian tribe is entitled under this section directly to the tribal organization of the Indian tribe.

EVALUATIONS; RESEARCH; TECHNICAL ASSISTANCE

SEC. 435. [42 U.S.C. 629e] (a) EVALUATIONS.—

(1) IN GENERAL.—The Secretary shall evaluate and report to the Congress biennially on effectiveness of the programs carried out pursuant to this subpart in accomplishing the purposes of this subpart, and may evaluate any other Federal, State, or local program, regardless of whether federally assisted, that is designed to achieve the same purposes as the program under this subpart, in accordance with criteria established in accordance with paragraph (2).

(2) CRITERIA TO BE USED.—In developing the criteria to be used in evaluations under paragraph (1), the Secretary shall consult with appropriate parties, such as—

(A) State agencies administering programs under this part and part E;

(B) persons administering child and family services programs (including family preservation and family support programs) for private, nonprofit organizations with an interest in child welfare; and

(C) other persons with recognized expertise in the evaluation of child and family services programs (including family preservation and family support programs) or other related programs.

(3) TIMING OF REPORT.—Beginning in 2003, the Secretary shall submit the biennial report required by this subsection not later than April 1 of every other year, and shall include in each such report the funding level, the status of ongoing evaluations, findings to date, and the nature of any technical assistance provided to States under subsection (d).

(b) COORDINATION OF EVALUATIONS.—The Secretary shall develop procedures to coordinate evaluations under this section, to the extent feasible, with evaluations by the States of the effectiveness of programs under this subpart.

(c) RESEARCH.—The Secretary shall give priority consideration to the following topics for research and evaluation under this subsection, using rigorous evaluation methodologies where feasible:

(1) Promising program models in the service categories specified in section 430(b), particularly time–limited reunification services and postadoption services.

(2) Multi–disciplinary service models designed to address parental substance abuse and to reduce its impacts on children.

(3) The efficacy of approaches directed at families with specific problems and with children of specific age ranges.

(4) The outcomes of adoptions finalized after enactment of the Adoption and Safe Families Act of 1997[63].

(d) TECHNICAL ASSISTANCE.—To the extent funds are available therefor, the Secretary shall provide technical assistance that helps States and Indian tribes to—

(1) develop research–based protocols for identifying families at risk of abuse and neglect of use in the field;

(2) develop treatment models that address the needs of families at risk, particularly families with substance abuse issues;

(3) implement programs with well–articulated theories of how the intervention will result in desired changes among families at risk;

(4) establish mechanisms to ensure that service provision matches the treatment model; and

(5) establish mechanisms to ensure that postadoption services meet the needs of the individual families and develop models to reduce the disruption rates of adoption.

[63] P.L. 105-89 was enacted November 19, 1997.

AUTHORIZATION OF APPROPRIATIONS; RESERVATION OF CERTAIN AMOUNTS

SEC. 436. [42 USC 629f] (a) AUTHORIZATION.—There are authorized to be appropriated to carry out the provisions of this subpart $305,000,000 for each of fiscal years 2002 through 2006.

(b) RESERVATION OF CERTAIN AMOUNTS.—From the amount specified in subsection (a) for a fiscal year, the Secretary shall reserve amounts as follows:

(1) EVALUATION, RESEARCH, TRAINING, AND TECHNICAL ASSISTANCE.—The Secretary shall reserve $6,000,000 for expenditure by the Secretary—

(A) for research, training, and technical assistance costs related to the program under this subpart; and

(B) for evaluation of State programs based on the plans approved under section 432 and funded under this subpart, and any other Federal, State, or local program, regardless of whether federally assisted, that is designed to achieve the same purposes as the State programs.

(2) STATE COURT IMPROVEMENTS.—The Secretary shall reserve $10,000,000 for grants under section 438.

(3) INDIAN TRIBES.—The Secretary shall reserve 1 percent for allotment to Indian tribes in accordance with section 433(a).

DISCRETIONARY GRANTS

SEC. 437. [42 USC 629g] (a) LIMITATIONS ON AUTHORIZATION OF APPROPRIATIONS.—In addition to any amount appropriated pursuant to section 436, there are authorized to be appropriated to carry out this section $200,000,000 for each of fiscal years 2002 through 2006.

(b) RESERVATION OF CERTAIN AMOUNTS.—From the amount (if any) appropriated pursuant to subsection (a) for a fiscal year, the Secretary shall reserve amounts as follows:

(1) EVALUATION, RESEARCH, TRAINING, AND TECHNICAL ASSISTANCE.—The Secretary shall reserve 3.3 percent for expenditure by the Secretary for the activities described in section 436(b)(1).

(2) STATE COURT IMPROVEMENTS.—The Secretary shall reserve 3.3 percent for grants under section 438.

(3) INDIAN TRIBES.—The Secretary shall reserve 2 percent for allotment to Indian tribes in accordance with subsection (c)(1).

(c) ALLOTMENTS.—

(1) INDIAN TRIBES.—From the amount (if any) reserved pursuant to subsection (b)(3) for any fiscal year, the Secretary shall allot to each Indian tribe with a plan approved under this subpart an amount that bears the same ratio to such reserved amount as the number of children in the Indian tribe bears to the total number of children in all Indian tribes with State plans so approved, as determined by the Secretary on the basis of the most current and reliable information available to the Secretary.

(2) TERRITORIES.—From the amount (if any) appropriated pursuant to subsection (a) for any fiscal year that remains after applying subection (b) for the fiscal year, the Secretary shall allot to each of the jurisdictions of Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and Amer-

ican Samoa an amount determined in the same manner as the allotment to each of such jurisdictions is determined under section 421.

(3) OTHER STATES.—From the amount (if any) appropriated pursuant to subsection (a) for any fiscal year that remains after applying subsection (b) and paragraph (2) of this subsection for the fiscal year, the Secretary shall allot to each State (other than an Indian tribe) which is not specified in paragraph (2) of this subsection an amount equal to such remaining amount multiplied by the food stamp percentage (as defined in section 433(c)(2)) of the State for the fiscal year.

(d) GRANTS.—The Secretary may make a grant to a State which has a plan approved under this subpart in an amount equal to the lesser of—

(1) 75 percent of the total expenditures by the State for activities under the plan during the fiscal year or the immediately succeeding fiscal year; or

(2) the allotment of the State under subsection (c) for the fiscal year.

(e) APPLICABILITY OF CERTAIN RULES.—The rules of subsections (b) and (c) of section 434 shall apply in like manner to the amounts made available pursuant to this section.

ENTITLEMENT FUNDING FOR STATE COURTS TO ASSESS AND IMPROVE HANDLING OF PROCEEDINGS RELATING TO FOSTER CARE AND ADOPTION

SEC. 438. [42 U.S.C. 629h] (a) IN GENERAL.—The Secretary shall make grants, in accordance with this section, to the highest State courts in States participating in the program under part E of title IV of the Social Security Act, for the purpose of enabling such courts—

(1) to conduct assessments, in accordance with such requirements as the Secretary shall publish, of the role, responsibilities, and effectiveness of State courts in carrying out State laws requiring proceedings (conducted by or under the supervision of the courts)—

(A) that implement parts B and E ;

(B) that determine the advisability or appropriateness of foster care placement;

(C) that determine whether to terminate parental rights; and

(D) that determine whether to approve the adoption or other permanent placement of a child; and

(2) to implement improvements the highest state courts deem necessary as a result of the assessments, including—

(A) to provide for the safety, well–being, and permanence of children in foster care, as set forth in the Adoption and Safe Families Act of 1997 (Public Law 105–89); and

(B) to implement a corrective action plan, as necessary, resulting from reviews of child and family service programs under section 1123A of this Act.

(b) APPLICATIONS.—In order to be eligible for a grant under this section, a highest State court shall submit to the Secretary an application at such time, in such form, and including such information and assurances as the Secretary shall require.

(c) ALLOTMENTS.—

(1) IN GENERAL.—Each highest State court which has an application approved under subsection (b), and is conducting assessment and improvement activities in accordance with this section, shall be entitled to payment, for each of fiscal years 2002 through 2006, from the amount reserved pursuant to section 436(b)(2) (and the amount, if any, reserved pursuant to section 437(b)(2)), of an amount equal to the sum of $85,000 plus the amount described in paragraph (2) of this subsection for the fiscal year.

(2) FORMULA.—The amount described in this paragraph for any fiscal year is the amount that bears the same ratio to the amount reserved pursuant to section 436(b)(2) (and the amount, if any, reserved pursuant to section 437(b)(2)) for the fiscal year (reduced by the dollar amount specified in paragraph (1) of this subsection for the fiscal year) as the number of individuals in the State who have not attained 21 years of age bears to the total number of such individuals in all States the highest State courts of which have approved applications under subsection (b).

(d) FEDERAL SHARE.—Each highest State court which receives funds paid under this section may use such funds to pay not more than 75 percent of the cost of activities under this section in each of fiscal years 2002 through 2006.

GRANTS FOR PROGRAMS FOR MENTORING CHILDREN OF PRISONERS

SEC. 439. [42 U.S.C. 629i] (a) FINDINGS AND PURPOSE.—

(1) FINDINGS.—

(A) In the period between 1991 and 1999, the number of children with a parent incarcerated in a Federal or State correctional facility increased by more than 100 percent, from approximately 900,000 to approximately 2,000,000. In 1999, 2.1 percent of all children in the United States had a parent in Federal or State prison.

(B) Prior to incarceration, 64 percent of female prisoners and 44 percent of male prisoners in State facilities lived with their children.

(C) Nearly 90 percent of the children of incarcerated fathers live with their mothers, and 79 percent of the children of incarcerated mothers live with a grandparent or other relative.

(D) Parental arrest and confinement lead stress, trauma, stigmatization, and separation problems for children. These problems are coupled with existing problems that include poverty, violence, parental substance abuse, high–crime environments, intrafamilial abuse, child abuse and neglect, multiple care givers, and/or prior separations. As a result, these children often exhibit a broad variety of behavioral, emotional, health, and educational problems that are often compounded by the pain of separation.

(E) Empirical research demonstrates that mentoring is a potent force for improving children's behavior across all risk behaviors affecting health. Quality, one–on–one relationships that provide young people with caring role models for future success have profound, life–changing poten-

tial. Done right, mentoring markedly advances youths' life prospects. A widely cited 1995 study by Public/Private Ventures measured the impact of one Big Brothers Big Sisters program and found significant effects in the lives of youth—cutting first–time drug use by almost half and first–time alcohol use by about a third, reducing school absenteeism by half, cutting assaultive behavior by a third, improving parental and peer relationships, giving youth greater confidence in their school work, and improving academic performance.

(2) PURPOSE.—The purpose of this section is to authorize the Secretary to make competitive grants to applicants in areas with substantial numbers of children of incarcerated parents, to support the establishment or expansion and operation of programs using a network of public and private community entities to provide mentoring services for children of prisoners.

(b) DEFINITIONS.—In this section:

(1) CHILDREN OF PRISONERS.—The term "children of prisoners" means children one or both of whose parents are incarcerated in a Federal, State, or local correctional facility. The term is deemed to include children who are in an ongoing mentoring relationship in a program under this section at the time of their parents' release from prison, for purposes of continued participation in the program.

(2) MENTORING.—The term "mentoring" means a structured, managed program in which children are appropriately matched with screened and trained adult volunteers for one–on–one relationships, involving meetings and activities on a regular basis, intended to meet, in part, the child's need for involvement with a caring and supportive adult who provides a positive role model.

(3) MENTORING SERVICES.—The term "mentoring services" means those services and activities that support a structured, managed program of mentoring, including the management by trained personnel of outreach to, and screening of, eligible children; outreach to, education and training of, and liaison with sponsoring local organizations; screening and training of adult volunteers; matching of children with suitable adult volunteer mentors; support and oversight of the mentoring relationship; and establishment of goals and evaluation of outcomes for mentored children.

(c) PROGRAM AUTHORIZED.—From the amounts appropriated under subsection (h) for a fiscal year that remain after applying subsection (h)(2), the Secretary shall make grants under this section for each of fiscal years 2002 through 2006 to State or local governments, tribal governments or tribal consortia, faith–based organizations, and community–based organizations in areas that have significant numbers of children of prisoners and that submit applications meeting the requirements of this section, in amounts that do not exceed $5,000,000 per grant.

(d) APPLICATION REQUIREMENTS.—In order to be eligible for a grant under this section, the chief executive officer of the applicant must submit to the Secretary an application containing the following:

(1) PROGRAM DESIGN.—A description of the proposed program, including—

(A) a list of local public and private organizations and entities that will participate in the mentoring network;

(B) the name, description, and qualifications of the entity that will coordinate and oversee the activities of the mentoring network;

(C) the number of mentor–child matches proposed to be established and maintained annually under the program;

(D) such information as the Secretary may require concerning the methods to be used to recruit, screen support, and oversee individuals participating as mentors, (which methods shall include criminal background checks on the individuals), and to evaluate outcomes for participating children, including information necessary to demonstrate compliance with requirements established by the Secretary for the program; and

(E) such other information as the Secretary may require.

(2) COMMUNITY CONSULTATION; COORDINATION WITH OTHER PROGRAMS.—A demonstration that, in developing and implementing the program, the applicant will, to the extent feasible and appropriate—

(A) consult with public and private community entities, including religious organizations, and including, as appropriate, Indian tribal organizations and urban Indian organizations, and with family members of potential clients;

(B) coordinate the programs and activities under the program with other Federal, State, and local programs serving children and youth; and

(C) consult with appropriate Federal, State, and local corrections, workforce development, and substance abuse and mental health agencies.

(3) EQUAL ACCESS FOR LOCAL SERVICE PROVIDERS.—An assurance that public and private entities and community organizations, including religious organizations and Indian organizations, will be eligible to participate on an equal basis.

(4) RECORDS, REPORTS, AND AUDITS.—An agreement that the applicant will maintain such records, make such reports, and cooperate with such reviews or audits as the Secretary may find necessary for purposes of oversight of project activities and expenditures.

(5) EVALUATION.—An agreement that the applicant will cooperate fully with the Secretary's ongoing and final evaluation of the program under the plan, by means including providing the Secretary access to the program and program– related records and documents, staff, and grantees receiving funding under the plan.

(e) FEDERAL SHARE.—

(1) IN GENERAL.—A grant for a program under this section shall be available to pay a percentage share of the costs of the program up to—

(A) 75 percent for the first and second fiscal years for which the grant is awarded; and

(B) 50 percent for the third and each succeeding such fiscal years.

(2) NON–FEDERAL SHARE.—The non–Federal share of the cost of projects under this section may be in cash or in kind. In determining the amount of the non–Federal share, the Secretary

may attribute fair market value to goods, services, and facilities contributed from non–Federal sources.

(f) CONSIDERATIONS IN AWARDING GRANTS.—In awarding grants under this section, the Secretary shall take into consideration—

(1) the qualifications and capacity of applicants and networks of organizations to effectively carry out a mentoring program under this section;

(2) the comparative severity of need for mentoring services in local areas, taking into consideration data on the numbers of children (and in particular of low–income children) with an incarcerated parents (or parents) in the areas;

(3) evidence of consultation with existing youth and family service programs, as appropriate; and

(4) any other factors the Secretary may deem significant with respect to the need for or the potential success of carrying out a mentoring program under this section.

(g) EVALUATION.—The Secretary shall conduct an evaluation of the programs conducted pursuant to this section, and submit to the Congress not later than April 15, 2005, a report on the findings of the evaluation.

(h) AUTHORIZATION OF APPROPRIATIONS; RESERVATION OF CERTAIN AMOUNTS.—

(1) AUTHORIZATION.—There are authorized to be appropriated to carry out this section $67,000,000 for each of fiscal years 2002 and 2003, and such sums as may be necessary for each succeeding fiscal year.

(2) RESERVATION.— The Secretary shall reserve 2.5 percent of the amount appropriated for each fiscal year under paragraph (1) for expenditure by the Secretary for research, technical assistance, and evaluation related to programs under this section.

[Part C— Repealed.[64]]

Part D—Child Support and Establishment of Paternity[65]

APPROPRIATION

SEC. 451. [42 U.S.C. 651] For the purpose of enforcing the support obligations owed by noncustodial parents to their children and the spouse (or former spouse) with whom such children are living, locating noncustodial parents, establishing paternity, obtaining child and spousal support, and assuring that assistance in obtaining support will be available under this part to all children (whether or not eligible for assistance under a State program funded under part A) for whom such assistance is requested, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this part.

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[64] P.L. 100-485, §202(a); 102 Stat. 2377.

[65] See Vol. II, P.L. 73–30, §3, for the requirement that State employment offices supply data in aid of administration of the child support programs.

See Vol. II, P.L. 83–591, §6103(l)(1), with respect to disclosure of returns and return information by the Secretary of the Treasury to the Social Security Administration, and §7213(a)(1) with respect to the penalty for unauthorized disclosure of that tax return information.

See Vol. II, P.L. 95–630, §§1101–1121, with respect to an individual's right to financial privacy.

See Vol. II, P.L. 99–177, §256, with respect to treatment of the child support enforcement program.

DUTIES OF THE SECRETARY

SEC. 452. [42 U.S.C. 652] (a) The Secretary shall establish, within the Department of Health and Human Services a separate organizational unit, under the direction of a designee of the Secretary, who shall report directly to the Secretary and who shall—

(1) establish such standards for State programs for locating noncustodial parents, establishing paternity, and obtaining child support and support for the spouse (or former spouse) with whom the noncustodial parent's child is living as he determines to be necessary to assure that such programs will be effective;

(2) establish minimum organizational and staffing requirements for State units engaged in carrying out such programs under plans approved under this part;

(3) review and approve State plans for such programs;

(4)(A) review data and calculations transmitted by State agencies pursuant to section 454(15)(B) on State program accomplishments with respect to performance indicators for purposes of subsection (g) of this section and section 458;

(B) review annual reports submitted pursuant to section 454(15)(A) and, as appropriate, provide to the State comments, recommendations for additional or alternative corrective actions, and technical assistance; and

(C) conduct audits, in accordance with the Government auditing standards of the Comptroller General of the United States—

(i) at least once every 3 years (or more frequently, in the case of a State which fails to meet the requirements of this part concerning performance standards and reliability of program data) to assess the completeness, reliability, and security of the data and the accuracy of the reporting systems used in calculating performance indicators under subsection (g) of this section and section 458;

(ii) of the adequacy of financial management of the State program operated under the State plan approved under this part, including assessments of—

(I) whether Federal and other funds made available to carry out the State program are being appropriately expended, and are properly and fully accounted for; and

(II) whether collections and disbursements of support payments are carried out correctly and are fully accounted for; and

(iii) for such other purposes as the Secretary may find necessary;

(5) assist States in establishing adequate reporting procedures and maintain records of the operations of programs established pursuant to this part in each State, and establish procedures to be followed by States for collecting and reporting information required to be provided under this part, and establish uniform definitions (including those necessary to enable the measurement of State compliance with the requirements of this part relating to expedited processes) to be applied in following such procedures;

(6) maintain records of all amounts collected and disbursed under programs established pursuant to the provisions of this part and of the costs incurred in collecting such amounts;

(7) provide technical assistance to the States to help them establish effective systems for collecting child and spousal support and establishing paternity, and specify the minimum requirements of an affidavit to be used for the voluntary acknowledgment of paternity which shall include the social security number of each parent and, after consultation with the States, other common elements as determined by such designee;

(8) receive applications from States for permission to utilize the courts of the United States to enforce court orders for support against noncustodial parents and, upon a finding that (A) another State has not undertaken to enforce the court order of the originating State against the noncustodial parent within a reasonable time, and (B) that utilization of the Federal courts is the only reasonable method of enforcing such order, approve such applications;

(9) operate the Federal Parent Locator Service established by section 453;

(10) not later than three months after the end of each fiscal year, beginning with the year 1977, submit to the Congress a full and complete report on all activities undertaken pursuant to the provisions of this part, which report shall include, but not be limited to, the following:

(A) total program costs and collections set forth in sufficient detail to show the cost to the States and the Federal Government, the distribution of collections to families, State and local governmental units, and the Federal Government; and an identification of the financial impact of the provisions of this part, including—

(i) the total amount of child support payments collected as a result of services furnished during the fiscal year to individuals receiving services under this part;

(ii) the cost to the States and to the Federal Government of so furnishing the services; and

(iii) the number of cases involving families—

(I) who became ineligible for assistance under State programs funded under part A during a month in the fiscal year; and

(II) with respect to whom a child support payment was received in the month;

(B) costs and staff associated with the Office of Child Support Enforcement;

(C) the following data, separately stated for cases where the child is receiving assistance under a State program funded under part A (or foster care maintenance payments under part E), or formerly received such assistance or payments and the State is continuing to collect support assigned to it pursuant to section 408(a)(3) or under section 471(a)(17) or 1912, and for all other cases under this part:

(i) the total number of cases in which a support obligation has been established in the fiscal year for which the report is submitted;

(ii) the total number of cases in which a support obligation has been established;

(iii) the number of cases in which support was collected during the fiscal year;

(iv) the total amount of support collected during such fiscal year and distributed as current support;

(v) the total amount of support collected during such fiscal year and distributed as arrearages;

(vi) the total amount of support due and unpaid for all fiscal years; and

(vii) the number of child support cases filed in each State in such fiscal year, and the amount of the collections made in each State in such fiscal year, on behalf of children residing in another State or against parents residing in another State;

(D) the status of all State plans under this part as of the end of the fiscal year last ending before the report is submitted, together with an explanation of any problems which are delaying or preventing approval of State plans under this part;

(E) data, by State, on the use of the Federal Parent Locator Service, and the number of locate requests submitted without the noncustodial parent's social security account number;

(F) the number of cases, by State, in which an applicant for or recipient assistance under a State program funded under part A has refused to cooperate in identifying and locating the noncustodial parent and the number of cases in which refusal so to cooperate is based on good cause (as determined by the State);

(G) data, by State, on use of the Internal Revenue Service for collections, the number of court orders on which collections were made, the number of paternity determinations made and the number of parents located, in sufficient detail to show the cost and benefits to the States and to the Federal Government;

(H) the major problems encountered which have delayed or prevented implementation of the provisions of this part during the fiscal year last ending prior to the submission of such report; and

(I) compliance, by State, with the standards established pursuant to subsections (h) and (i); and

(11) not later than October 1, 1996, after consulting with the State directors of programs under this part, promulgate forms to be used by States in interstate cases for—

(A) collection of child support through income withholding;

(B) imposition of liens; and

(C) administrative subpoenas.

(b) The Secretary shall, upon the request of any State having in effect a State plan approved under this part, certify to the Secretary of the Treasury for collection pursuant to the provisions of section 6305 of the Internal Revenue Code of 1954[66] the amount of any child support obligation (including any support obligation

[66] See Vol. II, P.L. 83–591.

with respect to the parent who is living with the child and receiving assistance under the State program funded under part A) which is assigned to such State or is undertaken to be collected by such State pursuant to section 454(4). No amount may be certified for collection under this subsection except the amount of the delinquency under a court or administrative order for support and upon a showing by the State that such State has made diligent and reasonable efforts to collect such amounts utilizing its own collection mechanisms, and upon an agreement that the State will reimburse the Secretary of the Treasury for any costs involved in making the collection. All reimbursements shall be credited to the appropriation accounts which bore all or part of the costs involved in making the collections. The Secretary after consultation with the Secretary of the Treasury may, by regulation, establish criteria for accepting amounts for collection and for making certification under this subsection including imposing such limitations on the frequency of making such certifications under this subsection.

(c) The Secretary of the Treasury shall from time to time pay to each State for distribution in accordance with the provisions of section 457 the amount of each collection made on behalf of such State pursuant to subsection (b).

(d)(1) Except as provided in paragraph (3), the Secretary shall not approve the initial and annually updated advance automated data processing planning document, referred to in section 454(16), unless he finds that such document, when implemented, will generally carry out the objectives of the management system referred to in such subsection, and such document—

(A) provides for the conduct of, and reflects the results of, requirements analysis studies, which include consideration of the program mission, functions, organization, services, constraints, and current support, of, in, or relating to, such system,

(B) contains a description of the proposed management system referred to in section 454(16), including a description of information flows, input data, and output reports and uses,

(C) sets forth the security and interface requirements to be employed in such management system,

(D) describes the projected resource requirements for staff and other needs, and the resources available or expected to be available to meet such requirements,

(E) contains an implementation plan and backup procedures to handle possible failures,

(F) contains a summary of proposed improvement of such management system in terms of qualitative and quantitative benefits, and

(G) provides such other information as the Secretary determines under regulation is necessary.

(2)(A) The Secretary shall through the separate organizational unit established pursuant to subsection (a), on a continuing basis, review, assess, and inspect the planning, design, and operation of, management information systems referred to in section 454(16), with a view to determining whether, and to what extent, such systems meet and continue to meet requirements imposed under paragraph (1) and the conditions specified under section 454(16).

(B) If the Secretary finds with respect to any statewide management information system referred to in section 454(16) that there is a failure substantially to comply with criteria, requirements, and

other undertakings, prescribed by the advance automated data processing planning document theretofore approved by the Secretary with respect to such system, then the Secretary shall suspend his approval of such document until there is no longer any such failure of such system to comply with such criteria, requirements, and other undertakings so prescribed.

(3) The Secretary may waive any requirement of paragraph (1) or any condition specified under section 454(16), and shall waive the single statewide system requirement under sections 454(16) and 454A, with respect to a State if—

(A) the State demonstrates to the satisfaction of the Secretary that the State has or can develop an alternative system or systems that enable the State—

(i) for purposes of section 409(a)(8), to achieve the paternity establishment percentages (as defined in section 452(g)(2)) and other performance measures that may be established by the Secretary;

(ii) to submit data under section 454(15)(B) that is complete and reliable;

(iii) to substantially comply with the requirements of this part; and

(iv) in the case of a request to waive the single statewide system requirement, to—

(I) meet all functional requirements of sections 454(16) and 454A;

(II) ensure that calculation of distributions meets the requirements of section 457 and accounts for distributions to children in different families or in different States or sub–State jurisdictions, and for distributions to other States;

(III) ensure that there is only one point of contact in the State which provides seamless case processing for all interstate case processing and coordinated, automated intrastate case management;

(IV) ensure that standardized data elements, forms, and definitions are used throughout the State;

(V) complete the alternative system in no more time than it would take to complete a single statewide system that meets such requirement and

(VI) process child support cases as quickly, efficiently, and effectively as such cases would be processed through a single statewide system that meets such requirement;

(B)(i) the waiver meets the criteria of paragraphs (1), (2), and (3) of section 1115(c); or

(ii) the State provides assurances to the Secretary that steps will be taken to otherwise improve the State's child support enforcement program; and

(C) in the case of a request to waive the single statewide system requirement, the State has submitted to the Secretary separate estimates of the total cost of a single statewide system that meets such requirement, and of any such alternative system or systems, which shall include estimates of the cost of developing and completing the system and of operating and maintaining the system for 5 years, and the Secretary has agreed with the estimates.

(e) The Secretary shall provide such technical assistance to States as he determines necessary to assist States to plan, design, develop, or install and provide for the security of, the management information systems referred to in section 454(16).

(f) The Secretary shall issue regulations to require that State agencies administering the child support enforcement program under this part petition for the inclusion of medical support as part of any child support order whenever health care coverage is available to the noncustodial parent at a reasonable cost. Such regulation shall also provide for improved information exchange between such State agencies and the State agencies administering the State medicaid programs under title XIX with respect to the availability of health insurance coverage.

(g)(1) A State's program under this part shall be found, for purposes of section 409(a)(8), not to have complied substantially with the requirements of this part unless, for any fiscal year beginning on or after October 1, 1994, its paternity establishment percentage for such fiscal year is based on reliable data and (rounded to the nearest whole percentage point) equals or exceeds—

(A) 90 percent;

(B) for a State with a paternity establishment percentage of not less than 75 percent but less than 90 percent for such fiscal year, the paternity establishment percentage of the State for the immediately preceding fiscal year plus 2 percentage points;

(C) for a State with a paternity establishment percentage of not less than 50 percent but less than 75 percent for such fiscal year, the paternity establishment percentage of the State for the immediately preceding fiscal year plus 3 percentage points;

(D) for a State with a paternity establishment percentage of not less than 45 percent but less than 50 percent for such fiscal year, the paternity establishment percentage of the State for the immediately preceding fiscal year plus 4 percentage points;

(E) for a State with a paternity establishment percentage of not less than 40 percent but less than 45 percent for such fiscal year, the paternity establishment percentage of the State for the immediately preceding fiscal year plus 5 percentage points; or

(F) for a State with a paternity establishment percentage of less than 40 percent for such fiscal year, the paternity establishment percentage of the State for the immediately preceding fiscal year plus 6 percentage points.

In determining compliance under this section, a State may use as its paternity establishment percentage either the State's IV–D paternity establishment percentage (as defined in paragraph (2)(A)) or the State's statewide paternity establishment percentage (as defined in paragraph (2)(B)).

(2) For purposes of this section—

(A) the term "IV–D paternity establishment percentage" means, with respect to a State for a fiscal year, the ratio (expressed as a percentage) that the total number of children—

(i) who have been born out of wedlock,

(ii)(I) except as provided in the last sentence of this paragraph, with respect to whom assistance is being pro-

vided under the State program funded under part A in the fiscal year or, at the option of the State, as of the end of such year, or (II) with respect to whom services are being provided under the State's plan approved under this part in the fiscal year or, at the option of the State, as of the end of such year pursuant to an application submitted under section 454(4)(A)(ii), and

(iii) the paternity of whom has been established or acknowledged,

bears to the total number of children born out of wedlock and (except as provided in such last sentence) with respect to whom assistance was being provided under the State program funded under part A as of the end of the preceding fiscal year or with respect to whom services were being provided under the State's plan approved under this part as of the end of the preceding fiscal year pursuant to an application submitted under section 454(4)(A)(ii);

(B) the term "statewide paternity establishment percentage" means, with respect to a State for a fiscal year, the ratio (expressed as a percentage) that the total number of minor children—

(i) who have been born out of wedlock, and

(ii) the paternity of whom has been established or acknowledged during the fiscal year,

bears to the total number of children born out of wedlock during the preceding fiscal year; and

(C) the term "reliable data" means the most recent data available which are found by the Secretary to be reliable for purposes of this section.

For purposes of subparagraphs (A) and (B), the total number of children shall not include any child with respect to whom assistance is being provided under the State program funded under part A by reason of the death of a parent unless paternity is established for such child or any child with respect to whom an applicant or recipient is found by the State to qualify for a good cause or other exception to cooperation pursuant to section 454(29).

(3)(A) The Secretary may modify the requirements of this subsection to take into account such additional variables as the Secretary identifies (including the percentage of children in a State who are born out of wedlock or for whom support has not been established) that affect the ability of a State to meet the requirements of this subsection.

(B) The Secretary shall submit an annual report to the Congress that sets forth the data upon which the paternity establishment percentages for States for a fiscal year are based, lists any additional variables the Secretary has identified under subparagraph (A), and describes State performance in establishing paternity.[67]

(h) The standards required by subsection (a)(1) shall include standards establishing time limits governing the period or periods within which a State must accept and respond to requests (from States, jurisdictions thereof, or individuals who apply for services furnished by the State agency under this part or with respect to whom an assignment pursuant to section 408(a)(3) is in effect) for

[67] See Vol. II, P.L. 100–485, §111(f)(3), with respect to the Secretary's collection of data necessary to implement the requirements of this subsection.

assistance in establishing and enforcing support orders, including requests to locate noncustodial parents, establish paternity, and initiate proceedings to establish and collect child support awards.

(i) The standards required by subsection (a)(1) shall include standards establishing time limits governing the period or periods within which a State must distribute, in accordance with section 457, amounts collected as child support pursuant to the State's plan approved under this part.

(j) Out of any money in the Treasury of the United States not otherwise appropriated, there is hereby appropriated to the Secretary for each fiscal year an amount equal to 1 percent of the total amount paid to the Federal Government pursuant to a plan approved under this part during the immediately preceding fiscal year (as determined on the basis of the most recent reliable data available to the Secretary as of the end of the third calendar quarter following the end of such preceding fiscal year), which shall be available for use by the Secretary, either directly or through grants, contracts, or interagency agreements, for—

(1) information dissemination and technical assistance to States, training of State and Federal staff, staffing studies, and related activities needed to improve programs under this part (including technical assistance concerning State automated systems required by this part); and

(2) research, demonstration, and special projects of regional or national significance relating to the operation of State programs under this part.

The amount appropriated under this subsection shall remain available until expended.

(k)(1) If the Secretary receives a certification by a State agency in accordance with the requirements of section 454(31) that an individual owes arrearages of child support in an amount exceeding $5,000, the Secretary shall transmit such certification to the Secretary of State for action (with respect to denial, revocation, or limitation of passports) pursuant to paragraph (2).

(2) The Secretary of State shall, upon certification by the Secretary transmitted under paragraph (1), refuse to issue a passport to such individual, and may revoke, restrict, or limit a passport issued previously to such individual.

(3) The Secretary and the Secretary of State shall not be liable to an individual for any action with respect to a certification by a State agency under this section.

(l) The Secretary, through the Federal Parent Locator Service, may aid State agencies providing services under State programs operated pursuant to this part and financial institutions doing business in two or more States in reaching agreements regarding the receipt from such institutions, and the transfer to the State agencies, of information that may be provided pursuant to section 466(a)(17)(A)(i), except that any State that, as of the date of the enactment of this subsection, is conducting data matches pursuant to section 466(a)(17)(A)(i) shall have until January 1, 2000, to allow the Secretary to obtain such information from such institutions that are operating in the State. For purposes of section 1113(d) of the Right to Financial Privacy Act of 1978, a disclosure pursuant to this subsection shall be considered a disclosure pursuant to a Federal statute.

FEDERAL PARENT LOCATOR SERVICE

SEC. 453. [42 U.S.C. 653] (a) ESTABLISHMENT; PURPOSE.—

(1) The Secretary shall establish and conduct a Federal Parent Locator Service, under the direction of the designee of the Secretary referred to in section 652(a) of this title, which shall be used for the purposes specified in paragraphs (2) and (3).

(2) For the purpose of establishing parentage or establishing, setting the amount of, modifying, or enforcing child support obligations, the Federal Parent Locator Service shall obtain and transmit to any authorized person specified in subsection (c)—

(A) information on, or facilitating the discovery of, the location of any individual—

(i) who is under an obligation to pay child support;

(ii) against whom such an obligation is sought;

(iii) to whom such an obligation is owed, including the individual's social security number (or numbers), most recent address, and the name, address, and employer identification number of the individual's employer; or

(iv) who has or may have parental rights with respect to a child,

(B) information on the individual's wages (or other income) from, and benefits of, employment (including rights to or enrollment in group health care coverage); and

(C) information on the type, status, location, and amount of any assets of, or debts owed by or to, any such individual.

(3) For the purpose of enforcing any Federal or State law with respect to the unlawful taking or restraint of a child, or making or enforcing a child custody or visitation determination, as defined in section 463(d)(1), the Federal Parent Locator Service shall be used to obtain and transmit the information specified in section 463(c) to the authorized persons specified in section 463(d)(2).

(b)(1) Upon request, filed in accordance with subsection (d), of any authorized person, as defined in subsection (c) for the information described in subsection (a)(2), or of any authorized person, as defined in section 463(d)(2) for the information described in section 463(c), the Secretary shall, notwithstanding any other provision of law, provide through the Federal Parent Locator Service such information to such person, if such information—

(A) is contained in any files or records maintained by the Secretary or by the Department of Health and Human Services; or

(B) is not contained in such files or records, but can be obtained by the Secretary, under the authority conferred by subsection (e), from any other department, agency, or instrumentality of the United States or of any State, and is not prohibited from disclosure under paragraph (2).

(2) No information shall be disclosed to any person if the disclosure of such information would contravene the national policy or security interests of the United States or the confidentiality of census data. The Secretary shall give priority to requests made by any authorized person described in subsection (c)(1). No information shall be disclosed to any person if the State has notified the Secretary that the State has reasonable

evidence of domestic violence or child abuse and the disclosure of such information could be harmful to the custodial parent or the child of such parent, provided that—

(A) in response to a request from an authorized person (as defined in subsection (c) of this section and section 463(d)(2)), the Secretary shall advise the authorized person that the Secretary has been notified that there is reasonable evidence of domestic violence or child abuse and that information can only be disclosed to a court or an agent of a court pursuant to subparagraph (B); and

(B) information may be disclosed to a court or an agent of a court described in subsection (c)(2) of this section or section 463(d)(2)(B), if—

(i) upon receipt of information from the Secretary, the court determines whether disclosure to any other person of that information could be harmful to the parent or the child; and

(ii) if the court determines that disclosure of such information to any other person could be harmful, the court and its agents shall not make any such disclosure.

(3) Information received or transmitted pursuant to this section shall be subject to the safeguard provisions contained in section 454(26).

(c) As used in subsection (a), the term "authorized person" means—

(1) any agent or attorney of any State having in effect a plan approved under this part, who has the duty or authority under such plans to seek to recover any amounts owed as child and spousal support or to seek to enforce orders providing child custody or visitation rights (including, when authorized under the State plan, any official of a political subdivision);

(2) the court which has authority to issue an order against a noncustodial parent for the support and maintenance of a child, or to issue an order against a resident parent for child custody or visitation rights, or any agent of such court;

(3) the resident parent, legal guardian, attorney, or agent of a child (other than a child receiving assistance under a State program funded under part A) (as determined by regulations prescribed by the Secretary) without regard to the existence of a court order against a noncustodial parent who has a duty to support and maintain any such child; and

(4) a State agency that is administering a program operated under a State plan under subpart 1 of part B, or a State plan approved under subpart 2 of part B or under part E.

(d) A request for information under this section shall be filed in such manner and form as the Secretary shall by regulation prescribe and shall be accompanied or supported by such documents as the Secretary may determine to be necessary.

(e)(1) Whenever the Secretary receives a request submitted under subsection (b) which he is reasonably satisfied meets the criteria established by subsections (a), (b), and (c), he shall promptly undertake to provide the information requested from the files and records maintained by any of the departments, agencies, or instrumentalities of the United States or of any State.

(2) Notwithstanding any other provision of law, whenever the individual who is the head of any department, agency, or instrumentality of the United States receives a request from the Secretary for information authorized to be provided by the Secretary under this section, such individual shall promptly cause a search to be made of the files and records maintained by such department, agency, or instrumentality with a view to determining whether the information requested is contained in any such files or records. If such search discloses the information requested, such individual shall immediately transmit such information to the Secretary, except that if any information is obtained the disclosure of which would contravene national policy or security interests of the United States or the confidentiality of census data, such information shall not be transmitted and such individual shall immediately notify the Secretary. If such search fails to disclose the information requested, such individual shall immediately so notify the Secretary. The costs incurred by any such department, agency, or instrumentality of the United States or of any State in providing such information to the Secretary shall be reimbursed by him in an amount which the Secretary determines to be reasonable payment for the information exchange (which amount shall not include payment for the costs of obtaining, compiling, or maintaining the information). Whenever such services are furnished to an individual specified in subsection (c)(3), a fee shall be charged such individual. The fee so charged shall be used to reimburse the Secretary or his delegate for the expense of providing such services.

(3) The Secretary of Labor shall enter into an agreement with the Secretary to provide prompt access for the Secretary (in accordance with this subsection) to the wage and unemployment compensation claims information and data maintained by or for the Department of Labor or State employment security agencies.

(f) The Secretary, in carrying out his duties and functions under this section, shall enter into arrangements with State agencies administering State plans approved under this part for such State agencies to accept from resident parents, legal guardians, or agents of a child described in subsection (c)(3) and to transmit to the Secretary requests for information with regard to the whereabouts of noncustodial parents and otherwise to cooperate with the Secretary in carrying out the purposes of this section.

(g) REIMBURSEMENT FOR REPORTS BY STATE AGENCIES.—The Secretary may reimburse Federal and State agencies for the costs incurred by such entities in furnishing information requested by the Secretary under this section in an amount which the Secretary determines to be reasonable payment for the information exchange (which amount shall not include payment for the costs of obtaining, compiling, or maintaining the information).

(h) FEDERAL CASE REGISTRY OF CHILD SUPPORT ORDERS.—

(1) IN GENERAL.—Not later than October 1, 1998, in order to assist States in administering programs under State plans approved under this part and programs funded under part A, and for the other purposes specified in this section, the Secretary shall establish and maintain in the Federal Parent Locator Service an automated registry (which shall be known as the

"Federal Case Registry of Child Support Orders"), which shall contain abstracts of support orders and other information described in paragraph (2) with respect to each case and order in each State case registry maintained pursuant to section 454A(e), as furnished (and regularly updated), pursuant to section 454A(f), by State agencies administering programs under this part.

(2) CASE AND ORDER INFORMATION.—The information referred to in paragraph (1) with respect to a case or an order shall be such information as the Secretary may specify in regulations (including the names, social security numbers or other uniform identification numbers, and State case identification numbers) to identify the individuals who owe or are owed support (or with respect to or on behalf of whom support obligations are sought to be established), and the State or States which have the case or order. Beginning not later than October 1, 1999, the information referred to in paragraph (1) shall include the names and social security numbers of the children of such individuals.

(3) ADMINISTRATION OF FEDERAL TAX LAWS.—The Secretary of the Treasury shall have access to the information described in paragraph (2) for the purpose of administering those sections of the Internal Revenue Code of 1986 which grant tax benefits based on support or residence of children.

(i) NATIONAL DIRECTORY OF NEW HIRES[68].—

(1) IN GENERAL.—In order to assist States in administering programs under State plans approved under this part and programs funded under part A, and for the other purposes specified in this section, the Secretary shall, not later than October 1, 1997, establish and maintain in the Federal Parent Locator Service an automated directory to be known as the National Directory of New Hires, which shall contain the information supplied pursuant to section 453A(g)(2).

(2) DATA ENTRY AND DELETION REQUIREMENTS.—

(A) IN GENERAL.—Information provided pursuant to section 453A(g)(2) shall be entered into the data base maintained by the National Directory of New Hires within two business days after receipt, and shall be deleted from the data base 24 months after the date of entry.

(B) 12–MONTH LIMIT ON ACCESS TO WAGE AND UNEMPLOYMENT COMPENSATION INFORMATION.—The Secretary shall not have access for child support enforcement purposes to information in the National Directory of New Hires that is provided pursuant to section 453A(g)(2)(B), if 12 months has elapsed since the date the information is so provided and there has not been a match resulting from the use of such information in any information comparison under this subsection.

(C) RETENTION OF DATA FOR RESEARCH PURPOSES.—Notwithstanding subparagraphs (A) and (B), the Secretary may retain such samples of data entered in the National Directory of New Hires as the Secretary may find necessary to assist in carrying out subsection (j)(5).

[68] See Vol. II, P.L. 104–193, §316(h), with respect to a requirement for cooperation in development of methods to access the various directories for new hires.

(3) ADMINISTRATION OF FEDERAL TAX LAWS.—The Secretary of the Treasury shall have access to the information in the National Directory of New Hires for purposes of administering section 32 of the Internal Revenue Code of 1986, or the advance payment of the earned income tax credit under section 3507 of such Code, and verifying a claim with respect to employment in a tax return.

(4) LIST OF MULTISTATE EMPLOYERS.—The Secretary shall maintain within the National Directory of New Hires a list of multistate employers that report information regarding newly hired employees pursuant to section 453A(b)(1)(B), and the State which each such employer has designated to receive such information.

(j) INFORMATION COMPARISONS AND OTHER DISCLOSURES.—

(1) VERIFICATION BY SOCIAL SECURITY ADMINISTRATION.—

(A) IN GENERAL.—The Secretary shall transmit information on individuals and employers maintained under this section to the Social Security Administration to the extent necessary for verification in accordance with subparagraph (B).

(B) VERIFICATION BY SSA.—The Social Security Administration shall verify the accuracy of, correct, or supply to the extent possible, and report to the Secretary, the following information supplied by the Secretary pursuant to subparagraph (A):

(i) The name, social security number, and birth date of each such individual.

(ii) The employer identification number of each such employer.

(2) INFORMATION COMPARISONS.—For the purpose of locating individuals in a paternity establishment case or a case involving the establishment, modification, or enforcement of a support order, the Secretary shall—

(A) compare information in the National Directory of New Hires against information in the support case abstracts in the Federal Case Registry of Child Support Orders not less often than every 2 business days; and

(B) within 2 business days after such a comparison reveals a match with respect to an individual, report the information to the State agency responsible for the case.

(3) INFORMATION COMPARISONS AND DISCLOSURES OF INFORMATION IN ALL REGISTRIES FOR TITLE IV PROGRAM PURPOSES.—To the extent and with the frequency that the Secretary determines to be effective in assisting States to carry out their responsibilities under programs operated under this part and programs funded under part A, the Secretary shall—

(A) compare the information in each component of the Federal Parent Locator Service maintained under this section against the information in each other such component (other than the comparison required by paragraph (2)), and report instances in which such a comparison reveals a match with respect to an individual to State agencies operating such programs; and

(B) disclose information in such components to such State agencies.

(4) PROVISION OF NEW HIRE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION.—The National Directory of New Hires shall provide the Commissioner of Social Security with all information in the National Directory.

(5) RESEARCH.—The Secretary may provide access to data in each component of the Federal Parent Locator Service maintained under this section to information reported by employers pursuant to section 453A(b) for research purposes found by the Secretary to be likely to contribute to achieving the purposes of part A or this part, but without personal identifiers.

(6) INFORMATION COMPARISONS AND DISCLOSURE FOR ENFORCEMENT OF OBLIGATIONS ON HIGHER EDUCATION ACT LOANS AND GRANTS.—

(A) FURNISHING OF INFORMATION BY THE SECRETARY OF EDUCATION.—The Secretary of Education shall furnish to the Secretary, on a quarterly basis or at such less frequent intervals as may be determined by the Secretary of Education, information in the custody of the Secretary of Education for comparison with information in the National Directory of New Hires, in order to obtain the information in such directory with respect to individuals who—

(i) are borrowers of loans made under title IV of the Higher Education Act of 1965 that are in default; or

(ii) owe an obligation to refund an overpayment of a grant awarded under such title.

(B) REQUIREMENT TO SEEK MINIMUM INFORMATION NECESSARY.—The Secretary of Education shall seek information pursuant to this section only to the extent essential to improving collection of the debt described in subparagraph (A).

(C) DUTIES OF THE SECRETARY.—

(i) INFORMATION COMPARISON; DISCLOSURE TO THE SECRETARY OF EDUCATION.—The Secretary, in cooperation with the Secretary of Education, shall compare information in the National Directory of New Hires with information in the custody of the Secretary of Education, and disclose information in that Directory to the Secretary of Education, in accordance with this paragraph, for the purposes specified in this paragraph.

(ii) CONDITION ON DISCLOSURE.—The Secretary shall make disclosures in accordance with clause (i) only to the extent that the Secretary determines that such disclosures do not interfere with the effective operation of the program under this part. Support collection under section 466(b) shall be given priority over collection of any defaulted student loan or grant overpayment against the same income.

(D) USE OF INFORMATION BY THE SECRETARY OF EDUCATION.—The Secretary of Education may use information resulting from a data match pursuant to this paragraph only—

(i) for the purpose of collection of the debt described in subparagraph (A) owed by an individual whose annualized wage level (determined by taking into con-

sideration information from the National Directory of New Hires) exceeds $16,000; and

(ii) after removal of personal identifiers, to conduct analyses of student loan defaults.

(E) DISCLOSURE OF INFORMATION BY THE SECRETARY OF EDUCATION.—

(i) DISCLOSURES PERMITTED.— The Secretary of Education may disclose information resulting from a data match pursuant to this paragraph only to—

(I) a guaranty agency holding a loan made under part B of title IV of the Higher Education Act of 1965 on which the individual is obligated;

(II) a contractor or agent of the guaranty agency described in subclause (I);

(III) a contractor or agent of the Secretary; and

(IV) the Attorney General.

(ii) Purpose of disclosure.—The Secretary of Education may make a disclosure under clause (i) only for the purpose of collection of the debts owed on defaulted student loans, or overpayments of grants, made under title IV of the Higher Education Act of 1965.

(iii) Restriction on redisclosure.—An entity to which information is disclosed under clause (i) may use or disclose such information only as needed for the purpose of collecting on defaulted student loans, or overpayments of grants, made under title IV of the Higher Education Act of 1965.

(F) REIMBURSEMENT OF HHS COSTS.—The Secretary of Education shall reimburse the Secretary, in accordance with subsection (k)(3), for the additional costs incurred by the Secretary in furnishing the information requested under this subparagraph.

(7)[69] INFORMATION COMPARISONS FOR HOUSING ASSISTANCE PROGRAMS.—

(A) FURNISHING OF INFORMATION BY HUD.—Subject to subparagraph (G), the Secretary of Housing and Urban Development shall furnish to the Secretary, on such periodic basis as determined by the Secretary of Housing and Urban Development in consultation with the Secretary, information in the custody of the Secretary of Housing and Urban Development for comparison with information in the National Directory of New Hires, in order to obtain information in such Directory with respect to individuals who are participating in any program under—

(i) the United States Housing Act of 1937 (42 U.S.C. 1437 et seq.);

(ii) section 202 of the Housing Act of 1959 (12 U.S.C. 1701q);

(iii) section 221(d)(3), 221(d)(5), or 236 of the National Housing Act (12 U.S.C. 1715l(d) and 1715z-1);

(iv) section 811 of the Cranston-Gonzalez National Affordable Housing Act (42 U.S.C. 8013); or

[69] P.L. 108-199, §217(a), added paragraph (7), effective January 23, 2004.

(v) section 101 of the Housing and Urban Development Act of 1965 (12 U.S.C. 1701s).

(B) REQUIREMENT TO SEEK MINIMUM INFORMATION.—The Secretary of Housing and Urban Development shall seek information pursuant to this section only to the extent necessary to verify the employment and income of individuals described in subparagraph (A).

(C) DUTIES OF THE SECRETARY.—

(i) INFORMATION DISCLOSURE.—The Secretary, in cooperation with the Secretary of Housing and Urban Development, shall compare information in the National Directory of New Hires with information provided by the Secretary of Housing and Urban Development with respect to individuals described in subparagraph (A), and shall disclose information in such Directory regarding such individuals to the Secretary of Housing and Urban Development, in accordance with this paragraph, for the purposes specified in this paragraph.

(ii) CONDITION ON DISCLOSURE.—The Secretary shall make disclosures in accordance with clause (i) only to the extent that the Secretary determines that such disclosures do not interfere with the effective operation of the program under this part.

(D) USE OF INFORMATION BY HUD.—The Secretary of Housing and Urban Development may use information resulting from a data match pursuant to this paragraph only—

(i) for the purpose of verifying the employment and income of individuals described in subparagraph (A); and

(ii) after removal of personal identifiers, to conduct analyses of the employment and income reporting of individuals described in subparagraph (A).

(E) DISCLOSURE OF INFORMATION BY HUD.—

(i) PURPOSE OF DISCLOSURE.—The Secretary of Housing and Urban Development may make a disclosure under this subparagraph only for the purpose of verifying the employment and income of individuals described in subparagraph (A).

(ii) DISCLOSURES PERMITTED.—Subject to clause (iii), the Secretary of Housing and Urban Development may disclose information resulting from a data match pursuant to this paragraph only to a public housing agency, the Inspector General of the Department of Housing and Urban Development, and the Attorney General in connection with the administration of a program described in subparagraph (A). Information obtained by the Secretary of Housing and Urban Development pursuant to this paragraph shall not be made available under section 552 of title 5, United States Code.

(iii) CONDITIONS ON DISCLOSURE.—Disclosures under this paragraph shall be—

(I) made in accordance with data security and control policies established by the Secretary of

Housing and Urban Development and approved by the Secretary;

(II) subject to audit in a manner satisfactory to the Secretary; and

(III) subject to the sanctions under subsection (l)(2).

(iv) ADDITIONAL DISCLOSURES.—

(I) Determination by secretaries.—The Secretary of Housing and Urban Development and the Secretary shall determine whether to permit disclosure of information under this paragraph to persons or entities described in subclause (II), based on an evaluation made by the Secretary of Housing and Urban Development (in consultation with and approved by the Secretary), of the costs and benefits of disclosures made under clause (ii) and the adequacy of measures used to safeguard the security and confidentiality of information so disclosed.

(II) PERMITTED PERSONS OR ENTITIES.—If the Secretary of Housing and Urban Development and the Secretary determine pursuant to subclause (I) that disclosures to additional persons or entities shall be permitted, information under this paragraph may be disclosed by the Secretary of Housing and Urban Development to a private owner, a management agent, and a contract administrator in connection with the administration of a program described in subparagraph (A), subject to the conditions in clause (iii) and such additional conditions as agreed to by the Secretaries.

(v) RESTRICTIONS ON REDISCLOSURE.—A person or entity to which information is disclosed under this subparagraph may use or disclose such information only as needed for verifying the employment and income of individuals described in subparagraph (A), subject to the conditions in clause (iii) and such additional conditions as agreed to by the Secretaries.

(F) REIMBURSEMENT OF HHS COSTS.—The Secretary of Housing and Urban Development shall reimburse the Secretary, in accordance with subsection (k)(3), for the costs incurred by the Secretary in furnishing the information requested under this paragraph.

(G) CONSENT.—The Secretary of Housing and Urban Development shall not seek, use, or disclose information under this paragraph relating to an individual without the prior written consent of such individual (or of a person legally authorized to consent on behalf of such individual).

(7)[70] INFORMATION COMPARISONS AND DISCLOSURE TO ASSIST IN FEDERAL DEBT COLLECTION.—

(A) FURNISHING OF INFORMATION BY THE SECRETARY OF THE TREASURY.—The Secretary of the Treasury shall furnish to the Secretary, on such periodic basis as determined

[70] P.L. 108-447, §643, added this second paragraph (7), effective December 8, 2004.

by the Secretary of the Treasury in consultation with the Secretary, information in the custody of the Secretary of the Treasury for comparison with information in the National Directory of New Hires, in order to obtain information in such Directory with respect to persons—

(i) who owe delinquent nontax debt to the United States; and

(ii) whose debt has been referred to the Secretary of the Treasury in accordance with 31 U.S.C. 3711(g).

(B) REQUIREMENT TO SEEK MINIMUM INFORMATION.—The Secretary of the Treasury shall seek information pursuant to this section only to the extent necessary to improve collection of the debt described in subparagraph (A).

(C) DUTIES OF THE SECRETARY.—

(i) INFORMATION DISCLOSURE.—The Secretary, in cooperation with the Secretary of the Treasury, shall compare information in the National Directory of New Hires with information provided by the Secretary of the Treasury with respect to persons described in subparagraph (A) and shall disclose information in such Directory regarding such persons to the Secretary of the Treasury in accordance with this paragraph, for the purposes specified in this paragraph. Such comparison of information shall not be considered a matching program as defined in 5 U.S.C. 552a.

(ii) CONDITION ON DISCLOSURE.—The Secretary shall make disclosures in accordance with clause (i) only to the extent that the Secretary determines that such disclosures do not interfere with the effective operation of the program under this part. Support collection under section 466(b) of this title shall be given priority over collection of any delinquent Federal nontax debt against the same income.

(D) USE OF INFORMATION BY THE SECRETARY OF THE TREASURY.—The Secretary of the Treasury may use information provided under this paragraph only for purposes of collecting the debt described in subparagraph (A).

(E) DISCLOSURE OF INFORMATION BY THE SECRETARY OF THE TREASURY.—

(i) PURPOSE OF DISCLOSURE.—The Secretary of the Treasury may make a disclosure under this subparagraph only for purposes of collecting the debt described in subparagraph (A).

(ii) DISCLOSURES PERMITTED.—Subject to clauses (iii) and (iv), the Secretary of the Treasury may disclose information resulting from a data match pursuant to this paragraph only to the Attorney General in connection with collecting the debt described in subparagraph (A).

(iii) CONDITIONS ON DISCLOSURE.—Disclosures under this subparagraph shall be—

(I) made in accordance with data security and control policies established by the Secretary of the Treasury and approved by the Secretary;

(II) subject to audit in a manner satisfactory to the Secretary; and

(III) subject to the sanctions under subsection (l)(2).

(iv) ADDITIONAL DISCLOSURES.—

(I) DETERMINATION BY SECRETARIES.—The Secretary of the Treasury and the Secretary shall determine whether to permit disclosure of information under this paragraph to persons or entities described in subclause (II), based on an evaluation made by the Secretary of the Treasury (in consultation with and approved by the Secretary), of the costs and benefits of such disclosures and the adequacy of measures used to safeguard the security and confidentiality of information so disclosed.

(II) PERMITTED PERSONS OR ENTITIES.—If the Secretary of the Treasury and the Secretary determine pursuant to subclause (I) that disclosures to additional persons or entities shall be permitted, information under this paragraph may be disclosed by the Secretary of the Treasury, in connection with collecting the debt described in subparagraph (A), to a contractor or agent of either Secretary and to the Federal agency that referred such debt to the Secretary of the Treasury for collection, subject to the conditions in clause (iii) and such additional conditions as agreed to by the Secretaries.

(v) RESTRICTIONS ON REDISCLOSURE.—A person or entity to which information is disclosed under this subparagraph may use or disclose such information only as needed for collecting the debt described in subparagraph (A), subject to the conditions in clause (iii) and such additional conditions as agreed to by the Secretaries.

(F) REIMBURSEMENT OF HHS COSTS.—The Secretary of the Treasury shall reimburse the Secretary, in accordance with subsection (k)(3), for the costs incurred by the Secretary in furnishing the information requested under this paragraph. Any such costs paid by the Secretary of the Treasury shall be considered costs of implementing 31 U.S.C. 3711(g) in accordance with 31 U.S.C. 3711(g)(6) and may be paid from the account established pursuant to 31 U.S.C. 3711(g)(7).

(8)[71] INFORMATION COMPARISONS AND DISCLOSURE TO ASSIST IN ADMINISTRATION OF UNEMPLOYMENT COMPENSATION PROGRAMS.—

(A) IN GENERAL.—If, for purposes of administering an unemployment compensation program under Federal or State law, a State agency responsible for the administration of such program transmits to the Secretary the names and social security account numbers of individuals, the Secretary shall disclose to such State agency information on such individuals and their employers maintained in the

[71] P.L. 108-295, §3, added paragraph (8), effective August 4, 2004.

National Directory of New Hires, subject to this paragraph.

(B) CONDITION ON DISCLOSURE BY THE SECRETARY.—The Secretary shall make a disclosure under subparagraph (A) only to the extent that the Secretary determines that the disclosure would not interfere with the effective operation of the program under this part.

(C) USE AND DISCLOSURE OF INFORMATION BY STATE AGENCIES.—

(i) IN GENERAL.—A State agency may not use or disclose information provided under this paragraph except for purposes of administering a program referred to in subparagraph (A).

(ii) INFORMATION SECURITY.—The State agency shall have in effect data security and control policies that the Secretary finds adequate to ensure the security of information obtained under this paragraph and to ensure that access to such information is restricted to authorized persons for purposes of authorized uses and disclosures.

(iii) PENALTY FOR MISUSE OF INFORMATION.—An officer or employee of the State agency who fails to comply with this subparagraph shall be subject to the sanctions under subsection (l)(2) to the same extent as if such officer or employee was an officer or employee of the United States.

(D) PROCEDURAL REQUIREMENTS.—State agencies requesting information under this paragraph shall adhere to uniform procedures established by the Secretary governing information requests and data matching under this paragraph.

(E) REIMBURSEMENT OF COSTS.—The State agency shall reimburse the Secretary, in accordance with subsection (k)(3), for the costs incurred by the Secretary in furnishing the information requested under this paragraph.

(k) FEES.—

(1) FOR SSA VERIFICATION.—The Secretary shall reimburse the Commissioner of Social Security, at a rate negotiated between the Secretary and the Commissioner, for the costs incurred by the Commissioner in performing the verification services described in subsection (j).

(2) FOR INFORMATION FROM STATE DIRECTORIES OF NEW HIRES.—The Secretary shall reimburse costs incurred by State directories of new hires in furnishing information as required by section 453A(g)(2), at rates which the Secretary determines to be reasonable (which rates shall not include payment for the costs of obtaining, compiling, or maintaining such information).

(3) FOR INFORMATION FURNISHED TO STATE AND FEDERAL AGENCIES.—A State or Federal agency that receives information from the Secretary pursuant to this section shall reimburse the Secretary for costs incurred by the Secretary in furnishing the information, at rates which the Secretary determines to be reasonable (which rates shall include payment for the costs of obtaining, verifying, maintaining, and comparing the information).

(l) RESTRICTION ON DISCLOSURE AND USE.—

(1) IN GENERAL.—Information in the Federal Parent Locator Service, and information resulting from comparisons using such information, shall not be used or disclosed except as expressly provided in this section, subject to section 6103 of the Internal Revenue Code of 1986.

(2) PENALTY FOR MISUSE OF INFORMATION IN THE NATIONAL DIRECTORY OF NEW HIRES.—The Secretary shall require the imposition of an adminstrative penalty (up to and including dismissal from employment), and a fine of $1,000, for each act of unauthorized access to, disclosure of, or use of, information in the National Directory of New Hires established under subsection (i) by any officer or employee of the United States who knowingly and willfully violates this paragraph.

(m) INFORMATION INTEGRITY AND SECURITY.—The Secretary shall establish and implement safeguards with respect to the entities established under this section designed to—

(1) ensure the accuracy and completeness of information in the Federal Parent Locator Service; and

(2) restrict access to confidential information in the Federal Parent Locator Service to authorized persons, and restrict use of such information to authorized purposes.

(n) FEDERAL GOVERNMENT REPORTING.—Each department, agency, and instrumentality of the United States shall on a quarterly basis report to the Federal Parent Locator Service the name and social security number of each employee and the wages paid to the employee during the previous quarter, except that such a report shall not be filed with respect to an employee of a department, agency, or instrumentality performing intelligence or counter–intelligence functions, if the head of such department, agency, or instrumentality has determined that filing such a report could endanger the safety of the employee or compromise an ongoing investigation or intelligence mission.

(o) USE OF SET–ASIDE FUNDS.—Out of any money in the Treasury of the United States not otherwise appropriated, there is hereby appropriated to the Secretary for each fiscal year an amount equal to 2 percent of the total amount paid to the Federal government pursuant to a plan approved under this part during the immediately preceding fiscal year (as determined on the basis of the most recent reliable data available to the Secretary as of the end of the third calendar quarter following the end of such preceding fiscal year), which shall be available for use by the Secretary, either directly or through grants, contracts, or interagency agreements, for operation of the Federal Parent Locator Service under this section, to the extent such costs are not recovered through user fees. Amounts appropriated under this subsection for each of fiscal years 1997 through 2001 shall remain available until expended.

(p) SUPPORT ORDER DEFINED.—As used in this part, the term "support order" means a judgment, decree, or order, whether temporary, final, or subject to modification, issued by a court or an administrative agency of competent jurisdiction, for the support and maintenance of a child, including a child who has attained the age of majority under the law of the issuing State, or of the parent with whom the child is living, which provides for monetary support, health care, arrearages, or reimbursement, and which may include

related costs and fees, interest and penalties, income withholding, attorneys' fees, and other relief.

STATE DIRECTORY OF NEW HIRES [72]

SEC. 453A. [42 U.S.C. 653a] (a) ESTABLISHMENT.—

(1) IN GENERAL.—

(A) REQUIREMENT FOR STATES THAT HAVE NO DIRECTORY.—Except as provided in subparagraph (B), not later than October 1, 1997, each State shall establish an automated directory (to be known as the "State Directory of New Hires") which shall contain information supplied in accordance with subsection (b) by employers on each newly hired employee.

(B) STATES WITH NEW HIRE REPORTING LAW IN EXISTENCE.—A State which has a new hire reporting law in existence on the date of the enactment of this section may continue to operate under the State law, but the State must meet the requirements of subsection (g)(2) not later than October 1, 1997, and the requirements of this section (other than subsection (g)(2)) not later than October 1, 1998.

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

(A) EMPLOYEES.—The term "employee"—

(i) means an individual who is an employee within the meaning of chapter 24 of the Internal Revenue Code of 1986; and

(ii) does not include an employee of a Federal or State agency performing intelligence or counterintelligence functions, if the head of such agency has determined that reporting pursuant to paragraph (1) with respect to the employee could endanger the safety of the employee or compromise an ongoing investigation or intelligence mission.

(B) EMPLOYER.—

(i) IN GENERAL.—The term "employer" has the meaning given such term in section 3401(d) of the Internal Revenue Code of 1986 and includes any governmental entity and any labor organization.

(ii) LABOR ORGANIZATION.—The term "labor organization" shall have the meaning given such term in section 2(5) of the National Labor Relations Act, and includes any entity (also known as a "hiring hall") which is used by the organization and an employer to carry out requirements described in section 8(f)(3) of such Act of an agreement between the organization and the employer.

(b) EMPLOYER INFORMATION.—

(1) REPORTING REQUIREMENT.—

(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), each employer shall furnish to the Directory of New Hires of the State in which a newly hired employee works, a report that contains the name, address, and social security number of the employee, and the name and ad-

[72] See Vol. II, P.L. 104–193, §316(h), with respect to a requirement for cooperation in development of methods to access the various directories of new hires.

dress of, and identifying number assigned under section 6109 of the Internal Revenue Code of 1986 to, the employer.

(B) MULTISTATE EMPLOYERS.—An employer that has employees who are employed in 2 or more States and that transmits reports magnetically or electronically may comply with subparagraph (A) by designating 1 State in which such employer has employees to which the employer will transmit the report described in subparagraph (A), and transmitting such report to such State. Any employer that transmits reports pursuant to this subparagraph shall notify the Secretary in writing as to which State such employer designates for the purpose of sending reports.

(C) FEDERAL GOVERNMENT EMPLOYERS.—Any department, agency, or instrumentality of the United States shall comply with subparagraph (A) by transmitting the report described in subparagraph (A) to the National Directory of New Hires established pursuant to section 453.

(2) TIMING OF REPORT.—Each State may provide the time within which the report required by paragraph (1) shall be made with respect to an employee, but such report shall be made—

(A) not later than 20 days after the date the employer hires the employee; or

(B) in the case of an employer transmitting reports magnetically or electronically, by 2 monthly transmissions (if necessary) not less than 12 days nor more than 16 days apart.

(c) REPORTING FORMAT AND METHOD.—Each report required by subsection (b) shall be made on a W–4 form or, at the option of the employer, an equivalent form, and may be transmitted by 1st class mail, magnetically, or electronically.

(d) CIVIL MONEY PENALTIES ON NONCOMPLYING EMPLOYERS.—The State shall have the option to set a State civil money penalty which shall not exceed—

(1) $25 per failure to meet the requirements of this section with respect to a newly hired employee; or

(2) $500 if, under State law, the failure is the result of a conspiracy between the employer and the employee to not supply the required report or to supply a false or incomplete report.

(e) ENTRY OF EMPLOYER INFORMATION.—Information shall be entered into the data base maintained by the State Directory of New Hires within 5 business days of receipt from an employer pursuant to subsection (b).

(f) INFORMATION COMPARISONS.—

(1) IN GENERAL.—Not later than May 1, 1998, an agency designated by the State shall, directly or by contract, conduct automated comparisons of the social security numbers reported by employers pursuant to subsection (b) and the social security numbers appearing in the records of the State case registry for cases being enforced under the State plan.

(2) NOTICE OF MATCH.—When an information comparison conducted under paragraph (1) reveals a match with respect to the social security number of an individual required to provide support under a support order, the State Directory of New Hires shall provide the agency administering the State plan

approved under this part of the appropriate State with the name, address, and social security number of the employee to whom the social security number is assigned, and the name and address of, and identifying number assigned under section 6109 of the Internal Revenue Code of 1986[73] to, the employer.

(g) TRANSMISSION OF INFORMATION.—

(1) TRANSMISSION OF WAGE WITHHOLDING NOTICES TO EMPLOYERS.—Within 2 business days after the date information regarding a newly hired employee is entered into the State Directory of New Hires, the State agency enforcing the employee's child support obligation shall transmit a notice to the employer of the employee directing the employer to withhold from the income of the employee an amount equal to the monthly (or other periodic) child support obligation (including any past due support obligation) of the employee, unless the employee's income is not subject to withholding pursuant to section 466(b)(3).

(2) TRANSMISSIONS TO THE NATIONAL DIRECTORY OF NEW HIRES.—

(A) NEW HIRE INFORMATION.—Within 3 business days after the date information regarding a newly hired employee is entered into the State Directory of New Hires, the State Directory of New Hires shall furnish the information to the National Directory of New Hires.

(B) WAGE AND UNEMPLOYMENT COMPENSATION INFORMATION.—The State Directory of New Hires shall, on a quarterly basis, furnish to the National Directory of New Hires information concerning the wages and unemployment compensation paid to individuals, by such dates, in such format, and containing such information as the Secretary of Health and Human Services shall specify in regulations.

(3) BUSINESS DAY DEFINED.—As used in this subsection, the term "business day" means a day on which State offices are open for regular business.

(h) OTHER USES OF NEW HIRE INFORMATION.—

(1) LOCATION OF CHILD SUPPORT OBLIGORS.—The agency administering the State plan approved under this part shall use information received pursuant to subsection (f)(2) to locate individuals for purposes of establishing paternity and establishing, modifying, and enforcing child support obligations, and may disclose such information to any agent of the agency that is under contract with the agency to carry out such purposes.

(2) VERIFICATION OF ELIGIBILITY FOR CERTAIN PROGRAMS.—A State agency responsible for administering a program specified in section 1137(b) shall have access to information reported by employers pursuant to subsection (b) of this section for purposes of verifying eligibility for the program.

(3) ADMINISTRATION OF EMPLOYMENT SECURITY AND WORKERS' COMPENSATION.—State agencies operating employment security and workers' compensation programs shall have access to information reported by employers pursuant to subsection (b) for the purposes of administering such programs.

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[73] See Vol. II, P.L. 83-591, §6109.

STATE PLAN FOR CHILD AND SPOUSAL SUPPORT

SEC. 454. [42 U.S.C. 654] A State plan for child and spousal support must—

(1) provide that it shall be in effect in all political subdivisions of the State;

(2) provide for financial participation by the State;

(3) provide for the establishment or designation of a single and separate organizational unit, which meets such staffing and organizational requirements as the Secretary may by regulation prescribe, within the State to administer the plan;

(4) provide that the State will—

(A) provide services relating to the establishment of paternity or the establishment, modification, or enforcement of child support obligations, as appropriate, under the plan with respect to—

(i) each child for whom (I) assistance is provided under the State program funded under part A of this title, (II) benefits or services for foster care maintenance are provided under the State program funded under part E of this title, (III) medical assistance is provided under the State plan approved under title XIX, or (IV) cooperation is required pursuant to section 6(l)(1) of the Food Stamp Act of 1977 (7 U.S.C. 2015(l)(1))[74], unless, in accordance with paragraph (29), good cause or other exceptions exist;

(ii) any other child, if an individual applies for such services with respect to the child; and

(B) enforce any support obligation established with respect to—

(i) a child with respect to whom the State provides services under the plan; or

(ii) the custodial parent of such a child;

(5) provide that (A) in any case in which support payments are collected for an individual with respect to whom an assignment pursuant to section 408(a)(3) is effective, such payments shall be made to the State for distribution pursuant to section 457 and shall not be paid directly to the family, and the individual will be notified on a monthly basis (or on a quarterly basis for so long as the Secretary determines with respect to a State that requiring such notice on a monthly basis would impose an unreasonable administrative burden) of the amount of the support payments collected, and (B) in any case in which support payments are collected for an individual pursuant to the assignment made under section 1912, such payments shall be made to the State for distribution pursuant to section 1912, except that this clause shall not apply to such payments for any month after the month in which the individual ceases to be eligible for medical assistance;

(6) provide that—

(A) services under the plan shall be made available to residents of other States on the same terms as to residents of the State submitting the plan;

(B) an application fee for furnishing such services shall be imposed on an individual, other than an individual re-

[74] See Vol. II, P.L. 78-410 §6.

ceiving assistance under a State program funded under part A or E, or under a State plan approved under title XIX, or who is required by the State to cooperate with the State agency administering the program under this part pursuant to subsection (l) or (m) of section 6 of the Food Stamp Act of 1977[75], and shall be paid by the individual applying for such services, or recovered from the absent parent, or paid by the State out of its own funds (the payment of which from State funds shall not be considered as an administrative cost of the State for the operation of the plan, and shall be considered income to the program), the amount of which (i) will not exceed $25 (or such higher or lower amount (which shall be uniform for all States) as the Secretary may determine to be appropriate for any fiscal year to reflect increases or decreases in administrative costs), and (ii) may vary among such individuals on the basis of ability to pay (as determined by the State);

(C) a fee of not more than $25 may be imposed in any case where the State requests the Secretary of the Treasury to withhold past-due support owed to or on behalf of such individual from a tax refund pursuant to section 464(a)(2);

(D) a fee (in accordance with regulations of the Secretary) for performing genetic tests may be imposed on any individual who is not a recipient of assistance under a State program funded under part A, and

(E) any costs in excess of the fees so imposed may be collected—

(i) from the parent who owes the child or spousal support obligation involved;, or

(ii) at the option of the State, from the individual to whom such services are made available, but only if such State has in effect a procedure whereby all persons in such State having authority to order child or spousal support are informed that such costs are to be collected from the individual to whom such services were made available;[76]

(7) provide for entering into cooperative arrangements with appropriate courts and law enforcement officials and Indian tribes or tribal organizations (as defined in subsections (e) and (l) of section 4 of the Indian Self–Determination and Education Assistance Act (25 U.S.C. 450B)[77]) (A) to assist the agency administering the plan, including the entering into of financial arrangements with such courts and officials in order to assure optimum results under such program, and (B) with respect to any other matters of common concern to such courts or officials and the agency administering the plan;

(8) provide that, for the purpose of establishing parentage, establishing, setting the amount of, modifying, or enforcing child support obligations, or making or enforcing a child custody or visitation determination, as defined in section 463(d)(1)

[75] See Vol. II, P.L. 88-525, §§6(l) and (m).

[76] See Vol. II, 31 U.S.C. 9701, with respect to fees and charges for Government services and things of value.

[77] See Vol. II, P.L. 94-437, §4.

the agency administering the plan will establish a service to locate parents utilizing—

(A) all sources of information and available records; and

(B) the Federal Parent Locator Service established under section 453,

and shall, subject to the privacy safeguards required under paragraph (26), disclose only the information described in sections 453 and 463 to the authorized persons specified in such sections for the purpose specified in such sections;

(9) provide that the State will, in accordance with standards prescribed by the Secretary, cooperate with any other State—

(A) in establishing paternity, if necessary,

(B) in locating a noncustodial parent residing in the State (whether or not permanently) against whom any action is being taken under a program established under a plan approved under this part in another State,

(C) in securing compliance by a noncustodial parent residing in such State (whether or not permanently) with an order issued by a court of competent jurisdiction against such parent for the support and maintenance of the child or children or the parent of such child or children with respect to whom aid is being provided under the plan of such other State;

(D) in carrying out other functions required under a plan approved under this part;

(E) not later than March 1, 1997, in using the forms promulgated pursuant to section 452(a)(11) for income withholding, imposition of liens, and issuance of administrative subpoenas in interstate child support cases;

(10) provide that the State will maintain a full record of collections and disbursements made under the plan and have an adequate reporting system;

(11)(A) provide that amounts collected as support shall be distributed as provided in section 457; and

(B) provide that any payment required to be made under section 456 or 457 to a family shall be made to the resident parent, legal guardian, or caretaker relative having custody of or responsibility for the child or children;

(12) provide for the establishment of procedures to require the State to provide individuals who are applying for or receiving services under the State plan, or who are parties to cases in which services are being provided under the State plan—

(A) with notice of all proceedings in which support obligations might be established or modified; and

(B) with a copy of any order establishing or modifying a child support obligation, or (in the case of a petition for modification) a notice of determination that there should be no change in the amount of the child support award, within 14 days after issuance of such order or determination;

(13) provide that the State will comply with such other requirements and standards as the Secretary determines to be necessary to the establishment of an effective program for locating noncustodial parents, establishing paternity, obtaining support orders, and collecting support payments and provide that information requests by parents who are residents of

other States be treated with the same priority as requests by parents who are residents of the State submitting the plan;

(14)(A) comply with such bonding requirements, for employees who receive, disburse, handle, or have access to, cash, as the Secretary shall by regulations prescribe;[78]

(B) maintain methods of administration which are designed to assure that persons responsible for handling cash receipts shall not participate in accounting or operating functions which would permit them to conceal in the accounting records the misuse of cash receipts (except that the Secretary shall by regulations provide for exceptions to this requirement in the case of sparsely populated areas where the hiring of unreasonable additional staff would otherwise be necessary);

(15) provide for—

(A) a process for annual reviews of and reports to the Secretary on the State program operated under the State plan approved under this part, including such information as may be necessary to measure State compliance with Federal requirements for expedited procedures, using such standards and procedures as are required by the Secretary, under which the State agency will determine the extent to which the program is operated in compliance with this part; and

(B) a process of extracting from the automated data processing system required by paragraph (16) and transmitting to the Secretary data and calculations concerning the levels of accomplishment (and rates of improvement) with respect to applicable performance indicators (including paternity establishment percentages) to the extent necessary for purposes of sections 452(g) and 458;

(16) provide for the establishment and operation by the State agency, in accordance with an (initial and annually updated) advance automated data processing planning document approved under section 452(d), of a statewide automated data processing and information retrieval system meeting the requirements of section 454A designed effectively and efficiently to assist management in the administration of the State plan, so as to control, account for, and monitor all the factors in the support enforcement collection and paternity determination process under such plan;

(17) provide that the State will have in effect an agreement with the Secretary entered into pursuant to section 463 for the use of the Parent Locator Service established under section 453 and, provide that the State will accept and transmit to the Secretary requests for information authorized under the provisions of the agreement to be furnished by such Service to authorized persons, will impose and collect (in accordance with regulations of the Secretary) a fee sufficient to cover the costs to the State and to the Secretary incurred by reason of such requests, will transmit to the Secretary from time to time (in accordance with such regulations) so much of the fees collected as are attributable to such costs to the Secretary so incurred, and during the period that such agreement is in effect will otherwise

[78] See Vol. II, 31 U.S.C. 9309, with respect to priority of sureties.

comply with such agreement and regulations of the Secretary with respect thereto;

(18) provide that the State has in effect procedures necessary to obtain payment of past-due support from overpayments made to the Secretary of the Treasury as set forth in section 464, and take all steps necessary to implement and utilize such procedures;

(19) provide that the agency administering the plan—

(A) shall determine on a periodic basis, from information supplied pursuant to section 508 of the Unemployment Compensation Amendments of 1976[79] , whether any individuals receiving compensation under the State's unemployment compensation law (including amounts payable pursuant to any agreement under any Federal unemployment compensation law) owe child support obligations which are being enforced by such agency; and

(B) shall enforce any such child support obligations which are owed by such an individual but are not being met—

(i) through an agreement with such individual to have specified amounts withheld from compensation otherwise payable to such individual and by submitting a copy of any such agreement to the State agency administering the unemployment compensation law;

(ii) in the absence of such an agreement, by bringing legal process (as defined in section 459(i)(5) of this Act) to require the withholding of amounts from such compensation;

(20) provide, to the extent required by section 466, that the State (A) shall have in effect all of the laws to improve child support enforcement effectiveness which are referred to in that section, and (B) shall implement the procedures which are prescribed in or pursuant to such laws;

(21)(A) at the option of the State, impose a late payment fee on all overdue support (as defined in section 466(e)) under any obligation being enforced under this part, in an amount equal to a uniform percentage determined by the State (not less than 3 percent nor more than 6 percent) of the overdue support, which shall be payable by the noncustodial parent owing the overdue support; and

(B) assure that the fee will be collected in addition to, and only after full payment of, the overdue support, and that the imposition of the late payment fee shall not directly or indirectly result in a decrease in the amount of the support which is paid to the child (or spouse) to whom, or on whose behalf, it is owed;

(22) in order for the State to be eligible to receive any incentive payments under section 458, provide that, if one or more political subdivisions of the State participate in the costs of carrying out activities under the State plan during any period, each such subdivision shall be entitled to receive an appropriate share (as determined by the State) of any such incentive payments made to the State for such period, taking into ac-

[79] See Vol II, P.L. 94–566.

count the efficiency and effectiveness of the activities carried out under the State plan by such political subdivision;

(23) provide that the State will regularly and frequently publicize, through public service announcements, the availability of child support enforcement services under the plan and otherwise, including information as to any application fees for such services and a telephone number or postal address at which further information may be obtained and will publicize the availability and encourage the use of procedures for voluntary establishment of paternity and child support by means the State deems appropriate;

(24) provide that the State will have in effect an automated data processing and information retrieval system—

(A) by October 1, 1997, which meets all requirements of this part which were enacted on or before the date of enactment of the Family Support Act of 1988,

(B) by October 1, 2000, which meets all requirements of this part enacted on or before the date of the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996[80], except that such deadline shall be extended by 1 day for each day (if any) by which the Secretary fails to meet the deadline imposed by section 344(a)(3) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996;

(25) provide that if a family with respect to which services are provided under the plan ceases to receive assistance under the State program funded under part A, the State shall provide appropriate notice to the family and continue to provide such services, subject to the same conditions and on the same basis as in the case of other individuals to whom services are furnished under the plan, except that an application or other request to continue services shall not be required of such a family and paragraph (6)(B) shall not apply to the family;

(26) have in effect safeguards, applicable to all confidential information handled by the State agency, that are designed to protect the privacy rights of the parties, including—

(A) safeguards against unauthorized use or disclosure of information relating to proceedings or actions to establish paternity, or to establish, modify or enforce support, or to make or enforce a child custody determination;

(B) prohibitions against the release of information on the whereabouts of 1 party or the child to another party against whom a protective order with respect to the former party or the child has been entered;

(C) prohibitions against the release of information on the whereabouts of 1 party or the child to another person if the State has reason to believe that the release of the information may to that person result in physical or emotional harm to the party or the child;

(D) in cases in which the prohibitions under subparagraphs (B) and (C) apply, the requirement to notify the Secretary, for purposes of section 453(b)(2), that the State has reasonable evidence of domestic violence or child abuse

[80] August 22, 1996 [P.L. 104–193, 110 Stat. 2105].

against a party or the child and that the disclosure of such information could be harmful to the party or the child; and

(E) procedures providing that when the Secretary discloses information about a parent or child to a State court or an agent of a State court described in section 453(c)(2) or 463(d)(2)(B), and advises that court or agent that the Secretary has been notified that there is reasonable evidence of domestic violence or child abuse pursuant to section 453(b)(2), the court shall determine whether disclosure to any other person of information received from the Secretary could be harmful to the parent or child and, if the court determines that disclosure to any other person could be harmful, the court and its agents shall not make any such disclosure;

(27) provide that, on and after October 1, 1998, the State agency will—

(A) operate a State disbursement unit in accordance with section 454B; and

(B) have sufficient State staff (consisting of State employees) and (at State option) contractors reporting directly to the State agency to—

(i) monitor and enforce support collections through the unit in cases being enforced by the State pursuant to section 454(4) (including carrying out the automated data processing responsibilities described in section 454A(g)); and

(ii) take the actions described in section 466(c)(1) in appropriate cases;

(28) provide that, on and after October 1, 1997, the State will operate a State Directory of New Hires in accordance with section 453A;

(29) provide that the State agency responsible for administering the State plan—

(A) shall make the determination (and redetermination at appropriate intervals) as to whether an individual who has applied for or is receiving assistance under the State program funded under part A, the State program under part E, the State program under title XIX, or the food stamp program, as defined under section 3(h) of the Food Stamp Act of 1977 (7 U.S.C. 2012(h)[81]), is cooperating in good faith with the State in establishing the paternity of, or in establishing, modifying, or enforcing a support order for, any child of the individual by providing the State agency with the name of, and such other information as the State agency may require with respect to, the noncustodial parent of the child, subject to good cause and other exceptions which—

(i) in the case of the State program funded under part A, the State program under part E, or the State program under title XIX shall, at the option of the State, be defined, taking into account the best interests of the child, and applied in each case, by the State agency administering such program; and

[81] See Vol. II, P.L. 88-525, §3(h).

(ii) in the case of the food stamp program, as defined under section 3(h) of the Food Stamp Act of 1977 (7 U.S.C. 2012(h)), shall be defined and applied in each case under that program in accordance with section 6(l)(2) of the Food Stamp Act of 1977 (7 U.S.C. 2015(l)(2))[82];

(B) shall require the individual to supply additional necessary information and appear at interviews, hearings, and legal proceedings;

(C) shall require the individual and the child to submit to genetic tests pursuant to judicial or administrative order;

(D) may request that the individual sign a voluntary acknowledgment of paternity, after notice of the rights and consequences of such an acknowledgment, but may not require the individual to sign an acknowledgment or otherwise relinquish the right to genetic tests as a condition of cooperation and eligibility for assistance under the State program funded under part A, the State program under part E, the State program under title XIX, or the food stamp program, as defined under section 3(h) of the Food Stamp Act of 1977 (7 U.S.C. 2012(h)); and

(E) shall promptly notify the individual and the State agency administering the State program funded under part A, the State agency administering the State program under part E, the State agency administering the State program under title XIX, or the State agency administering the food stamp program, as defined under section 3(h) of the Food Stamp Act of 1977 (7 U.S.C. 2012(h)), of each such determination, and if noncooperation is determined, the basis therefor;

(30) provide that the State shall use the definitions established under section 452(a)(5) in collecting and reporting information as required under this part;

(31) provide that the State agency will have in effect a procedure for certifying to the Secretary, for purposes of the procedure under section 452(k), determinations that individuals owe arrearages of child support in an amount exceeding $5,000, under which procedure—

(A) each individual concerned is afforded notice of such determination and the consequences thereof, and an opportunity to contest the determination; and

(B) the certification by the State agency is furnished to the Secretary in such format, and accompanied by such supporting documentation, as the Secretary may require;

(32)(A) provide that any request for services under this part by a foreign reciprocating country or a foreign country with which the State has an arrangement described in section 459A(d) shall be treated as a request by a State;

(B) provide, at State option, notwithstanding paragraph (4) or any other provision of this part, for services under the plan for enforcement of a spousal support order not described in paragraph (4)(B) entered by such a country (or subdivision); and

[82] See Vol. II, P.L. 88-525.

(C) provide that no applications will be required from, and no costs will be assessed for such services against, the foreign reciprocating country or foreign obligee (but costs may at State option be assessed against the obligor); and

(33) provide that a State that receives funding pursuant to section 428 and that has within its borders Indian country (as defined in section 1151 of title 18, United States Code) may enter into cooperative agreements with an Indian tribe or tribal organization (as defined in subsections (e) and (l) of section 4 of the Indian Self–Determination and Education Assistance Act (25 U.S.C. 450b)), if the Indian tribe or tribal organization demonstrates that such tribe or organization has an established tribal court system or a Court of Indian Offenses with the authority to establish paternity, establish, modify, or enforce support orders or, and to enter support orders in accordance with child support guidelines established or adopted by such tribe or organization, under which the State and tribe or organization, under which the State and tribe or organization shall provide for the cooperative delivery of child support enforcement services in Indian country and for the forwarding of all collections pursuant to the functions performed by the tribe or organization to the State agency, or conversely, by the State agency to the tribe or organization, which shall distribute such collections in accordance with such agreement.

The State may allow the jurisdiction which makes the collection involved to retain any application fee under paragraph (6)(B) or any late payment fee under paragraph (21). Nothing in paragraph (33) shall void any provision of any cooperative agreement entered into before the date of the enactment of such paragraph, nor shall such paragraph deprive any State of jurisdiction over Indian country (as so defined) that is lawfully exercised under section 402 of the Act entitled "An Act to prescribe penalties for certain acts of violence or intimidation, and for other purposes", approved April 11, 1968 (25 U.S.C. 1322) .

AUTOMATED DATA PROCESSING

SEC. 454A. [42 U.S.C. 654a] (a) IN GENERAL.—In order for a State to meet the requirements of this section, the State agency administering the State program under this part shall have in operation a single statewide automated data processing and information retrieval system which has the capability to perform the tasks specified in this section with the frequency and in the manner required by or under this part.

(b) PROGRAM MANAGEMENT.—The automated system required by this section shall perform such functions as the Secretary may specify relating to management of the State program under this part, including—

(1) controlling and accounting for use of Federal, State, and local funds in carrying out the program; and

(2) maintaining the data necessary to meet Federal reporting requirements under this part on a timely basis.

(c) CALCULATION OF PERFORMANCE INDICATORS.—In order to enable the Secretary to determine the incentive payments and penalty adjustments required by sections 452(g) and 458, the State agency shall—

(1) use the automated system—

(A) to maintain the requisite data on State performance with respect to paternity establishment and child support enforcement in the State; and

(B) to calculate the paternity establishment percentage for the State for each fiscal year; and

(2) have in place systems controls to ensure the completeness and reliability of, and ready access to, the data described in paragraph (1)(A), and the accuracy of the calculations described in paragraph (1)(B).

(d) INFORMATION INTEGRITY AND SECURITY.—The State agency shall have in effect safeguards on the integrity, accuracy, and completeness of, access to, and use of data in the automated system required by this section, which shall include the following (in addition to such other safeguards as the Secretary may specify in regulations):

(1) POLICIES RESTRICTING ACCESS.—Written policies concerning access to data by State agency personnel, and sharing of data with other persons, which—

(A) permit access to and use of data only to the extent necessary to carry out the State program under this part; and

(B) specify the data which may be used for particular program purposes, and the personnel permitted access to such data.

(2) SYSTEMS CONTROLS.—Systems controls (such as passwords or blocking of fields) to ensure strict adherence to the policies described in paragraph (1).

(3) MONITORING OF ACCESS.—Routine monitoring of access to and use of the automated system, through methods such as audit trails and feedback mechanisms, to guard against and promptly identify unauthorized access or use.

(4) TRAINING AND INFORMATION.—Procedures to ensure that all personnel (including State and local agency staff and contractors) who may have access to or be required to use confidential program data are informed of applicable requirements and penalties (including those in section 6103 of the Internal Revenue Code of 1986[83]), and are adequately trained in security procedures.

(5) PENALTIES.—Administrative penalties (up to and including dismissal from employment) for unauthorized access to, or disclosure or use of, confidential data.

(e) STATE CASE REGISTRY.—

(1) CONTENTS.—The automated system required by this section shall include a registry (which shall be known as the "State case registry") that contains records with respect to—

(A) each case in which services are being provided by the State agency under the State plan approved under this part; and

(B) each support order established or modified in the State on or after October 1, 1998.

(2) LINKING OF LOCAL REGISTRIES.—The State case registry may be established by linking local case registries of support

[83] See Vol. II, P.L. 83–591, §6103.

orders through an automated information network, subject to this section.

(3) USE OF STANDARDIZED DATA ELEMENTS.—Such records shall use standardized data elements for both parents (such as names, social security numbers and other uniform identification numbers, dates of birth, and case identification numbers), and contain such other information (such as on case status) as the Secretary may require.

(4) PAYMENT RECORDS.—Each case record in the State case registry with respect to which services are being provided under the State plan approved under this part and with respect to which a support order has been established shall include a record of—

(A) the amount of monthly (or other periodic) support owed under the order, and other amounts (including arrearages, interest or late payment penalties, and fees) due or overdue under the order;

(B) any amount described in subparagraph (A) that has been collected;

(C) the distribution of such collected amounts;

(D) the birth date and, beginning not later than October 1, 1999, the social security number, of any child for whom the order requires the provision of support; and

(E) the amount of any lien imposed with respect to the order pursuant to section 466(a)(4).

(5) UPDATING AND MONITORING.—The State agency operating the automated system required by this section shall promptly establish and update, maintain, and regularly monitor, case records in the State case registry with respect to which services are being provided under the State plan approved under this part, on the basis of—

(A) information on administrative actions and administrative and judicial proceedings and orders relating to paternity and support;

(B) information obtained from comparison with Federal, State, or local sources of information;

(C) information on support collections and distributions; and

(D) any other relevant information.

(f) INFORMATION COMPARISONS AND OTHER DISCLOSURES OF INFORMATION.—The State shall use the automated system required by this section to extract information from (at such times, and in such standardized format or formats, as may be required by the Secretary), to share and compare information with, and to receive information from, other data bases and information necessary to enable the State agency (or the Secretary or other State or Federal agencies) to carry out this part, subject to section 6103 of the Internal Revenue Code of 1986[84]. Such information comparison activities shall include the following:

(1) FEDERAL CASE REGISTRY OF CHILD SUPPORT ORDERS.—Furnishing to the Federal Case Registry of Child Support Orders established under section 453(h) (and update as necessary, with information including notice of expiration of orders) the minimum amount of information on child support

[84] See Vol. II, P.L. 83-591, §6103.

cases recorded in the State case registry that is necessary to operate the registry (as specified by the Secretary in regulations).

(2) FEDERAL PARENT LOCATOR SERVICE.—Exchanging information with the Federal Parent Locator Service for the purposes specified in section 453.

(3) TEMPORARY FAMILY ASSISTANCE AND MEDICAID AGENCIES.—Exchanging information with State agencies (of the State and of other States) administering programs funded under part A, programs operated under a State plan approved under title XIX, and other programs designated by the Secretary, as necessary to perform State agency responsibilities under this part and under such programs.

(4) INTRASTATE AND INTERSTATE INFORMATION COMPARISONS.—Exchanging information with other agencies of the State, agencies of other States, and interstate information networks, as necessary and appropriate to carry out (or assist other States to carry out) the purposes of this part.

(5) PRIVATE INDUSTRY COUNCILS RECEIVING WELFARE–TO–WORK GRANTS.—Disclosing to a private industry council (as defined in section 403(a)(5)(D)(ii)) to which funds are provided under section 403(a)(5) the names, addresses, telephone numbers, and identifying case number information in the State program funded under part A, of noncustodial parents residing in the service delivery area of the private industry council, for the purpose of identifying and contacting noncustodial parents regarding participation in the program under section 403(a)(5).

(g) COLLECTION AND DISTRIBUTION OF SUPPORT PAYMENTS.—

(1) IN GENERAL.—The State shall use the automated system required by this section, to the maximum extent feasible, to assist and facilitate the collection and disbursement of support payments through the State disbursement unit operated under section 454B, through the performance of functions, including, at a minimum—

(A) transmission of orders and notices to employers (and other debtors) for the withholding of income—

(i) within 2 business days after receipt of notice of, and the income source subject to, such withholding from a court, another State, an employer, the Federal Parent Locator Service, or another source recognized by the State; and

(ii) using uniform formats prescribed by the Secretary;

(B) ongoing monitoring to promptly identify failures to make timely payment of support; and

(C) automatic use of enforcement procedures (including procedures authorized pursuant to section 466(c)) if payments are not timely made.

(2) BUSINESS DAY DEFINED.—As used in paragraph (1), the term "business day" means a day on which State offices are open for regular business.

(h) EXPEDITED ADMINISTRATIVE PROCEDURES.—The automated system required by this section shall be used, to the maximum extent feasible, to implement the expedited administrative procedures required by section 466(c).

COLLECTION AND DISBURSEMENT OF SUPPORT PAYMENTS

SEC. 454B. [42 U.S.C. 654b] (a) STATE DISBURSEMENT UNIT.—

(1) IN GENERAL.—In order for a State to meet the requirements of this section, the State agency must establish and operate a unit (which shall be known as the "State disbursement unit") for the collection and disbursement of payments under support orders—

(A) in all cases being enforced by the State pursuant to section 454(4); and

(B) in all cases not being enforced by the State under this part in which the support order is initially issued in the State on or after January 1, 1994, and in which the income of the noncustodial parent is subject to withholding pursuant to section 466(a)(8)(B).

(2) OPERATION.—The State disbursement unit shall be operated—

(A) directly by the State agency (or 2 or more State agencies under a regional cooperative agreement), or (to the extent appropriate) by a contractor responsible directly to the State agency; and

(B) except in cases described in paragraph (1)(B), in coordination with the automated system established by the State pursuant to section 454A.

(3) LINKING OF LOCAL DISBURSEMENT UNITS.—The State disbursement unit may be established by linking local disbursement units through an automated information network, subject to this section, if the Secretary agrees that the system will not costs more nor take more time to establish or operate than a centralized system. In addition, employers shall be given 1 location to which income withholding is sent.

(b) REQUIRED PROCEDURES.—The State disbursement unit shall use automated procedures, electronic processes, and computer–driven technology to the maximum extent feasible, efficient, and economical, for the collection and disbursement of support payments, including procedures—

(1) for receipt of payments from parents, employers, and other States, and for disbursements to custodial parents and other obligees, the State agency, and the agencies of other States;

(2) for accurate identification of payments;

(3) to ensure prompt disbursement of the custodial parent's share of any payment; and

(4) to furnish to any parent, upon request, timely information on the current status of support payments under an order requiring payments to be made by or to the parent, except that in cases described in subsection (a)(1)(B), the State disbursement unit shall not be required to convert and maintain in automated form records of payments kept pursuant to section 466(a)(8)(B)(iii) before the effective date of this section.

(c) TIMING OF DISBURSEMENTS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the State disbursement unit shall distribute all amounts payable under section 457(a) within 2 business days after receipt from the employer or other source of periodic income, if sufficient information identifying the payee is provided. The date of collection for amounts collected and distributed under this part is

the date of receipt by the State disbursement unit, except that if current support is withheld by an employer in the month when due and is received by the State disbursement unit in a month other than the month when due, the date of withholding may be deemed to be the date of collection.

(2) PERMISSIVE RETENTION OF ARREARAGES.—The State disbursement unit may delay the distribution of collections toward arrearages until the resolution of any timely appeal with respect to such arrearages.

(d) BUSINESS DAY DEFINED.—As used in this section, the term "business day" means a day on which State offices are open for regular business.

PAYMENTS TO STATES[85]

SEC. 455. [42 U.S.C. 655] (a)(1) From the sums appropriated therefor, the Secretary shall pay to each State for each quarter an amount—

(A) equal to the percent specified in paragraph (2) of the total amounts expended by such State during such quarter for the operation of the plan approved under section 454,

(B) equal to the percent specified in paragraph (3) of the sums expended during such quarter that are attributable to the planning, design, development, installation or enhancement of an automatic data processing and information retrieval system (including in such sums the full cost of the hardware components of such system), and

(C) equal to 90 percent (rather than the percentage specified in subparagraph (A)) of so much of the sums expended during such quarter as are attributable to laboratory costs incurred in determining paternity, and

(D) equal to 66 percent of the sums expended by the State during the quarter for an alternative statewide system for which a waiver has been granted under section 452(d)(3), but only to the extent that the total of the sums so expended by the State on or after the date of the enactment of this subparagraph does not exceed the least total cost estimate submitted by the State pursuant to section 452(d)(3)(C) in the request for the waiver;

except that no amount shall be paid to any State on account of amounts expended to carry out an agreement which it has entered into pursuant to section 463. In determining the total amounts expended by any State during a quarter, for purposes of this subsection, there shall be excluded an amount equal to the total of any fees collected or other income resulting from services provided under the plan approved under this part.

(2) The percent applicable to quarters in a fiscal year for purposes of paragraph (1)(A) is—

(A) 70 percent for fiscal years 1984, 1985, 1986, and 1987,

(B) 68 percent for fiscal years 1988 and 1989, and

(C) 66 percent for fiscal year 1990 and each fiscal year thereafter.

[85] See Vol. II, P.L. 99–177, Title II, "Balanced Budget and Emergency Deficit Control Act of 1985", §256 [as amended by P.L. 100–119], with respect to treatment of child enforcement program; and §257(11), with respect to references to §401(c)(2) of the "Congressional Budget Act of 1974".

(3)(A) The Secretary shall pay to each State, for each quarter in fiscal years 1996 and 1997, 90 percent of so much of the State expenditures described in paragraph (1)(B) as the Secretary finds are for a system meeting the requirements specified in section 454(16) (as in effect on September 30, 1995) but limited to the amount approved for States in the advance planning documents of such States submitted on or before September 30, 1995.

(B)(i) The Secretary shall pay to each State or system described in clause (iii), for each quarter in fiscal years 1996 through 2001, the percentage specified in clause (ii) of so much of the State or system expenditures described in paragraph (1)(B) as the Secretary finds are for a system meeting the requirements of sections 454(16) and 454A.

(ii) The percentage specified in this clause is 80 percent.

(iii) For purposes of clause (i), a system described in this clause is a system that has been approved by the Secretary to receive enhanced funding pursuant to the Family Support Act of 1988 (Public Law 100–485; 102 Stat. 2343) for the purpose of developing a system that meets the requirements of sections 454(16) (as in effect on and after September 30, 1995) and 454A, including systems that have received funding for such purpose pursuant to a waiver under section 1115(a).

(4)(A)(i) If—

(I) the Secretary determines that a State plan under section 454 would (in the absence of this paragraph) be disapproved for the failure of the State to comply with a particular subparagraph of section 454(24), and that the State has made and is continuing to make a good faith effort to so comply; and

(II) the State has submitted to the Secretary a corrective compliance plan that describes how, by when, and at what cost the State will achieve such compliance, which has been approved by the Secretary, then the Secretary shall not disapprove the State plan under section 454, and the Secretary shall reduce the amount otherwise payable to the State under paragraph (1)(A) of this subsection for the fiscal year by the penalty amount.

(ii) All failures of a State during a fiscal year to comply with any of the requirements referred to in the same subparagraph of section 454(24) shall be considered a single failure of the State to comply with that subparagraph during the fiscal year for purposes of this paragraph.

(B) In this paragraph:

(i) The term "penalty amount" means, with respect to a failure of a State to comply with a subparagraph of section 454(24)—

(I) 4 percent of the penalty base, in the case of the first fiscal year in which such a failure by the State occurs (regardless of whether a penalty is imposed under this paragraph with respect to the failure);

(II) 8 percent of the penalty base, in the case of the second such fiscal year;

(III) 16 percent of the penalty base, in the case of the third such fiscal year;

(IV) 25 percent of the penalty base, in the case of the fourth such fiscal year; or

(V) 30 percent of the penalty base, in the case of the fifth or any subsequent such fiscal year.

(ii) The term "penalty base" means, with respect to a failure of a State to comply with a subparagraph of section 454(24) during a fiscal year, the amount otherwise payable to the State under paragraph (1)(A) of this subsection for the preceding fiscal year.

(C)(i) The Secretary shall waive a penalty under this paragraph for any failure of a State to comply with section 454(24)(A) during fiscal year 1998 if—

(I) on or before August 1, 1998, the State has submitted to the Secretary a request that the Secretary certify the State as having met the requirements of such section;

(II) the Secretary subsequently provides the certification as a result of a timely review conducted pursuant to the request; and

(III) the State has not failed such a review.

(ii) If a State with respect to which a reduction is made under this paragraph for a fiscal year with respect to a failure to comply with a subparagraph of section 454(24) achieves compliance with such subparagraph by the beginning of the succeeding fiscal year, the Secretary shall increase the amount otherwise payable to the State under paragraph (1)(A) of this subsection for the succeeding fiscal year by an amount equal to 90 percent of the reduction for the fiscal year.

(iii) The Secretary shall reduce the amount of any reduction that, in the absence of this clause, would be required to be made under this paragraph by reason of the failure of a State to achieve compliance with section 454(24)(B) during the fiscal year, by an amount equal to 20 percent of the amount of the otherwise required reduction, for each State performance measure described in section 458(b)(4) with respect to which the applicable percentage under section 458(b)(6) for the fiscal year is 100 percent, if the Secretary has made the determination described in section 458(b)(5)(B) with respect to the State for the fiscal year.

(5)(A)(i) If—

(I) the Secretary determines that a State plan under section 454 would (in the absence of this paragraph) be disapproved for the failure of the State to comply with subparagraphs (A) and (B)(i) of section 454(27), and that the State has made and is continuing to make a good faith effort to so comply; and

(II) the State has submitted to the Secretary, not later than April 1, 2000, a corrective compliance plan that describes how, by when, and at what cost the State will achieve such compliance, which has been approved by the Secretary,

then the Secretary shall not disapprove the State plan under section 454, and the Secretary shall reduce the amount otherwise payable to the State under paragraph (1)(A) of this subsection for the fiscal year by the penalty amount.

(ii) All failures of a State during a fiscal year to comply with any of the requirements of section 454B shall be considered a single failure of the State to comply with subparagraphs (A) and (B)(i) of section 454(27) during the fiscal year for purposes of this paragraph.

(B) In this paragraph:

(i) The term "penalty amount" means, with respect to a failure of a State to comply with subparagraphs (A) and (B)(i) of section 454(27)—

(I) 4 percent of the penalty base, in the case of the 1st fiscal year in which such a failure by the State occurs (regardless of whether a penalty is imposed in that fiscal year under this paragraph with respect to the failure), except as provided in subparagraph (C)(ii) of this paragraph;

(II) 8 percent of the penalty base, in the case of the 2nd such fiscal year;

(III) 16 percent of the penalty base, in the case of the 3rd such fiscal year;

(IV) 25 percent of the penalty base, in the case of the 4th such fiscal year; or

(V) 30 percent of the penalty base, in the case of the 5th or any subsequent such fiscal year.

(ii) The term "penalty base" means, with respect to a failure of a State to comply with subparagraphs (A) and (B)(i) of section 454(27) during a fiscal year, the amount otherwise payable to the State under paragraph (1)(A) of this subsection for the preceding fiscal year.

(C)(i) The Secretary shall waive all penalties imposed against a State under this paragraph for any failure of the State to comply with subparagraphs (A) and (B)(i) of section 454(27) if the Secretary determines that, before April 1, 2000, the State has achieved such compliance.

(ii) If a State with respect to which a reduction is required to be made under this paragraph with respect to a failure to comply with subparagraphs (A) and (B)(i) of section 454(27) achieves such compliance on or after April 1, 2000, and on or before September 30, 2000, then the penalty amount applicable to the State shall be 1 percent of the penalty base with respect to the failure involved.

(D) The Secretary may not impose a penalty under this paragraph against a State for a fiscal year for which the amount otherwise payable to the State under paragraph (1)(A) of this subsection is reduced under paragraph (4) of this subsection for failure to comply with section 454(24)(A).

(b)(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsection (a) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

(2) Subject to subsection (d), the Secretary shall then pay, in such installments as he may determine, to the State the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

(3) Upon the making of any estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

[(c) Repealed.[86]]

(d) Notwithstanding any other provision of law, no amount shall be paid to any State under this section for any quarter, prior to the close of such quarter, unless for the period consisting of all prior quarters for which payment is authorized to be made to such State under subsection (a), there shall have been submitted by the State to the Secretary, with respect to each quarter in such period (other than the last two quarters in such period), a full and complete report (in such form and manner and containing such information as the Secretary shall prescribe or require) as to the amount of child support collected and disbursed and all expenditures with respect to which payment is authorized under subsection (a).

(e)(1) In order to encourage and promote the development and use of more effective methods of enforcing support obligations under this part in cases where either the children on whose behalf the support is sought or their noncustodial parents do not reside in the State where such cases are filed, the Secretary is authorized to make grants, in such amounts and on such terms and conditions as the Secretary determines to be appropriate, to States which propose to undertake new or innovative methods of support collection in such cases and which will use the proceeds of such grants to carry out special projects designed to demonstrate and test such methods.

(2) A grant under this subsection shall be made only upon a finding by the Secretary that the project involved is likely to be of significant assistance in carrying out the purpose of this subsection; and with respect to such project the Secretary may waive any of the requirements of this part which would otherwise be applicable, to such extent and for such period as the Secretary determines is necessary or desirable in order to enable the State to carry out the project.

(3) At the time of its application for a grant under this subsection the State shall submit to the Secretary a statement describing in reasonable detail the project for which the proceeds of the grant are to be used, and the State shall from time to time thereafter submit to the Secretary such reports with respect to the project as the Secretary may specify.

(4) Amounts expended by a State in carrying out a special project assisted under this section shall be considered, for purposes of section 458(b) (as amended by section 5(a) of the Child Support Enforcement Amendments of 1984[87]), to have been expended for the operation of the State's plan approved under section 454.

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[86] P.L. 97–248, §174(b); 96 Stat. 403.
[87] P.L. 98–378.

(5) There is authorized to be appropriated the sum of $7,000,000 for fiscal year 1985, $12,000,000 for fiscal year 1986, and $15,000,000 for each fiscal year thereafter, to be used by the Secretary in making grants under this subsection.

(f) The Secretary may make direct payments under this part to an Indian tribe or tribal organization that demonstrates to the satisfaction of the Secretary that it has the capacity to operate a child support enforcement program meeting the objectives of this part, including establishment of paternity, establishment, modification, and enforcement of support orders, and location of absent parents. The Secretary shall promulgate regulations establishing the requirements which must be met by an Indian tribe or tribal organization to be eligible for a grant under this subsection.

SUPPORT OBLIGATIONS

SEC. 456. [42 U.S.C. 656] (a)(1) The support rights assigned to the State pursuant to section 408(a)(3) or secured on behalf of a child receiving foster care maintenance payments shall constitute an obligation owed to such State by the individual responsible for providing such support. Such obligation shall be deemed for collection purposes to be collectible under all applicable State and local processes.

(2) The amount of such obligation shall be—

(A) the amount specified in a court order which covers the assigned support rights, or

(B) if there is no court order, an amount determined by the State in accordance with a formula approved by the Secretary.

(3) Any amounts collected from a noncustodial parent under the plan shall reduce, dollar for dollar, the amount of his obligation under subparagraphs (A) and (B) of paragraph (2).

(b) NONDISCHARGEABILITY.—A debt (as defined in section 101 of title 11 of the United States Code) owed under State law to a State (as defined in such section) or municipality (as defined in such section) that is in the nature of support and that is enforceable under this part is not released by a discharge in bankruptcy under title 11 of the United States Code.[88]

DISTRIBUTION OF COLLECTED SUPPORT

SEC. 457. [42 U.S.C. 657] (a) IN GENERAL.—Subject to subsections (d) and (e), an amount collected on behalf of a family as support by a State pursuant to a plan approved under this part shall be distributed as follows:

(1) FAMILIES RECEIVING ASSISTANCE.—In the case of a family receiving assistance from the State, the State shall—

(A) pay to the Federal Government the Federal share of the amount so collected; and

(B) retain, or distribute to the family, the State share of the amount so collected.

In no event shall the total of the amounts paid to the Federal Government and retained by the State exceed the total of the amounts that have been paid to the family as assistance by the State.

[88] See Vol. II, Title 11.

(2) FAMILIES THAT FORMERLY RECEIVED ASSISTANCE.—In the case of a family that formerly received assistance from the State:

(A) CURRENT SUPPORT PAYMENTS.—To the extent that the amount so collected does not exceed the amount required to be paid to the family for the month in which collected, the State shall distribute the amount so collected to the family.

(B) PAYMENTS OF ARREARAGES.—To the extent that the amount so collected exceeds the amount required to be paid to the family for the month in which collected, the State shall distribute the amount so collected as follows:

(i) DISTRIBUTION OF ARREARAGES THAT ACCRUED AFTER THE FAMILY CEASED TO RECEIVE ASSISTANCE.—

(I) PRE–OCTOBER 1997.—Except as provided in subclause (II), the provisions of this section as in effect and applied on the day before the date of the enactment of section 302 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (other than subsection (b)(1) (as so in effect))[89] shall apply with respect to the distribution of support arrearages that—

(aa) accrued after the family ceased to receive assistance, and

(bb) are collected before October 1, 1997.

(II) POST–SEPTEMBER 1997.—With respect to the amount so collected on or after October 1, 1997 (or before such date, at the option of the State)—

(aa) IN GENERAL.—The State shall first distribute the amount so collected (other than any amount described in clause (iv)) to the family to the extent necessary to satisfy any support arrearages with respect to the family that accrued after the family ceased to receive assistance from the State.

(bb) REIMBURSEMENT OF GOVERNMENTS FOR ASSISTANCE PROVIDED TO THE FAMILY.—After the application of division (aa) and clause (ii)(II)(aa) with respect to the amount so collected, the State shall retain the State share of the amount so collected, and pay to the Federal Government the Federal share (as defined in subsection (c)(2)) of the amount so collected, but only to the extent necessary to reimburse amounts paid to the family as assistance by the State.

(cc) DISTRIBUTION OF THE REMAINDER TO THE FAMILY.—To the extent that neither division (aa) nor division (bb) applies to the amount so collected, the State shall distribute the amount to the family.

(ii) DISTRIBUTION OF ARREARAGES THAT ACCRUED BEFORE THE FAMILY RECEIVED ASSISTANCE.—

[89] August 22, 1996 is the date of enactment for P.L. 104–193.

(I) PRE–OCTOBER 2000.—Except as provided in subclause (II), the provisions of this section as in effect and applied on the day before the date of enactment of section 302 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (other than subsection (b)(1) (as so in effect)) shall apply with respect to the distribution of support arrearages that—

(aa) accrued before the family received assistance, and

(bb) are collected before October 1, 2000.

(II) POST–SEPTEMBER 2000.—Unless, based on the report required by paragraph (5), the Congress determines otherwise, with respect to the amount so collected on or after October 1, 2000 (or before such date, at the option of the State)—

(aa) IN GENERAL.—The State shall first distribute the amount so collected (other than any amount described in clause (iv)) to the family to the extent necessary to satisfy any support arrearages with respect to the family that accrued before the family received assistance from the State.

(bb) REIMBURSEMENT OF GOVERNMENTS FOR ASSISTANCE PROVIDED TO THE FAMILY.—After the application of clause (i)(II)(aa) and division (aa) with respect to the amount so collected, the State shall retain the State share of the amount so collected, and pay to the Federal Government the Federal share (as defined in subsection (c)(2)) of the amount so collected, but only to the extent necessary to reimburse amounts paid to the family as assistance by the State.

(cc) DISTRIBUTION OF THE REMAINDER TO THE FAMILY.—To the extent that neither division (aa) nor division (bb) applies to the amount so collected, the State shall distribute the amount to the family.

(iii) DISTRIBUTION OF ARREARAGES THAT ACCRUED WHILE THE FAMILY RECEIVED ASSISTANCE.—In the case of a family described in this subparagraph, the provisions of paragraph (1) shall apply with respect to the distribution of support arrearages that accrued while the family received assistance.

(iv) AMOUNTS COLLECTED PURSUANT TO SECTION 464.—Notwithstanding any other provision of this section, any amount of support collected pursuant to section 464 shall be retained by the State to the extent past–due support has been assigned to the State as a condition of receiving assistance from the State, up to the amount necessary to reimburse the State for amounts paid to the family as assistance by the State. The State shall pay to the Federal Government the Federal share of the amounts so retained. To the extent the amount collected pursuant to section 464 ex-

ceeds the amount so retained, the State shall distribute the excess to the family.

(v) ORDERING RULES FOR DISTRIBUTIONS.—For purposes of this subparagraph, unless an earlier effective date is required by this section, effective October 1, 2000, the State shall treat any support arrearages collected, except for amounts collected pursuant to section 464, as accruing in the following order:

(I) To the period after the family ceased to receive assistance.

(II) To the period before the family received assistance.

(III) To the period while the family was receiving assistance.

(3) FAMILIES THAT NEVER RECEIVED ASSISTANCE.—In the case of any other family, the State shall distribute the amount so collected to the family.

(4) FAMILIES UNDER CERTAIN AGREEMENTS.—In the case of an amount collected for a family in accordance with a cooperative agreement under section 454(33), distribute the amount so collected pursuant to the terms of the agreement.

(5) STUDY AND REPORT.—Not later than October 1, 1999, the Secretary shall report to the Congress the Secretary's findings with respect to—

(A) whether the distribution of post–assistance arrearages to families has been effective in moving people off of welfare and keeping them off of welfare;

(B) whether early implementation of a pre–assistance arrearage program by some States has been effective in moving people off of welfare and keeping them off of welfare;

(C) what the overall impact has been of the amendments made by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 with respect to child support enforcement in moving people off of welfare and keeping them off of welfare; and

(D) based on the information and data the Secretary has obtained, what changes, if any, should be made in the policies related to the distribution of child support arrearages.

(6) STATE OPTION FOR APPLICABILITY.—Notwithstanding any other provision of this subsection, a State may elect to apply the rules described in clauses (i)(II), (ii)(II), and (v) of paragraph (2)(B) to support arrearages collected on and after October 1, 1998, and, if the State makes such an election, shall apply the provisions of this section, as in effect and applied on the day before the date of enactment of section 302 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193, 110 Stat. 2200), other than subsection (b)(1) (as so in effect), to amounts collected before October 1, 1998.

(b) CONTINUATION OF ASSIGNMENTS.—Any rights to support obligations, assigned to a State as a condition of receiving assistance from the State under part A and in effect on September 30, 1997 (or such earlier date, on or after August 22, 1996, as the State may choose), shall remain assigned after such date.

(c) DEFINITIONS.—As used in subsection (a):

(1) ASSISTANCE.—The term "assistance from the State" means—

(A) assistance under the State program funded under part A or under the State plan approved under part A of this title (as in effect on the day before the date of the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996); and

(B) foster care maintenance payments under the State plan approved under part E of this title.

(2) FEDERAL SHARE.—The term "Federal share" means that portion of the amount collected resulting from the application of the Federal medical assistance percentage in effect for the fiscal year in which the amount is distributed.

(3) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The term "Federal medical assistance percentage" means—

(A) 75 percent, in the case of Puerto Rico, the Virgin Islands, Guam, and American Samoa; or

(B) the Federal medical assistance percentage (as defined in section 1905(b), as such section was in effect on September 30, 1995) in the case of any other State.

(4) STATE SHARE.—The term "State share" means 100 percent minus the Federal share.

(d) GAP PAYMENTS NOT SUBJECT TO DISTRIBUTION UNDER THIS SECTION.—At State option, this section shall not apply to any amount collected on behalf of a family as support by the State (and paid to the family in addition to the amount of assistance otherwise payable to the family) pursuant to a plan approved under this part if such amount would have been paid to the family by the State under section 402(a)(28), as in effect and applied on the day before the date of the enactment of section 302 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

(e) Notwithstanding the preceding provisions of this section, amounts collected by a State as child support for months in any period on behalf of a child for whom a public agency is making foster care maintenance payments under part E—

(1) shall be retained by the State to the extent necessary to reimburse it for the foster care maintenance payments made with respect to the child during such period (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing);

(2) shall be paid to the public agency responsible for supervising the placement of the child to the extent that the amounts collected exceed the foster care maintenance payments made with respect to the child during such period but not the amounts required by a court or administrative order to be paid as support on behalf of the child during such period; and the responsible agency may use the payments in the manner it determines will serve the best interests of the child, including setting such payments aside for the child's future needs or making all or a part thereof available to the person responsible for meeting the child's day–to–day needs; and

(3) shall be retained by the State, if any portion of the amounts collected remains after making the payments required under paragraphs (1) and (2), to the extent that such portion is necessary to reimburse the State (with appropriate reim-

bursement to the Federal Government to the extent of its participation in the financing) for any past foster care maintenance payments (or payments of assistance under the State program funded under part A) which were made with respect to the child (and with respect to which past collections have not previously been retained); and any balance shall be paid to the State agency responsible for supervising the placement of the child, for use by such agency in accordance with paragraph (2).

INCENTIVE PAYMENTS TO STATES

SEC. 458. [42 U.S.C. 658a] (a) IN GENERAL.—In addition to any other payment under this part, the Secretary shall, subject to subsection (f), make an incentive payment to each State for each fiscal year in an amount determined under subsection (b).

(b) AMOUNT OF INCENTIVE PAYMENT.—

(1) IN GENERAL.—The incentive payment for a State for a fiscal year is equal to the incentive payment pool for the fiscal year, multiplied by the State incentive payment share for the fiscal year.

(2) INCENTIVE PAYMENT POOL.—

(A) IN GENERAL.—In paragraph (1), the term "incentive payment pool" means—

(i) $422,000,000 for fiscal year 2000;
(ii) $429,000,000 for fiscal year 2001;
(iii) $450,000,000 for fiscal year 2002;
(iv) $461,000,000 for fiscal year 2003;
(v) $454,000,000 for fiscal year 2004;
(vi) $446,000,000 for fiscal year 2005;
(vii) $458,000,000 for fiscal year 2006;
(viii) $471,000,000 for fiscal year 2007;
(ix) $483,000,000 for fiscal year 2008; and
(x) for any succeeding fiscal year, the amount of the incentive payment pool for the fiscal year that precedes such succeeding fiscal year, multiplied by the percentage (if any) by which the CPI for such preceding fiscal year exceeds the CPI for the second preceding fiscal year.

(B) CPI.—For purposes of subparagraph (A), the CPI for a fiscal year is the average of the Consumer Price Index for the 12–month period ending on September 30 of the fiscal year. As used in the preceding sentence, the term "Consumer Price Index" means the last Consumer Price Index for all–urban consumers published by the Department of Labor.

(3) STATE INCENTIVE PAYMENT SHARE.—In paragraph (1), the term "State incentive payment share" means, with respect to a fiscal year—

(A) the incentive base amount for the State for the fiscal year; divided by

(B) the sum of the incentive base amounts for all of the States for the fiscal year.

(4) INCENTIVE BASE AMOUNT.—In paragraph (3), the term "incentive base amount" means, with respect to a State and a fiscal year, the sum of the applicable percentages (determined

in accordance with paragraph (6)) multiplied by the corresponding maximum incentive base amounts for the State for the fiscal year, with respect to each of the following measures of State performance for the fiscal year:

(A) The paternity establishment performance level.

(B) The support order performance level.

(C) The current payment performance level.

(D) The arrearage payment performance level.

(E) The cost–effectiveness performance level.

(5) Maximum incentive base amount.—

(A) IN GENERAL.—For purposes of paragraph (4), the maximum incentive base amount for a State for a fiscal year is—

(i) with respect to the performance measures described in subparagraphs (A), (B), and (C) of paragraph (4), the State collections base for the fiscal year; and

(ii) with respect to the performance measures described in subparagraphs (D) and (E) of paragraph (4), 75 percent of the State collections base for the fiscal year.

(B) DATA REQUIRED TO BE COMPLETE AND RELIABLE.—Notwithstanding subparagraph (A), the maximum incentive base amount for a State for a fiscal year with respect to a performance measure described in paragraph (4) is zero, unless the Secretary determines, on the basis of an audit performed under section 452(a)(4)(C)(i), that the data which the State submitted pursuant to section 454(15)(B) for the fiscal year and which is used to determine the performance level involved is complete and reliable.

(C) STATE COLLECTIONS BASE.—For purposes of subparagraph (A), the State collections base for a fiscal year is equal to the sum of—

(i) 2 times the sum of—

(I) the total amount of support collected during the fiscal year under the State plan approved under this part in cases in which the support obligation involved is required to be assigned to the State pursuant to part A or E of this title or title XIX; and

(II) the total amount of support collected during the fiscal year under the State plan approved under this part in cases in which the support obligation involved was so assigned but, at the time of collection, is not required to be so assigned; and

(ii) the total amount of support collected during the fiscal year under the State plan approved under this part in all other cases.

(6) DETERMINATION OF APPLICABLE PERCENTAGES BASED ON PERFORMANCE LEVELS.—

(A) PATERNITY ESTABLISHMENT.—

(i) DETERMINATION OF PATERNITY ESTABLISHMENT PERFORMANCE LEVEL.—The paternity establishment performance level for a State for a fiscal year is, at the option of the State, the IV–D paternity establishment

percentage determined under section 452(g)(2)(A) or the statewide paternity establishment percentage determined under section 452(g)(2)(B).

(ii) DETERMINATION OF APPLICABLE PERCENTAGE.—The applicable percentage with respect to a State's paternity establishment performance level is as follows:

If the paternity establishment performance level is:		The applicable percentage is:
At least:	But less than:	
80%		100
79%	80%	98
78%	79%	96
77%	78%	94
76%	77%	92
75%	76%	90
74%	75%	88
73%	74%	86
72%	73%	84
71%	72%	82
70%	71%	80
69%	70%	79
68%	69%	78
67%	68%	77
66%	67%	76
65%	66%	75
64%	65%	74
63%	64%	73
62%	63%	72
61%	62%	71
60%	61%	70
59%	60%	69
58%	59%	68
57%	58%	67
56%	57%	66
55%	56%	65
54%	55%	64
53%	54%	63
52%	53%	62
51%	52%	61
50%	51%	60
0%	50%	0.

Notwithstanding the preceding sentence, if the paternity establishment performance level of a State for a fiscal year is less than 50 percent but exceeds by at least 10 percentage points the paternity establishment performance level of the State for the immediately preceding fiscal year, then the applicable percentage with respect to the State's paternity establishment performance level is 50 percent.

(B) ESTABLISHMENT OF CHILD SUPPORT ORDERS.—

(i) Determination of support order performance level.—The support order performance level for a State for a fiscal year is the percentage of the total number of cases under the State plan approved under

this part in which there is a support order during the fiscal year.

(ii) Determination of applicable percentage.—The applicable percentage with respect to a State's support order performance level is as follows:

If the support order performance level is:		The applicable percentage is:
At least:	But less than:	
80%		100
79%	80%	98
78%	79%	96
77%	78%	94
76%	77%	92
75%	76%	90
74%	75%	88
73%	74%	86
72%	73%	84
71%	72%	82
70%	71%	80
69%	70%	79
68%	69%	78
67%	68%	77
66%	67%	76
65%	66%	75
64%	65%	74
63%	64%	73
62%	63%	72
61%	62%	71
60%	61%	70
59%	60%	69
58%	59%	68
57%	58%	67
56%	57%	66
55%	56%	65
54%	55%	64
53%	54%	63
52%	53%	62
51%	52%	61
50%	51%	60
0%	50%	0.

Notwithstanding the preceding sentence, if the support order performance level of a State for a fiscal year is less than 50 percent but exceeds by at least 5 percentage points the support order performance level of the State for the immediately preceding fiscal year, then the applicable percentage with respect to the State's support order performance level is 50 percent.

(C) COLLECTIONS ON CURRENT CHILD SUPPORT DUE.—

(i) DETERMINATION OF CURRENT PAYMENT PERFORMANCE LEVEL.—The current payment performance level for a State for a fiscal year is equal to the total amount of current support collected during the fiscal year under the State plan approved under this part divided by the total amount of current support owed

during the fiscal year in all cases under the State plan, expressed as a percentage.

(ii) DETERMINATION OF APPLICABLE PERCENTAGE.—The applicable percentage with respect to a State's current payment performance level is as follows:

If the support order performance level is:		The applicable percentage is:
At least:	But less than:	
80%		100
79%	80%	98
78%	79%	96
77%	78%	94
76%	77%	92
75%	76%	90
74%	75%	88
73%	74%	86
72%	73%	84
71%	72%	82
70%	71%	80
69%	70%	79
68%	69%	78
67%	68%	77
66%	67%	76
65%	66%	75
64%	65%	74
63%	64%	73
62%	63%	72
61%	62%	71
60%	61%	70
59%	60%	69
58%	59%	68
57%	58%	67
56%	57%	66
55%	56%	65
54%	55%	64
53%	54%	63
52%	53%	62
51%	52%	61
50%	51%	60
49%	50%	59
48%	49%	58
47%	48%	57
46%	47%	56
45%	46%	55
44%	45%	54
43%	44%	53
42%	43%	52
41%	42%	51
40%	41%	50
0%	40%	0.

Notwithstanding the preceding sentence, if the current payment performance level of a State for a fiscal year is less than 40 percent but exceeds by at least 5 percentage points the current payment performance level of the State for the immediately preceding fiscal

year, then the applicable percentage with respect to the State's current payment performance level is 50 percent.

(D) COLLECTIONS ON CHILD SUPPORT ARREARAGES.—

(i) DETERMINATION OF ARREARAGE PAYMENT PERFORMANCE LEVEL.—The arrearage payment performance level for a State for a fiscal year is equal to the total number of cases under the State plan approved under this part in which payments of past–due child support were received during the fiscal year and part or all of the payments were distributed to the family to whom the past–due child support was owed (or, if all past–due child support owed to the family was, at the time of receipt, subject to an assignment to the State, part or all of the payments were retained by the State) divided by the total number of cases under the State plan in which there is past–due child support, expressed as a percentage.

(ii) DETERMINATION OF APPLICABLE PERCENTAGE.—The applicable percentage with respect to a State's arrearage payment performance level is as follows:

If the support order performance level is:		The applicable percentage is:
At least:	But less than:	
80%		100
79%	80%	98
78%	79%	96
77%	78%	94
76%	77%	92
75%	76%	90
74%	75%	88
73%	74%	86
72%	73%	84
71%	72%	82
70%	71%	80
69%	70%	79
68%	69%	78
67%	68%	77
66%	67%	76
65%	66%	75
64%	65%	74
63%	64%	73
62%	63%	72
61%	62%	71
60%	61%	70
59%	60%	69
58%	59%	68
57%	58%	67
56%	57%	66
55%	56%	65
54%	55%	64
53%	54%	63
52%	53%	62
51%	52%	61
50%	51%	60
49%	50%	59

If the support order performance level is:		The applicable percentage is:
At least:	But less than:	
48%	49%	58
47%	48%	57
46%	47%	56
45%	46%	55
44%	45%	54
43%	44%	53
42%	43%	52
41%	42%	51
40%	41%	50
0%	40%	0.

Notwithstanding the preceding sentence, if the arrearage payment performance level of a State for a fiscal year is less than 40 percent but exceeds by at least 5 percentage points the arrearage payment performance level of the State for the immediately preceding fiscal year, then the applicable percentage with respect to the State's arrearage payment performance level is 50 percent.

(E) COST–EFFECTIVENESS.—

(i) DETERMINATION OF COST–EFFECTIVENESS PERFORMANCE LEVEL.—The cost–effectiveness performance level for a State for a fiscal year is equal to the total amount collected during the fiscal year under the State plan approved under this part divided by the total amount expended during the fiscal year under the State plan, expressed as a ratio.

(ii) DETERMINATION OF APPLICABLE PERCENTAGE.—The applicable percentage with respect to a State's cost–effectiveness performance level is as follows:

If the cost–effectiveness performance level is:		The applicable percentage is:
At least:	But less than:	
5.00		100
4.50	4.99	90
4.00	4.50	80
3.50	4.00	70
3.00	3.50	60
2.50	3.00	50
2.00	2.50	40
0.00	2.00	0

(c) TREATMENT OF INTERSTATE COLLECTIONS.—In computing incentive payments under this section, support which is collected by a State at the request of another State shall be treated as having been collected in full by both States, and any amounts expended by a State in carrying out a special project assisted under section 455(e) shall be excluded.

(d) ADMINISTRATIVE PROVISIONS.—The amounts of the incentive payments to be made to the States under this section for a fiscal year shall be estimated by the Secretary at/or before the beginning of the fiscal year on the basis of the best information available. The Secretary shall make the payments for the fiscal year, on a quar-

terly basis (with each quarterly payment being made no later than the beginning of the quarter involved), in the amounts so estimated, reduced or increased to the extent of any overpayments or underpayments which the Secretary determines were made under this section to the States involved for prior periods and with respect to which adjustment has not already been made under this subsection. Upon the making of any estimate by the Secretary under the preceding sentence, any appropriations available for payments under this section are deemed obligated.

(e) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary governing the calculation of incentive payments under this section, including directions for excluding from the calculations certain closed cases and cases over which the States do not have jurisdiction.

(f) REINVESTMENT.—A State to which a payment is made under this section shall expend the full amount of the payment to supplement, and not supplant, other funds used by the State—

(1) to carry out the State plan approved under this part; or

(2) for any activity (including cost–effective contracts with local agencies) approved by the Secretary, whether or not the expenditures for the activity are eligible for reimbursement under this part, which may contribute to improving the effectiveness or efficiency of the State program operated under this part.

CONSENT BY THE UNITED STATES TO INCOME WITHHOLDING, GARNISHMENT, AND SIMILAR PROCEEDINGS FOR ENFORCEMENT OF CHILD SUPPORT AND ALIMONY OBLIGATIONS

SEC. 459. [42 U.S.C. 659] (a) CONSENT TO SUPPORT ENFORCEMENT.—Notwithstanding any other provision of law (including section 207 of this Act and section 5301 of title 38, United States Code[90]), effective January 1, 1975, moneys (the entitlement to which is based upon remuneration for employment) due from, or payable by, the United States or the District of Columbia (including any agency, subdivision, or instrumentality thereof) to any individual, including members of the Armed Forces of the United States, shall be subject, in like manner and to the same extent as if the United States or the District of Columbia were a private person, to withholding in accordance with State law enacted pursuant to subsections (a)(1) and (b) of section 466 and regulations of the Secretary under such subsections, and to any other legal process brought, by a State agency administering a program under a State plan approved under this part or by an individual obligee, to enforce the legal obligation of the individual to provide child support or alimony.

(b) CONSENT TO REQUIREMENTS APPLICABLE TO PRIVATE PERSON.—With respect to notice to withhold income pursuant to subsection (a)(1) or (b) of section 466, or any other order or process to enforce support obligations against an individual (if the order or process contains or is accompanied by sufficient data to permit prompt identification of the individual and the moneys involved), each governmental entity specified in subsection (a) shall be subject to the same requirements as would apply if the entity were a private person, except as otherwise provided in this section.

[90] See Vol. II, Title 38, §5301.

(c) DESIGNATION OF AGENT; RESPONSE TO NOTICE OR PROCESS.—The head of each agency subject to this section shall—

(1) DESIGNATION OF AGENT.—

(A) designate an agent or agents to receive orders and accept service of process in matters relating to child support or alimony; and

(B) annually publish in the Federal Register the designation of the agent or agents, identified by title or position, mailing address, and telephone number.

(2) RESPONSE TO NOTICE OR PROCESS.—If an agent designated pursuant to paragraph (1) of this subsection receives notice pursuant to State procedures in effect pursuant to subsection (a)(1) or (b) of section 466, or is effectively served with any order, process, or interrogatory, with respect to an individual's child support or alimony payment obligations, the agent shall—

(A) as soon as possible (but not later than 15 days) thereafter, send written notice of the notice or service (together with a copy of the notice or service) to the individual at the duty station or last–known home address of the individual;

(B) within 30 days (or such longer period as may be prescribed by applicable State law) after receipt of a notice pursuant to such State procedures, comply with all applicable provisions of section 466; and

(C) within 30 days (or such longer period as may be prescribed by applicable State law) after effective service of any other such order, process, or interrogatory, withhold available sums in response to the order or process, or answer the interrogatory.

(d) PRIORITY OF CLAIMS.—If a governmental entity specified in subsection (a) receives notice or is served with process, as provided in this section, concerning amounts owed by an individual for more than 1 person—

(1) support collection under section 466(b) must be given priority over any other process, as provided in section 466(b)(7);

(2) allocation of moneys due or payable to an individual among claimants under section 466(b) shall be governed by section 466(b) and the regulations prescribed under such section; and

(3) such moneys as remain after compliance with paragraphs (1) and (2) shall be available to satisfy any other such processes on a first–come, first–served basis, with any such process being satisfied out of such moneys as remain after the satisfaction of all such processes which have been previously served.

(e) NO REQUIREMENT TO VARY PAY CYCLES.—A governmental entity that is affected by legal process served for the enforcement of an individual's child support or alimony payment obligations shall not be required to vary its normal pay and disbursement cycle in order to comply with the legal process.

(f) RELIEF FROM LIABILITY.—

(1) Neither the United States, nor the government of the District of Columbia, nor any disbursing officer shall be liable with respect to any payment made from moneys due or payable from the United States to any individual pursuant to legal process regular on its face, if the payment is made in accord-

ance with this section and the regulations issued to carry out this section.

(2) No Federal employee whose duties include taking actions necessary to comply with the requirements of subsection (a) with regard to any individual shall be subject under any law to any disciplinary action or civil or criminal liability or penalty for, or on account of, any disclosure of information made by the employee in connection with the carrying out of such actions.

(g) REGULATIONS.—Authority to promulgate regulations for the implementation of this section shall, insofar as this section applies to moneys due from (or payable by)—

(1) the United States (other than the legislative or judicial branches of the Federal Government) or the government of the District of Columbia, be vested in the President (or the designee of the President);

(2) the legislative branch of the Federal Government, be vested jointly in the President pro tempore of the Senate and the Speaker of the House of Representatives (or their designees), and

(3) the judicial branch of the Federal Government, be vested in the Chief Justice of the United States (or the designee of the Chief Justice).

(h) MONEYS SUBJECT TO PROCESS.—

(1) IN GENERAL.—Subject to paragraph (2), moneys payable to an individual which are considered to be based upon remuneration for employment, for purposes of this section—

(A) consist of—

(i) compensation payable for personal services of the individual, whether the compensation is denominated as wages, salary, commission, bonus, pay, allowances, or otherwise (including severance pay, sick pay, and incentive pay);

(ii) periodic benefits (including a periodic benefit as defined in section 228(h)(3)) or other payments—

(I) under the insurance system established by title II;

(II) under any other system or fund established by the United States which provides for the payment of pensions, retirement or retired pay, annuities, dependents' or survivors' benefits, or similar amounts payable on account of personal services performed by the individual or any other individual;

(III) as compensation for death under any Federal program;

(IV) under any Federal program established to provide "black lung" benefits; or

(V) by the Secretary of Veterans Affairs as compensation for a service–connected disability paid by the Secretary to a former member of the Armed Forces who is in receipt of retired or retainer pay if the former member has waived a portion of the retired or retainer pay in order to receive such compensation;

(iii) worker's compensation benefits paid or payable under Federal or State law;

(iv) benefits paid or payable under the Railroad Retirement System, and

(v) special benefis for certain World War II veterans payabable under title VIII; but

(B) do not include any payment—

(i) by way or reimbursement or otherwise, to defray expenses incurred by the individual in carrying out duties associated with the employment of the individual,

(ii) as allowances for members of the uniformed services payable pursuant to chapter 7 of title 37, United States Code[91], as prescribed by the Secretaries concerned (defined by section 101(5) of such title) as necessary for the efficient performance of duty; or

(iii) of periodic benefits under title 38, United States Code, except as provided in subparagraph (A)(ii)(V).

(2) CERTAIN AMOUNTS EXCLUDED.—In determining the amount of any moneys due from, or payable by, the United States to any individual, there shall be excluded amounts which—

(A) are owed by the individual to the United States;

(B) are required by law to be, and are, deducted from the remuneration or other payment involved, including Federal employment taxes, and fines and forfeitures ordered by court–martial;

(C) are properly withheld for Federal, State, or local income tax purposes, if the withholding of the amounts is authorized or required by law and if amounts withheld are not greater than would be the case if the individual claimed all dependents to which he was entitled (the withholding of additional amounts pursuant to section 3402(i) of the Internal Revenue Code of 1986 may be permitted only when the individual presents evidence of a tax obligation which supports the additional withholding);

(D) are deducted as health insurance premiums;

(E) are deducted as normal retirement contributions (not including amounts deducted for supplementary coverage); or

(F) are deducted as normal life insurance premiums from salary or other remuneration for employment (not including amounts deducted for supplementary coverage).

(i) DEFINITIONS.—For purposes of this section—

(1) UNITED STATES.—The term "United States" includes any department, agency, or instrumentality of the legislative, judicial, or executive branch of the Federal Government, the United States Postal Service, the Postal Rate Commission, any Federal corporation created by an Act of Congress that is wholly owned by the Federal Government, and the governments of the territories and possessions of the United States.

(2) CHILD SUPPORT.—The term "child support", when used in reference to the legal obligations of an individual to provide such support, means amounts required to be paid under a

[91] See Vol. II, 37 U.S.C. chapter 7 and §101(5).

judgment, decree, or order, whether temporary, final, or subject to modification, issued by a court or an administrative agency of competent jurisdiction, for the support and maintenance of a child, including a child who has attained the age of majority under the law of the issuing State, or a child and the parent with whom the child is living, which provides for monetary support, health care, arrearages or reimbursement, and which may include other related costs and fees, interest and penalties, income withholding, attorney's fees, and other relief.

(3) ALIMONY.—

(A) IN GENERAL.—The term "alimony", when used in reference to the legal obligations of an individual to provide the same, means periodic payments of funds for the support and maintenance of the spouse (or former spouse) of the individual, and (subject to and in accordance with State law) includes separate maintenance, alimony pendente lite, maintenance, and spousal support, and includes attorney's fees, interest, and court costs when and to the extent that the same are expressly made recoverable as such pursuant to a decree, order, or judgment issued in accordance with applicable State law by a court of competent jurisdiction.

(B) EXCEPTIONS.—Such term does not include—

(i) any child support; or

(ii) any payment or transfer of property or its value by an individual to the spouse or a former spouse of the individual in compliance with any community property settlement, equitable distribution of property, or other division of property between spouses of former spouses.

(4) PRIVATE PERSON.—The term "private person" means a person who does not have sovereign or other special immunity or privilege which causes the person not to be subject to legal process.

(5) LEGAL PROCESS.—The term "legal process" means any writ, order, summons, or other similar process in the nature of garnishment—

(A) which is issued by—

(i) a court or an administrative agency of competent jurisdiction in any State, territory, or possession of the United States;

(ii) a court or an administrative agency of competent jurisdiction in any foreign country with which the United States has entered into an agreement which requires the United States to honor the process; or

(iii) an authorized official pursuant to an order of such a court or an administrative agency of competent jurisdiction or pursuant to State or local law; and

(B) which is directed to, and the purpose of which is to compel, a governmental entity which holds moneys which are otherwise payable to an individual to make a payment from the moneys to another party in order to satisfy a legal obligation of the individual to provide child support or make alimony payments.

INTERNATIONAL SUPPORT ENFORCEMENT

SEC. 459A. [42 U.S.C. 659a] (a) AUTHORITY FOR DECLARATIONS.—

(1) DECLARATION.—The Secretary of State, with the concurrence of the Secretary of Health and Human Services, is authorized to declare any foreign country (or a political subdivision thereof) to be a foreign reciprocating country if the foreign country has established, or undertakes to establish, procedures for the establishment and enforcement of duties of support owed to obligees who are residents of the United States, and such procedures are substantially in conformity with the standards prescribed under subsection (b).

(2) REVOCATION.—A declaration with respect to a foreign country made pursuant to paragraph (1) may be revoked if the Secretaries of State and Health and Human Services determine that—

(A) the procedures established by the foreign country regarding the establishment and enforcement of duties of support have been so changed, or the foreign country's implementation of such procedures is so unsatisfactory, that such procedures do not meet the criteria for such a declaration; or

(B) continued operation of the declaration is not consistent with the purposes of this part.

(3) FORM OF DECLARATION.—A declaration under paragraph (1) may be made in the form of an international agreement, in connection with an international agreement or corresponding foreign declaration, or on a unilateral basis.

(b) STANDARDS FOR FOREIGN SUPPORT ENFORCEMENT PROCEDURES.—

(1) MANDATORY ELEMENTS.—Support enforcement procedures of a foreign country which may be the subject of a declaration pursuant to subsection (a)(1) shall include the following elements:

(A) The foreign country (or political subdivision thereof) has in effect procedures, available to residents of the United States—

(i) for establishment of paternity, and for establishment of orders of support for children and custodial parents; and

(ii) for enforcement of orders to provide support to children and custodial parents, including procedures for collection and appropriate distribution of support payments under such orders.

(B) The procedures described in subparagraph (A), including legal and administrative assistance, are provided to residents of the United States at no cost.

(C) An agency of the foreign country is designated as a Central Authority responsible for—

(i) facilitating support enforcement in cases involving residents of the foreign country and residents of the United States; and

(ii) ensuring compliance with the standards established pursuant to this subsection.

(2) ADDITIONAL ELEMENTS.—The Secretary of Health and Human Services and the Secretary of State, in consultation

with the States, may establish such additional standards as may be considered necessary to further the purposes of this section.

(c) DESIGNATION OF UNITED STATES CENTRAL AUTHORITY.—It shall be the responsibility of the Secretary of Health and Human Services to facilitate support enforcement in cases involving residents of the United States and residents of foreign countries that are the subject of a declaration under this section, by activities including—

(1) development of uniform forms and procedures for use in such cases;

(2) notification of foreign reciprocating countries of the State of residence of individuals sought for support enforcement purposes, on the basis of information provided by the Federal Parent Locator Service; and

(3) such other oversight, assistance, and coordination activities as the Secretary may find necessary and appropriate.

(d) EFFECT ON OTHER LAWS.—State may enter into reciprocal arrangements for the establishment and enforcement of support obligations with foreign countries that are not the subject of a declaration pursuant to subsection (a), to the extent consistent with Federal law.

CIVIL ACTIONS TO ENFORCE SUPPORT OBLIGATIONS

SEC. 460. [42 U.S.C. 660] The district courts of the United States shall have jurisdiction, without regard to any amount in controversy, to hear and determine any civil action certified by the Secretary of Health and Human Services under section 452(a)(8) of this Act. A civil action under this section may be brought in any judicial district in which the claim arose, the plaintiff resides, or the defendant resides.

SEC. 461. [Repealed.[92]]

SEC. 462. [Repealed.[93]]

USE OF FEDERAL PARENT LOCATOR SERVICE IN CONNECTION WITH THE ENFORCEMENT OR DETERMINATION OF CHILD CUSTODY AND IN CASES OF PARENTAL KIDNAPING OF A CHILD

SEC. 463. [42 U.S.C. 663] (a) The Secretary shall enter into an agreement with every State under which the services of the Federal Parent Locator Service established under section 453 shall be made available to each State for the purpose of determining the whereabouts of any parent or child when such information is to be used to locate such parent or child for the purpose of—

(1) enforcing any State or Federal law with respect to the unlawful taking or restraint of a child; or

(2) making or enforcing a child custody or visitation determination.

(b) An agreement entered into under subsection (a) shall provide that the State agency described in section 454 will, under procedures prescribed by the Secretary in regulations, receive and transmit to the Secretary requests from authorized persons for information as to (or useful in determining) the whereabouts of any parent

[92] P.L. 104–193, §362(b)(1); 110 Stat. 2246.
[93] P.L. 104–193, §362(b)(1); 110 Stat. 2246.

or child when such information is to be used to locate such parent or child for the purpose of—

(1) enforcing any State or Federal law with respect to the unlawful taking or restraint of a child; or

(2) making or enforcing a child custody or visitation determination.

(c) Information authorized to be provided by the Secretary under subsection (a), (b), (e), or (f) shall be subject to the same conditions with respect to disclosure as information authorized to be provided under section 453, and a request for information by the Secretary under this section shall be considered to be a request for information under section 453 which is authorized to be provided under such section. Only information as to the most recent address and place of employment of any parent or child shall be provided under this section.

(d) For purposes of this section—

(1) the term "custody or visitation determination" means a judgment, decree, or other order of a court providing for the custody or visitation of a child, and includes permanent and temporary orders, and initial orders and modification;

(2) the term "authorized person" means—

(A) any agent or attorney of any State having an agreement under this section, who has the duty or authority under the law of such State to enforce a child custody or visitation determination;

(B) any court having jurisdiction to make or enforce such a child custody or visitation determination, or any agent of such court; and

(C) any agent or attorney of the United States, or of a State having an agreement under this section, who has the duty or authority to investigate, enforce, or bring a prosecution with respect to the unlawful taking or restraint of a child.

(e) The Secretary shall enter into an agreement with the Central Authority designated by the President in accordance with section 7 of the International Child Abduction Remedies Act, under which the services of the Federal Parent Locator Service established under section 453 shall be made available to such Central Authority upon its request for the purpose of locating any parent or child on behalf of an applicant to such Central Authority within the meaning of section 3(1) of that Act. The Federal Parent Locator Service shall charge no fees for services requested pursuant to this subsection.

(f) The Secretary shall enter into an agreement with the Attorney General of the United States, under which the services of the Federal Parent Locator Service established under section 453 shall be made available to the Office of Juvenile Justice and Delinquency Prevention upon its request to locate any parent or child on behalf of such Office for the purpose of—

(1) enforcing any State or Federal law with respect to the unlawful taking or restraint of a child, or

(2) making or enforcing a child custody or visitation determination.

The Federal Parent Locator Service shall charge no fees for services requested pursuant to this subsection.

COLLECTION OF PAST-DUE SUPPORT FROM FEDERAL TAX REFUNDS

SEC. 464. [42 U.S.C. 664] (a)(1) Upon receiving notice from a State agency administering a plan approved under this part that a named individual owes past-due support which has been assigned to such State pursuant to section 408(a)(3) or section 471(a)(17), the Secretary of the Treasury shall determine whether any amounts, as refunds of Federal taxes paid, are payable to such individual (regardless of whether such individual filed a tax return as a married or unmarried individual). If the Secretary of the Treasury finds that any such amount is payable, he shall withhold from such refunds an amount equal to the past-due support, shall concurrently send notice to such individual that the withholding has been made (including in or with such notice a notification to any other person who may have filed a joint return with such individual of the steps which such other person may take in order to secure his or her proper share of the refund), and shall pay such amount to the State agency (together with notice of the individual's home address) for distribution in accordance with section 457. This subsection may be executed by the disbursing official of the Department of the Treasury.

(2)(A) Upon receiving notice from a State agency administering a plan approved under this part that a named individual owes past-due support (as that term is defined for purposes of this paragraph under subsection (c)) which such State has agreed to collect under section 454(4)(A)(ii), and that the State agency has sent notice to such individual in accordance with paragraph (3)(A), the Secretary of the Treasury shall determine whether any amounts, as refunds of Federal taxes paid, are payable to such individual (regardless of whether such individual filed a tax return as a married or unmarried individual). If the Secretary of the Treasury finds that any such amount is payable, he shall withhold from such refunds an amount equal to such past-due support, and shall concurrently send notice to such individual that the withholding has been made, including in or with such notice a notification to any other person who may have filed a joint return with such individual of the steps which such other person may take in order to secure his or her proper share of the refund. The Secretary of the Treasury shall pay the amount withheld to the State agency, and the State shall pay to the Secretary of the Treasury any fee imposed by the Secretary of the Treasury to cover the costs of the withholding and any required notification. The State agency shall, subject to paragraph (3)(B), distribute such amount to or on behalf of the child to whom the support was owed in accordance with section 457. This subsection may be executed by the Secretary of the Department of the Treasury or his designee.

(B) This paragraph shall apply only with respect to refunds payable under section 6402 of the Internal Revenue Code of 1954[94] after December 31, 1985.

(3)(A) Prior to notifying the Secretary of the Treasury under paragraph (1) or (2) that an individual owes past-due support, the State shall send notice to such individual that a withholding will be made from any refund otherwise payable to such individual. The notice shall also (i) instruct the individual owing the past-due support of the steps which may be taken to contest the State's deter-

[94] See Vol. II, P.L. 83–591.

mination that past-due support is owed or the amount of the past-due support, and (ii) provide information, as may be prescribed by the Secretary of Health and Human Services by regulation in consultation with the Secretary of the Treasury, with respect to procedures to be followed, in the case of a joint return, to protect the share of the refund which may be payable to another person.

(B) If the Secretary of the Treasury determines that an amount should be withheld under paragraph (1) or (2), and that the refund from which it should be withheld is based upon a joint return, the Secretary of the Treasury shall notify the State that the withholding is being made from a refund based upon a joint return, and shall furnish to the State the names and addresses of each taxpayer filing such joint return. In the case of a withholding under paragraph (2), the State may delay distribution of the amount withheld until the State has been notified by the Secretary of the Treasury that the other person filing the joint return has received his or her proper share of the refund, but such delay may not exceed six months.

(C) If the other person filing the joint return with the named individual owing the past-due support takes appropriate action to secure his or her proper share of a refund from which a withholding was made under paragraph (1) or (2), the Secretary of the Treasury shall pay such share to such other person. The Secretary of the Treasury shall deduct the amount of such payment from amounts subsequently payable to the State agency to which the amount originally withheld from such refund was paid.

(D) In any case in which an amount was withheld under paragraph (1) or (2) and paid to a State, and the State subsequently determines that the amount certified as past-due support was in excess of the amount actually owed at the time the amount withheld is to be distributed to or on behalf of the child, the State shall pay the excess amount withheld to the named individual thought to have owed the past-due support (or, in the case of amounts withheld on the basis of a joint return, jointly to the parties filing such return).

(b)(1) The Secretary of the Treasury shall issue regulations, approved by the Secretary of Health and Human Services, prescribing the time or times at which States must submit notices of past-due support, the manner in which such notices must be submitted, and the necessary information that must be contained in or accompany the notices. The regulations shall be consistent with the provisions of subsection (a)(3), shall specify the minimum amount of past-due support to which the offset procedure established by subsection (a) may be applied, and the fee that a State must pay to reimburse the Secretary of the Treasury for the full cost of applying the offset procedure, and shall provide that the Secretary of the Treasury will advise the Secretary of Health and Human Services, not less frequently than annually, of the States which have furnished notices of past-due support under subsection (a), the number of cases in each State with respect to which such notices have been furnished, the amount of support sought to be collected under this subsection by each State, and the amount of such collections actually made in the case of each State. Any fee paid to the Secretary of the Treasury pursuant to this subsection may be used to reimburse appropriations which bore all or part of the cost of applying such procedure.

(2) In the case of withholdings made under subsection (a)(2), the regulations promulgated pursuant to this subsection shall include the following requirements:

(A) The withholding shall apply only in the case where the State determines that the amount of the past-due support which will be owed at the time the withholding is to be made, based upon the pattern of payment of support and other enforcement actions being pursued to collect the past-due support, is equal to or greater than $500. The State may limit the $500 threshold amount to amounts of past-due support accrued since the time that the State first began to enforce the child support order involved under the State plan, and may limit the application of the withholding to past-due support accrued since such time.

(B) The fee which the Secretary of the Treasury may impose to cover the costs of the withholding and notification may not exceed $25 per case submitted.

(c)(1) Except as provided in paragraph (2), as used in this part the term "past-due support" means the amount of a delinquency, determined under a court order, or an order of an administrative process established under State law, for support and maintenance of a child, or of a child and the parent with whom the child is living.

(2) For purposes of subsection (a)(2), the term "past-due support" means only past-due support owed to or on behalf of a qualified child (or a qualified child and the parent with whom the child is living if the same support order includes support for the child and the parent).

(3) For purposes of paragraph (2), the term "qualified child" means a child—

(A) who is a minor; or

(B)(i) who, while a minor, was determined to be disabled under title II or XVI; and

(ii) for whom an order of support is in force.

ALLOTMENTS FROM PAY FOR CHILD AND SPOUSAL SUPPORT OWED BY MEMBERS OF THE UNIFORMED SERVICES ON ACTIVE DUTY

SEC. 465. [42 U.S.C. 665] (a)(1) In any case in which child support payments or child and spousal support payments are owed by a member of one of the uniformed services (as defined in section 101(3) of title 37, United States Code) on active duty, such member shall be required to make allotments from his pay and allowances (under chapter 13 of title 37, United States Code[95]) as payment of such support, when he has failed to make periodic payments under a support order that meets the criteria specified in section 303(b)(1)(A) of the Consumer Credit Protection Act[96] (15 U.S.C. 1673(b)(1)(A)) and the resulting delinquency in such payments is in a total amount equal to the support payable for two months or longer. Failure to make such payments shall be established by notice from an authorized person (as defined in subsection (b)) to the designated official in the appropriate uniformed service. Such notice (which shall in turn be given to the affected member) shall also specify the person to whom the allotment is to be payable. The

[95] See Vol. II, Title 37.
[96] See Vol. II, P.L. 90–321.

amount of the allotment shall be the amount necessary to comply with the order (which, if the order so provides, may include arrearages as well as amounts for current support), except that the amount of the allotment, together with any other amounts withheld for support from the wages of the member, as a percentage of his pay from the uniformed service, shall not exceed the limits prescribed in sections 303(b) and (c) of the Consumer Credit Protection Act (15 U.S.C. 1673(b) and (c)). An allotment under this subsection shall be adjusted or discontinued upon notice from the authorized person.

(2) Notwithstanding the preceding provisions of this subsection, no action shall be taken to require an allotment from the pay and allowances of any member of one of the uniformed services under such provisions (A) until such member has had a consultation with a judge advocate of the service involved (as defined in section 801(13) of title 10, United States Code[97]), or with a law specialist (as defined in section 801(11) of such title) in the case of the Coast Guard, or with a legal officer designated by the Secretary concerned (as defined in section 101(5) of title 37, United States Code) in any other case, in person, to discuss the legal and other factors involved with respect to the member's support obligation and his failure to make payments thereon, or (B) until 30 days have elapsed after the notice described in the second sentence of paragraph (1) is given to the affected member in any case where it has not been possible, despite continuing good faith efforts, to arrange such a consultation.

(b) For purposes of this section the term "authorized person" with respect to any member of the uniformed services means—

(1) any agent or attorney of a State having in effect a plan approved under this part who has the duty or authority under such plan to seek to recover any amounts owed by such member as child or child and spousal support (including, when authorized under the State plan, any official of a political subdivision); and

(2) the court which has authority to issue an order against such member for the support and maintenance of a child, or any agent of such court.

(c) The Secretary of Defense, in the case of the Army, Navy, Air Force, and Marine Corps, and the Secretary concerned (as defined in section 101(5) of title 37, United States Code) in the case of each of the other uniformed services, shall each issue regulations applicable to allotments to be made under this section, designating the officials to whom notice of failure to make support payments, or notice to discontinue or adjust an allotment, should be given, prescribing the form and content of the notice and specifying any other rules necessary for such Secretary to implement this section.

REQUIREMENT OF STATUTORILY PRESCRIBED PROCEDURES TO IMPROVE EFFECTIVENESS OF CHILD SUPPORT ENFORCEMENT

SEC. 466. [42 U.S.C. 666] (a) In order to satisfy section 454(20)(A), each State must have in effect laws requiring the use of the following procedures, consistent with this section and with regulations of the Secretary, to increase the effectiveness of the program which the State administers under this part:

[97] See Vol. II, Title 10.

(1)(A) Procedures described in subsection (b) for the withholding from income of amounts payable as support in cases subject to enforcement under the State plan.

(B) Procedures under which the income of a person with a support obligation imposed by a support order issued (or modified) in the State before January 1, 1994, if not otherwise subject to withholding under subsection (b), shall become subject to withholding as provided in subsection (b) if arrearages occur, without the need for a judicial or administrative hearing.

(2) Expedited administrative and judicial procedures (including the procedures specified in subsection (c)) for establishing paternity and for establishing, modifying, and enforcing support obligations. The Secretary may waive the provisions of this paragraph with respect to one or more political subdivisions within the State on the basis of the effectiveness and timeliness of support order issuance and enforcement or paternity establishment within the political subdivision (in accordance with the general rule for exemptions under subsection (d)).

(3) Procedures under which the State child support enforcement agency shall request, and the State shall provide, that for the purpose of enforcing a support order under any State plan approved under this part—

(A) any refund of State income tax which would otherwise be payable to a noncustodial parent will be reduced, after notice has been sent to that noncustodial parent of the proposed reduction and the procedures to be followed to contest it (and after full compliance with all procedural due process requirements of the State), by the amount of any overdue support owed by such noncustodial parent;

(B) the amount by which such refund is reduced shall be distributed in accordance with section 457 in the case of overdue support assigned to a State pursuant to section 408(a)(3) or 471(a)(17), or, in any other case, shall be distributed, after deduction of any fees imposed by the State to cover the costs of collection, to the child or parent to whom such support is owed; and

(C) notice of the noncustodial parent's social security account number (or numbers, if he has more than one such number) and home address shall be furnished to the State agency requesting the refund offset, and to the State agency enforcing the order.

(4) LIENS.—Procedures under which—

(A) liens arise by operation of law against real and personal property for amounts of overdue support owed by a noncustodial parent who resides or owns property in the State; and

(B) the State accords full faith and credit to liens described in subparagraph (A) arising in another State, when the State agency, party, or other entity seeking to enforce such a lien complies with the procedural rules relating to recording or serving liens that arise within the State, except that such rules may not require judicial notice or hearing prior to the enforcement of such a lien.

(5) PROCEDURES CONCERNING PATERNITY ESTABLISHMENT.—

(A) ESTABLISHMENT PROCESS AVAILABLE FROM BIRTH UNTIL AGE 18.—

(i) Procedures which permit the establishment of the paternity of a child at any time before the child attains 18 years of age.

(ii) As of August 16, 1984, clause (i) shall also apply to a child for whom paternity has not yet been established or for whom a paternity action was brought but dismissed because a statute of limitations of less than 18 years was then in effect in the State.

(B) PROCEDURES CONCERNING GENETIC TESTING.—

(i) GENETIC TESTING REQUIRED IN CERTAIN CONTESTED CASES.—Procedures under which the State is required, in a contested paternity case (unless otherwise barred by State law) to require the child and all other parties (other than individuals found under section 454(29) to have good cause and other exceptions for refusing to cooperate) to submit to genetic tests upon the request of any such party, if the request is supported by a sworn statement by the party—

(I) alleging paternity, and setting forth facts establishing a reasonable possibility of the requisite sexual contact between the parties; or

(II) denying paternity, and setting forth facts establishing a reasonable possibility of the nonexistence of sexual contact between the parties.

(ii) OTHER REQUIREMENTS.—Procedures which require the State agency, in any case in which the agency orders genetic testing—

(I) to pay costs of such tests, subject to recoupment (if the State so elects) from the alleged father if paternity is established; and

(II) to obtain additional testing in any case if an original test result is contested, upon request and advance payment by the contestant.

(C) VOLUNTARY PATERNITY ACKNOWLEDGMENT.—

(i) SIMPLE CIVIL PROCESS.—Procedures for a simple civil process for voluntarily acknowledging paternity under which the State must provide that, before a mother and a putative father can sign an acknowledgment of paternity, the mother and the putative father must be given notice, orally, or through the use of video or audio equipment, and in writing, of the alternatives to, the legal consequences of, and the rights (including, if 1 parent is a minor, any rights afforded due to minority status) and responsibilities that arise from, signing the acknowledgment.

(ii) HOSPITAL–BASED PROGRAM.—Such procedures must include a hospital–based program for the voluntary acknowledgment of paternity focusing on the period immediately before or after the birth of a child.

(iii) PATERNITY ESTABLISHMENT SERVICES.—

(I) STATE–OFFERED SERVICES.—Such procedures must require the State agency responsible for

maintaining birth records to offer voluntary paternity establishment services.

(II) REGULATIONS.—

(aa) SERVICES OFFERED BY HOSPITALS AND BIRTH RECORD AGENCIES.—The Secretary shall prescribe regulations governing voluntary paternity establishment services offered by hospitals and birth record agencies.

(bb) SERVICES OFFERED BY OTHER ENTITIES.—The Secretary shall prescribe regulations specifying the types of other entities that may offer voluntary paternity establishment services, and governing the provision of such services, which shall include a requirement that such an entity must use the same notice provisions used by, use the same materials used by, provide the personnel providing such services with the same training provided by, and evaluate the provision of such services in the same manner as the provision of such services is evaluated by, voluntary paternity establishment programs of hospitals and birth record agencies.

(iv) USE OF PATERNITY ACKNOWLEDGMENT AFFIDAVIT.—Such procedures must require the State to develop and use an affidavit for the voluntary acknowledgment of paternity which includes the minimum requirements of the affidavit specified by the Secretary under section 452(a)(7) for the voluntary acknowledgment of paternity, and to give full faith and credit to such an affidavit signed in any other State according to its procedures.

(D) STATUS OF SIGNED PATERNITY ACKNOWLEDGMENT.—

(i) INCLUSION IN BIRTH RECORDS.—Procedures under which the name of the father shall be included on the record of birth of the child of unmarried parents only if—

(I) the father and mother have signed a voluntary acknowledgment of paternity; or

(II) a court or an administrative agency of competent jurisdiction has issued an adjudication of paternity.

Nothing in this clause shall preclude a State agency from obtaining an admission of paternity from the father for submission in a judicial or administrative proceeding, or prohibit the issuance of an order in a judicial or administrative proceeding which bases a legal finding of paternity on an admission of paternity by the father and any other additional showing required by State law.

(ii) LEGAL FINDING OF PATERNITY.—Procedures under which a signed voluntary acknowledgment of paternity is considered a legal finding of paternity, subject to the right of any signatory to rescind the acknowledgment within the earlier of—

(I) 60 days; or

(II) the date of an administrative or judicial proceeding relating to the child (including a proceeding to establish a support order) in which the signatory is a party.

(iii) CONTEST.—Procedures under which, after the 60–day period referred to in clause (ii), a signed voluntary acknowledgment of paternity may be challenged in court only on the basis of fraud, duress, or material mistake of fact, with the burden of proof upon the challenger, and under which the legal responsibilities (including child support obligations) of any signatory arising from the acknowledgment may not be suspended during the challenge, except for good cause shown.

(E) BAR ON ACKNOWLEDGMENT RATIFICATION PROCEEDINGS.—Procedures under which judicial or administrative proceedings are not required or permitted to ratify an unchallenged acknowledgment of paternity.

(F) ADMISSIBILITY OF GENETIC TESTING RESULTS.—Procedures—

(i) requiring the admission into evidence, for purposes of establishing paternity, of the results of any genetic test that is—

(I) of a type generally acknowledged as reliable by accreditation bodies designated by the Secretary; and

(II) performed by a laboratory approved by such an accreditation body;

(ii) requiring an objection to genetic testing results to be made in writing not later than a specified number of days before any hearing at which the results may be introduced into evidence (or, at State option, not later than a specified number of days after receipt of the results); and

(iii) making the test results admissible as evidence of paternity without the need for foundation testimony or other proof of authenticity or accuracy, unless objection is made.

(G) PRESUMPTION OF PATERNITY IN CERTAIN CASES.—Procedures which create a rebuttable or, at the option of the State, conclusive presumption of paternity upon genetic testing results indicating a threshold probability that the alleged father is the father of the child.

(H) DEFAULT ORDERS.—Procedures requiring a default order to be entered in a paternity case upon a showing of service of process on the defendant and any additional showing required by State law.

(I) NO RIGHT TO JURY TRIAL.—Procedures providing that the parties to an action to establish paternity are not entitled to a trial by jury.

(J) TEMPORARY SUPPORT ORDER BASED ON PROBABLE PATERNITY IN CONTESTED CASES.—Procedures which require that a temporary order be issued, upon motion by a party, requiring the provision of child support pending an administrative or judicial determination of parentage, if there is

clear and convincing evidence of paternity (on the basis of genetic tests or other evidence).

(K) PROOF OF CERTAIN SUPPORT AND PATERNITY ESTABLISHMENT COSTS.—Procedures under which bills for pregnancy, childbirth, and genetic testing are admissible as evidence without requiring third–party foundation testimony, and shall constitute prima facie evidence of amounts incurred for such services or for testing on behalf of the child.

(L) STANDING OF PUTATIVE FATHERS.—Procedures ensuring that the putative father has a reasonable opportunity to initiate a paternity action.

(M) FILING OF ACKNOWLEDGMENTS AND ADJUDICATIONS IN STATE REGISTRY OF BIRTH RECORDS.—Procedures under which voluntary acknowledgments and adjudications of paternity by judicial or administrative processes are filed with the State registry of birth records for comparison with information in the State case registry.

(6) Procedures which require that a noncustodial parent give security, post a bond, or give some other guarantee to secure payment of overdue support, after notice has been sent to such noncustodial parent of the proposed action and of the procedures to be followed to contest it (and after full compliance with all procedural due process requirements of the State).

(7) REPORTING ARREARAGES TO CREDIT BUREAUS.—

(A) IN GENERAL.—Procedures (subject to safeguards pursuant to subparagraph (B)) requiring the State to report periodically to consumer reporting agencies (as defined in section 603(f) of the Fair Credit Reporting Act (15 U.S.C. 1681a(f)))[98] the name of any noncustodial parent who is delinquent in the payment of support, and the amount of overdue support owed by such parent.

(B) SAFEGUARDS.—Procedures ensuring that, in carrying out subparagraph (A), information with respect to a noncustodial parent is reported—

(i) only after such parent has been afforded all due process required under State law, including notice and a reasonable opportunity to contest the accuracy of such information; and

(ii) only to an entity that has furnished evidence satisfactory to the State that the entity is a consumer reporting agency (as so defined).

(8)(A) Procedures under which all child support orders not described in subparagraph (B) will include provision for withholding from income, in order to assure that withholding as a means of collecting child support is available if arrearages occur without the necessity of filing application for services under this part.

(B) Procedures under which all child support orders which are initially issued in the State on or after January 1, 1994, and are not being enforced under this part will include the following requirements:

(i) The income of a noncustodial parent shall be subject to withholding, regardless of whether support pay-

[98] See Vol. II, P.L. 90–321, Title VI.

ments by such parent are in arrears, on the effective date of the order; except that such income shall not be subject to withholding under this clause in any case where (I) one of the parties demonstrates, and the court (or administrative process) finds, that there is good cause not to require immediate income withholding, or (II) a written agreement is reached between both parties which provides for an alternative arrangement.

(ii) The requirements of subsection (b)(1) (which shall apply in the case of each noncustodial parent against whom a support order is or has been issued or modified in the State, without regard to whether the order is being enforced under the State plan).

(iii) The requirements of paragraphs (2), (5), (6), (7), (8), (9), and (10) of subsection (b), where applicable.

(iv) Withholding from income of amounts payable as support must be carried out in full compliance with all procedural due process requirements of the State.

(9) Procedures which require that any payment or installment of support under any child support order, whether ordered through the State judicial system or through the expedited processes required by paragraph (2), is (on and after the date it is due)—

(A) a judgment by operation of law, with the full force, effect, and attributes of a judgment of the State, including the ability to be enforced,

(B) entitled as a judgment to full faith and credit in such State and in any other State, and

(C) not subject to retroactive modification by such State or by any other State;

except that such procedures may permit modification with respect to any period during which there is pending a petition for modification, but only from the date that notice of such petition has been given, either directly or through the appropriate agent, to the obligee or (where the obligee is the petitioner) to the obligor.

(10) REVIEW AND ADJUSTMENT OF SUPPORT ORDERS UPON REQUEST.—

(A) 3–YEAR CYCLE.—

(i) IN GENERAL.—Procedures under which every 3 years (or such shorter cycle as the State may determine), upon the request of either parent, or, if there is an assignment under part A, upon the request of the State agency under the State plan or of either parent, the State shall with respect to a support order being enforced under this part, taking into account the best interests of the child involved—

(I) review and, if appropriate, adjust the order in accordance with the guidelines established pursuant to section 467(a) if the amount of the child support award under the order differs from the amount that would be awarded in accordance with the guidelines;

(II) apply a cost–of–living adjustment to the order in accordance with a formula developed by the State; or

(III) use automated methods (including automated comparisons with wage or State income tax data) to identify orders eligible for review, conduct the review, identify orders eligible for adjustment, and apply the appropriate adjustment to the orders eligible for adjustment under any threshold that may be established by the State.

(ii) OPPORTUNITY TO REQUEST REVIEW OF ADJUSTMENT.—If the State elects to conduct the review under subclause (II) or (III) of clause (i), procedures which permit either party to contest the adjustment, within 30 days after the date of the notice of the adjustment, by making a request for review and, if appropriate, adjustment of the order in accordance with the child support guidelines established pursuant to section 467(a).

(iii) NO PROOF OF CHANGE IN CIRCUMSTANCES NECESSARY IN 3–YEAR CYCLE REVIEW.—Procedures which provide that any adjustment under clause (i) shall be made without a requirement for proof or showing of a change in circumstances.

(B) PROOF OF SUBSTANTIAL CHANGE IN CIRCUMSTANCES NECESSARY IN REQUEST FOR REVIEW OUTSIDE 3–YEAR CYCLE.—Procedures under which, in the case of a request for a review, and if appropriate, an adjustment outside the 3–year cycle (or such shorter cycle as the State may determine) under clause (i), the State shall review and, if the requesting party demonstrates a substantial change in circumstances, adjust the order in accordance with the guidelines established pursuant to section 467(a).

(C) NOTICE OF RIGHT TO REVIEW.—Procedures which require the State to provide notice not less than once every 3 years to the parents subject to the order informing the parents of their right to request the State to review and, if appropriate, adjust the order pursuant to this paragraph. The notice may be included in the order.

(11) Procedures under which a State must give full faith and credit to a determination of paternity made by any other State, whether established through voluntary acknowledgment or through administrative or judicial processes.

(12) LOCATOR INFORMATION FROM INTERSTATE NETWORKS.—Procedures to ensure that all Federal and State agencies conducting activities under this part have access to any system used by the State to locate an individual for purposes relating to motor vehicles or law enforcement.

(13) RECORDING OF SOCIAL SECURITY NUMBERS IN CERTAIN FAMILY MATTERS.—Procedures requiring that the social security number of—

(A) any applicant for a professional license, driver's license, occupational license, recreational license, or marriage license be recorded on the application;

(B) any individual who is subject to a divorce decree, support order, or paternity determination or acknowledgment be placed in the records relating to the matter; and

(C) any individual who has died be placed in the records relating to the death and be recorded on the death certificate.

For purposes of subparagraph (A), if a State allows the use of a number other than the social security number to be used on the face of the document while the social security number is kept on file at the agency, the State shall so advise any applicants.

(14) HIGH–VOLUME, AUTOMATED ADMINISTRATIVE ENFORCEMENT IN INTERSTATE CASES.—

(A) IN GENERAL.—Procedures under which—

(i) the State shall use high–volume automated administrative enforcement, to the same extent as used for intrastate cases, in response to a request made by another State to enforce support orders, and shall promptly report the results of such enforcement procedure to the requesting State;

(ii) the State may, by electronic or other means, transmit to another State a request for assistance in enforcing support orders through high–volume, automated administrative enforcement, which request—

(I) shall include such information as will enable the State to which the request is transmitted to compare the information about the cases to the information in the data bases of the State; and

(II) shall constitute a certification by the requesting State—

(aa) of the amount of support under an order the payment of which is in arrears; and

(bb) that the requesting State has complied with all procedural due process requirements applicable to each case;

(iii) if the State provides assistance to another State pursuant to this paragraph with respect to a case, neither State shall consider the case to be transferred to the caseload of such other State; and

(iv) the State shall maintain records of—

(I) the number of such requests for assistance received by the State;

(II) the number of cases for which the State collected support in response to such a request; and

(III) the amount of such collected support.

(B) HIGH–VOLUME AUTOMATED ADMINISTRATIVE ENFORCEMENT.—In this part, the term "high–volume automated administrative enforcement" in interstate cases, means, on request of another State, the identification by a State, through automated data matches with financial institutions and other entities where assets may be found, of assets owned by persons who owe child support in other States, and the seizure of such assets by the State, through levy or other appropriate processes.

(15) PROCEDURES TO ENSURE THAT PERSONS OWING OVERDUE SUPPORT WORK OR HAVE A PLAN FOR PAYMENT OF SUCH SUPPORT.—Procedures under which the State has the authority, in any case in which an individual owes overdue support with respect to a child receiving assistance under a State program funded under part A, to issue an order or to request that a court or an administrative process established pursuant to State law issue an order that requires the individual to—

(A) pay such support in accordance with a plan approved by the court, or, at the option of the State, a plan approved by the State agency administering the State program under this part; or

(B) if the individual is subject to such a plan and is not incapacitated, participate in such work activities (as defined in section 407(d)) as the court, or, at the option of the State, the State agency administering the State program under this part, deems appropriate.

(16) AUTHORITY TO WITHHOLD OR SUSPEND LICENSES.—Procedures under which the State has (and uses in appropriate cases) authority to withhold or suspend, or to restrict the use of driver's licenses, professional and occupational licenses, and recreational and sporting licenses of individuals owing overdue support or failing, after receiving appropriate notice, to comply with subpoenas or warrants relating to paternity or child support proceedings.

(17) FINANCIAL INSTITUTION DATA MATCHES.—

(A) IN GENERAL.—Procedures under which the State agency shall enter into agreements with financial institutions doing business in the State—

(i) to develop and operate, in coordination with such financial institutions, and the Federal Parent Locator Service in the case of financial institutions doing business in two or more States, a data match system, using automated data exchanges to the maximum extent feasible, in which each such financial institution is required to provide for each calendar quarter the name, record address, social security number or other taxpayer identification number, and other identifying information for each noncustodial parent who maintains an account at such institution and who owes past–due support, as identified by the State by name and social security number or other taxpayer identification number; and

(ii) in response to a notice of lien or levy, encumber or surrender, as the case may be, assets held by such institution on behalf of any noncustodial parent who is subject to a child support lien pursuant to paragraph (4).

(B) REASONABLE FEES.—The State agency may pay a reasonable fee to a financial institution for conducting the data match provided for in subparagraph (A)(i), not to exceed the actual costs incurred by such financial institution.

(C) LIABILITY.—A financial institution shall not be liable under any Federal or State law to any person—

(i) for any disclosure of information to the State agency under subparagraph (A)(i);

(ii) for encumbering or surrendering any assets held by such financial institution in response to a notice of lien or levy issued by the State agency as provided for in subparagraph (A)(ii); or

(iii) for any other action taken in good faith to comply with the requirements of subparagraph (A).

(D) DEFINITIONS.—For purposes of this paragraph—

(i) FINANCIAL INSTITUTION.—The term "financial institution" has the meaning given to such term by section 469A(d)(1).

(ii) ACCOUNT.—The term "account" means a demand deposit account, checking or negotiable withdrawal order account, savings account, time deposit account, or money–market mutual fund account.

(18) ENFORCEMENT OF ORDERS AGAINST PATERNAL OR MATERNAL GRANDPARENTS.—Procedures under which, at the State's option, any child support order enforced under this part with respect to a child of minor parents, if the custodial parent of such child is receiving assistance under the State program under part A, shall be enforceable, jointly and severally, against the parents of the noncustodial parent of such child.

(19) HEALTH CARE COVERAGE.—Procedures under which all child support orders enforced pursuant to this part shall include a provision for the health care coverage of the child, and in the case in which a noncustodial parent provides such coverage and changes employment, and the new employer provides health care coverage, the State agency shall transfer notice of the provision to the employer, which notice shall operate to enroll the child in the noncustodial parent's health plan, unless the noncustodial parent contests the notice.

Notwithstanding section 454(20)(B), the procedures which are required under paragraphs (3), (4), (6), (7), and (15) need not be used or applied in cases where the State determines (using guidelines which are generally available within the State and which take into account the payment record of the noncustodial parent, the availability of other remedies, and other relevant considerations) that such use or application would not carry out the purposes of this part or would be otherwise inappropriate in the circumstances.

(b) The procedures referred to in subsection (a)(1)(A) (relating to the withholding from income of amounts payable as support) must provide for the following:

(1) In the case of each noncustodial parent against whom a support order is or has been issued or modified in the State, and is being enforced under the State plan, so much of such parent's income must be withheld, in accordance with the succeeding provisions of this subsection, as is necessary to comply with the order and provide for the payment of any fee to the employer which may be required under paragraph (6)(A), up to the maximum amount permitted under section 303(b) of the Consumer Credit Protection Act (15 U.S.C. 1673(b)). If there are arrearages to be collected, amounts withheld to satisfy such arrearages, when added to the amounts withheld to pay current support and provide for the fee, may not exceed the limit permitted under such section 303(b), but the State need not withhold up to the maximum amount permitted under such section in order to satisfy arrearages.

(2) Such withholding must be provided without the necessity of any application therefor in the case of a child (whether or not eligible for assistance under a State program funded under part A) with respect to whom services are already being provided under the State plan under this part, and must be provided in accordance with this subsection on the basis of an application for services under the State plan in the case of any other child in whose behalf a support order has been issued or modified in the State. In either case such withholding must occur without the need for any amendment to the support order involved or for any further action (other than those actions required under this part) by the court or other entity which issued such order.

(3)(A) The income of a noncustodial parent shall be subject to such withholding, regardless of whether support payments by such parent are in arrears, in the case of a support order being enforced under this part that is issued or modified on or after the first day of the 25th month beginning after the date of the enactment of this paragraph, on the effective date of the order; except that such income shall not be subject to such withholding under this subparagraph in any case where (i) one of the parties demonstrates, and the court (or administrative process) finds, that there is good cause not to require immediate income withholding, or (ii) a written agreement is reached between both parties which provides for an alternative arrangement.

(B) The income of a noncustodial parent shall become subject to such withholding, in the case of income not subject to withholding under subparagraph (A), on the date on which the payments which the noncustodial parent has failed to make under a support order are at least equal to the support payable for one month or, if earlier, and without regard to whether there is an arrearage, the earliest of—

(i) the date as of which the noncustodial parent requests that such withholding begin,

(ii) the date as of which the custodial parent requests that such withholding begin, if the State determines, in accordance with such procedures and standards as it may establish, that the request should be approved, or

(iii) such earlier date as the State may select.

(4)(A) Such withholding must be carried out in full compliance with all procedural due process requirements of the State, and the State must send notice to each noncustodial parent to whom paragraph (1) applies—

(i) that the withholding has commenced; and

(ii) of the procedures to follow if the noncustodial parent desires to contest such withholding on the grounds that the withholding or the amount withheld is improper due to a mistake of fact.

(B) The notice under subparagraph (A) of this paragraph shall include the information provided to the employer under paragraph (6)(A).

(5) Such withholding must be administered by the State through the State disbursement unit established pursuant to

section 454B, in accordance with the requirements of section 454B.

(6)(A)(i) The employer of any absent parent to whom paragraph (1) applies, upon being given notice as described in clause (ii), must be required to withhold from such noncustodial parent's income the amount specified by such notice (which may include a fee, established by the State, to be paid to the employer unless waived by such employer) and pay such amount (after deducting and retaining any portion thereof which represents the fee so established) to the State disbursement unit within 7 business days after the date the amount would (but for this subsection) have been paid or credited to the employee, for distribution in accordance with this part. The employer shall withhold funds as directed in the notice, except that when an employer receives an income withholding order issued by another State, the employer shall apply the income withholding law of the State of the obligor's principal place of employment in determining—

(I) the employer's fee for processing an income withholding order;

(II) the maximum amount permitted to be withheld from the obligor's income;

(III) the time periods within which the employer must implement the income withholding order and forward the child support payment;

(IV) the priorities for withholding and allocating income withheld for multiple child support obligees; and

(V) any withholding terms or conditions not specified in the order.

An employer who complies with an income withholding notice that is regular on its face shall not be subject to civil liability to any individual or agency for conduct in compliance with the notice.

(ii) The notice given to the employer shall be in a standard format prescribed by the Secretary, and contain only such information as may be necessary for the employer to comply with the withholding order.

(iii) As used in this subparagraph, the term "business day" means a day on which State offices are open for regular business.

(B) Methods must be established by the State to simplify the withholding process for employers to the greatest extent possible, including permitting any employer to combine all withheld amounts into a single payment to each appropriate agency or entity (with the portion thereof which is attributable to each individual employee being separately designated).

(C) The employer must be held liable to the State for any amount which such employer fails to withhold from income due an employee following receipt by such employer of proper notice under subparagraph (A), but such employer shall not be required to vary the normal pay and disbursement cycles in order to comply with this paragraph.

(D) Provision must be made for the imposition of a fine against any employer who—

(i) discharges from employment, refuses to employ, or takes disciplinary action against any noncustodial parent subject to income withholding required by this subsection because of the existence of such withholding and the obligations or additional obligations which it imposes upon the employer; or

(ii) fails to withhold support from income or to pay such amounts to the State disbursement unit in accordance with this subsection.

(7) Support collection under this subsection must be given priority over any other legal process under State law against the same income.

(8) For purposes of subsection (a) and this subsection, the term "income" means any periodic form of payment due to an individual, regardless of source, including wages, salaries, commissions, bonuses, worker's compensation, disability, payments pursuant to a pension or retirement program, and interest.

(9) The State must extend its withholding system under this subsection so that such system will include withholding from income derived within such State in cases where the applicable support orders were issued in other States, in order to assure that child support owed by noncustodial parents in such State or any other State will be collected without regard to the residence of the child for whom the support is payable or of such child's custodial parent.

(10) Provision must be made for terminating withholding.

(11) Procedures under which the agency administering the State plan approved under this part may execute a withholding order without advance notice to the obligor, including issuing the withholding order through electronic means.

(c) EXPEDITED PROCEDURES.—The procedures specified in this subsection are the following:

(1) ADMINISTRATIVE ACTION BY STATE AGENCY.—Procedures which give the State agency the authority to take the following actions relating to establishment of paternity or to establishment, modification, or enforcement of support orders, without the necessity of obtaining an order from any other judicial or administrative tribunal, and to recognize and enforce the authority of State agencies of other States to take the following actions:

(A) GENETIC TESTING.—To order genetic testing for the purpose of paternity establishment as provided in section 466(a)(5).

(B) FINANCIAL OR OTHER INFORMATION.—To subpoena any financial or other information needed to establish, modify, or enforce a support order, and to impose penalties for failure to respond to such a subpoena.

(C) RESPONSE TO STATE AGENCY REQUEST.—To require all entities in the State (including for–profit, nonprofit, and governmental employers) to provide promptly, in response to a request by the State agency of that or any other State administering a program under this part, information on the employment, compensation, and benefits of any individual employed by such entity as an employee

or contractor, and to sanction failure to respond to any such request.

(D) ACCESS TO INFORMATION CONTAINED IN CERTAIN RECORDS.—To obtain access, subject to safeguards on privacy and information security, and subject to the nonliability of entities that afford such access under this subparagraph, to information contained in the following records (including automated access, in the case of records maintained in automated data bases):

(i) Records of other State and local government agencies, including—

(I) vital statistics (including records of marriage, birth, and divorce);

(II) State and local tax and revenue records (including information on residence address, employer, income and assets);

(III) records concerning real and titled personal property;

(IV) records of occupational and professional licenses, and records concerning the ownership and control of corporations, partnerships, and other business entities;

(V) employment security records;

(VI) records of agencies administering public assistance programs;

(VII) records of the motor vehicle department; and

(VIII) corrections records.

(ii) Certain records held by private entities with respect to individuals who owe or are owed support (or against or with respect to whom a support obligation is sought), consisting of—

(I) the names and addresses of such individuals and the names and addresses of the employers of such individuals, as appearing in customer records of public utilities and cable television companies, pursuant to an administrative subpoena authorized by subparagraph (B); and

(II) information (including information on assets and liabilities) on such individuals held by financial institutions.

(E) CHANGE IN PAYEE.—In cases in which support is subject to an assignment in order to comply with a requirement imposed pursuant to part A, part E, or section 1912, or to a requirement to pay through the State disbursement unit established pursuant to section 454B, upon providing notice to obligor and obligee, to direct the obligor or other payor to change the payee to the appropriate government entity.

(F) INCOME WITHHOLDING.—To order income withholding in accordance with subsections (a)(1)(A) and (b).

(G) SECURING ASSETS.—In cases in which there is a support arrearage, to secure assets to satisfy any current support obligation and the arrearage by—

(i) intercepting or seizing periodic or lump–sum payments from—

(I) a State or local agency, including unemployment compensation, workers' compensation, and other benefits; and

(II) judgments, settlements, and lotteries;

(ii) attaching and seizing assets of the obligor held in financial institutions;

(iii) attaching public and private retirement funds; and

(iv) imposing liens in accordance with subsection (a)(4) and, in appropriate cases, to force sale of property and distribution of proceeds.

(H) INCREASE MONTHLY PAYMENTS.—For the purpose of securing overdue support, to increase the amount of monthly support payments to include amounts for arrearages, subject to such conditions or limitations as the State may provide.

Such procedures shall be subject to due process safeguards, including (as appropriate) requirements for notice, opportunity to contest the action, and opportunity for an appeal on the record to an independent administrative or judicial tribunal.

(2) SUBSTANTIVE AND PROCEDURAL RULES.—The expedited procedures required under subsection (a)(2) shall include the following rules and authority, applicable with respect to all proceedings to establish paternity or to establish, modify, or enforce support orders:

(A) LOCATOR INFORMATION; PRESUMPTIONS CONCERNING NOTICE.—Procedures under which—

(i) each party to any paternity or child support proceeding is required (subject to privacy safeguards) to file with the State case registry upon entry of an order, and to update as appropriate, information on location and identity of the party, including social security number, residential and mailing addresses, telephone number, driver's license number, and name, address, and telephone number of employer; and

(ii) in any subsequent child support enforcement action between the parties, upon sufficient showing that diligent effort has been made to ascertain the location of such a party, the court or administrative agency of competent jurisdiction shall may deem State due process requirements for notice and service of process to be met with respect to the party, upon delivery of written notice to the most recent residential or employer address filed with the State case registry pursuant to clause (i).

(B) STATEWIDE JURISDICTION.—Procedures under which—

(i) the State agency and any administrative or judicial tribunal with authority to hear child support and paternity cases exerts statewide jurisdiction over the parties; and

(ii) in a State in which orders are issued by courts or administrative tribunals, a case may be transferred between local jurisdictions in the State without need for any additional filing by the petitioner, or service of

process upon the respondent, to retain jurisdiction over the parties.

(3) COORDINATION WITH ERISA.—Notwithstanding subsection (d) of section 514 of the Employee Retirement Income Security Act of 1974[99] (relating to effect on other laws), nothing in this subsection shall be construed to alter, amend, modify, invalidate, impair, or supersede subsections (a), (b), and (c) of such section 514 as it applies with respect to any procedure referred to in paragraph (1) and any expedited procedure referred to in paragraph (2), except to the extent that such procedure would be consistent with the requirements of section 206(d)(3) of such Act (relating to qualified domestic relations orders) or the requirements of section 609(a) of such Act (relating to qualified medical child support orders) if the reference in such section 206(d)(3) to a domestic relations order and the reference in such section 609(a) to a medical child support order were a reference to a support order referred to in paragraphs (1) and (2) relating to the same matters, respectively.

(d) If a State demonstrates to the satisfaction of the Secretary, through the presentation to the Secretary of such data pertaining to caseloads, processing times, administrative costs, and average support collections, and such other data or estimates as the Secretary may specify, that the enactment of any law or the use of any procedure or procedures required by or pursuant to this section will not increase the effectiveness and efficiency of the State child support enforcement program, the Secretary may exempt the State, subject to the Secretary's continuing review and to termination of the exemption should circumstances change, from the requirement to enact the law or use the procedure or procedures involved.

(e) For purposes of this section, the term "overdue support" means the amount of a delinquency pursuant to an obligation determined under a court order, or an order of an administrative process established under State law, for support and maintenance of a minor child which is owed to or on behalf of such child, or for support and maintenance of the noncustodial parent's spouse (or former spouse) with whom the child is living if and to the extent that spousal support (with respect to such spouse or former spouse) would be included for section 454(4). At the option of the State, overdue support may include amounts which otherwise meet the definition in the first sentence of this subsection but which are owed to or on behalf of a child who is not a minor child. The option to include support owed to children who are not minors shall apply independently to each procedure specified under this section.

(f) UNIFORM INTERSTATE FAMILY SUPPORT ACT.—In order to satisfy section 454(20)(A), on and after January 1, 1998, each State must have in effect the Uniform Interstate Family Support Act, as approved by the American Bar Association on February 9, 1993, and as in effect on August 22, 1996, including any amendments officially adopted as of such date by the National Conference of Commissioners on Uniform State Laws.

(g) LAWS VOIDING FRAUDULENT TRANSFERS.—In order to satisfy section 454(20)(A), each State must have in effect—

(1)(A) the Uniform Fraudulent Conveyance Act of 1981;

(B) the Uniform Fraudulent Transfer Act of 1984; or

[99] See Vol. II, P.L. 93-406, §514.

(C) another law, specifying indicia of fraud which create a prima facie case that a debtor transferred income or property to avoid payment to a child support creditor, which the Secretary finds affords comparable rights to child support creditors; and

(2) procedures under which, in any case in which the State knows of a transfer by a child support debtor with respect to which such a prima facie case is established, the State must—

(A) seek to void such transfer; or

(B) obtain a settlement in the best interests of the child support creditor.

STATE GUIDELINES FOR CHILD SUPPORT AWARDS

SEC. 467. [42 U.S.C. 667] (a) Each State, as a condition for having its State plan approved under this part, must establish guidelines for child support award amounts within the State. The guidelines may be established by law or by judicial or administrative action, and shall be reviewed at least once every 4 years to ensure that their application results in the determination of appropriate child support award amounts.

(b)(1) The guidelines established pursuant to subsection (a) shall be made available to all judges and other officials who have the power to determine child support awards within such State.

(2) There shall be a rebuttable presumption, in any judicial or administrative proceeding for the award of child support, that the amount of the award which would result from the application of such guidelines is the correct amount of child support to be awarded. A written finding or specific finding on the record that the application of the guidelines would be unjust or inappropriate in a particular case, as determined under criteria established by the State, shall be sufficient to rebut the presumption in that case.

(c) The Secretary shall furnish technical assistance to the States for establishing the guidelines, and each State shall furnish the Secretary with copies of its guidelines.

ENCOURAGEMENT OF STATES TO ADOPT SIMPLE CIVIL PROCESS FOR VOLUNTARILY ACKNOWLEDGING PATERNITY AND A CIVIL PROCEDURE FOR ESTABLISHING PATERNITY IN CONTESTED CASES

SEC. 468. [42 U.S.C. 668] In the administration of the child support enforcement program under this part, each State is encouraged to establish and implement a civil procedure for establishing paternity in contested cases.

COLLECTION AND REPORTING OF CHILD SUPPORT ENFORCEMENT DATA

SEC. 469. [42 U.S.C. 669] (a) IN GENERAL.—With respect to each type of service described in subsection (b), the Secretary shall collect and maintain up–to–date statistics, by State, and on a fiscal year basis, on—

(1) the number of cases in the caseload of the State agency administering the plan approved under this part in which the service is needed; and

(2) the number of such cases in which the service has actually been provided.

(b) TYPES OF SERVICES.—The statistics required by subsection (a) shall be separately stated with respect to paternity establishment services and child support obligation establishment services.

(c) TYPES OF SERVICE RECIPIENTS.—The statistics required by subsection (a) shall be separately stated with respect to—

(1) recipients of assistance under a State program funded under part A or of payments or services under a State plan approved under part E; and

(2) individuals who are not such recipients.

(d) For purposes of subsection (a)(2), a service has actually been provided when the task described by the service has been accomplished.

NONLIABILITY FOR FINANCIAL INSTITUTIONS PROVIDING FINANCIAL RECORDS TO STATE CHILD SUPPORT ENFORCEMENT AGENCIES IN CHILD SUPPORT CASES

SEC. 469A. [42 U.S.C. 669a] (a) IN GENERAL.—Notwithstanding any other provision of Federal or State law, a financial institution shall not be liable under any Federal or State law to any person for disclosing any financial record of an individual to a State child support enforcement agency attempting to establish, modify, or enforce a child support obligation of such individual, or for disclosing any such record to the Federal Parent Locator Service pursuant to section 466(a)(17)(A).

(b) PROHIBITION OF DISCLOSURE OF FINANCIAL RECORD OBTAINED BY STATE CHILD SUPPORT ENFORCEMENT AGENCY.—A State child support enforcement agency which obtains a financial record of an individual from a financial institution pursuant to subsection (a) may disclose such financial record only for the purpose of, and to the extent necessary in, establishing, modifying, or enforcing a child support obligation of such individual.

(c) CIVIL DAMAGES FOR UNAUTHORIZED DISCLOSURE.—

(1) DISCLOSURE BY STATE OFFICER OR EMPLOYEE.—If any person knowingly, or by reason of negligence, discloses a financial record of an individual in violation of subsection (b), such individual may bring a civil action for damages against such person in a district court of the United States.

(2) NO LIABILITY FOR GOOD FAITH BUT ERRONEOUS INTERPRETATION.—No liability shall arise under this subsection with respect to any disclosure which results from a good faith, but erroneous, interpretation of subsection (b).

(3) DAMAGES.—In any action brought under paragraph (1), upon a finding of liability on the part of the defendant, the defendant shall be liable to the plaintiff in an amount equal to the sum of—

(A) the greater of—

(i) $1,000 for each act of unauthorized disclosure of a financial record with respect to which such defendant is found liable; or

(ii) the sum of—

(I) the actual damages sustained by the plaintiff as a result of such unauthorized disclosure; plus

(II) in the case of a willful disclosure or a disclosure which is the result of gross negligence, punitive damages; plus

(B) the costs (including attorney's fees) of the action.

(d) DEFINITIONS.—For purposes of this section—

(1) FINANCIAL INSTITUTION.—The term "financial institution" means—

(A) a depository institution, as defined in section 3(c) of the Federal Deposit Insurance Act (12 U.S.C. 1813(c));

(B) an institution–affiliated party, as defined in section 3(u) of such Act (12 U.S.C. 1813(u));

(C) any Federal credit union or State credit union, as defined in section 101 of the Federal Credit Union Act (12 U.S.C. 1752), including an institution–affiliated party of such a credit union, as defined in section 206(r) of such Act (12 U.S.C. 1786(r)); and

(D) any benefit association, insurance company, safe deposit company, money–market mutual fund, or similar entity authorized to do business in the State.

(2) FINANCIAL RECORD.—The term "financial record" has the meaning given such term in section 1101 of the Right to Financial Privacy Act of 1978 [100](12 U.S.C. 3401).

GRANTS TO STATES FOR ACCESS AND VISITATION PROGRAMS

SEC. 469B. [42 U.S.C. 669b] (a) IN GENERAL.—The Administration for Children and Families shall make grants under this section to enable States to establish and administer programs to support and facilitate noncustodial parents' access to and visitation of their children, by means of activities including mediation (both voluntary and mandatory), counseling, education, development of parenting plans, visitation enforcement (including monitoring, supervision and neutral dropoff and pickup), and development of guidelines for visitation and alternative custody arrangements.

(b) AMOUNT OF GRANT.—The amount of the grant to be made to a State under this section for a fiscal year shall be an amount equal to the lesser of—

(1) 90 percent of State expenditures during the fiscal year for activities described in subsection (a); or

(2) the allotment of the State under subsection (c) for the fiscal year.

(c) ALLOTMENTS TO STATES.—

(1) IN GENERAL.—The allotment of a State for a fiscal year is the amount that bears the same ratio to $10,000,000 for grants under this section for the fiscal year as the number of children in the State living with only 1 biological parent bears to the total number of such children in all States.

(2) MINIMUM ALLOTMENT.—The Administration for Children and Families shall adjust allotments to States under paragraph (1) as necessary to ensure that no State is allotted less than—

(A) $50,000 for fiscal year 1997 or 1998; or

(B) $100,000 for any succeeding fiscal year.

(d) NO SUPPLANTATION OF STATE EXPENDITURES FOR SIMILAR ACTIVITIES.—A State to which a grant is made under this section may not use the grant to supplant expenditures by the State for activities specified in subsection (a), but shall use the grant to supplement such expenditures at a level at least equal to the level of such expenditures for fiscal year 1995.

[100] See Vol. II, P.L. 95–630, §1101.

(e) STATE ADMINISTRATION.—Each State to which a grant is made under this section—

(1) may administer State programs funded with the grant directly or through grants to or contracts with courts, local public agencies, or nonprofit private entities;

(2) shall not be required to operate such programs on a statewide basis; and

(3) shall monitor, evaluate, and report on such programs in accordance with regulations prescribed by the Secretary.

Part E—Federal Payments for Foster Care and Adoption Assistance

PURPOSE: APPROPRIATION

SEC. 470. [42 U.S.C. 670] For the purpose of enabling each State to provide, in appropriate cases, foster care and transitional independent living programs for children who otherwise would have been eligible for assistance under the State's plan approved under part A (as such plan was in effect on June 1, 1995) and adoption assistance for children with special needs, there are authorized to be appropriated for each fiscal year (commencing with the fiscal year which begins October 1, 1980) such sums as may be necessary to carry out the provisions of this part. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans under this part.

STATE PLAN FOR FOSTER CARE AND ADOPTION ASSISTANCE

SEC. 471. [42 U.S.C. 671] (a) In order for a State to be eligible for payments under this part, it shall have a plan approved by the Secretary which—

(1) provides for foster care maintenance payments in accordance with section 472 and for adoption assistance in accordance with section 473;

(2) provides that the State agency responsible for administering the program authorized by subpart 1 of part B of this title shall administer, or supervise the administration of, the program authorized by this part;

(3) provides that the plan shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(4) provides that the State shall assure that the programs at the local level assisted under this part will be coordinated with the programs at the State or local level assisted under parts A and B of this title, under title XX of this Act, and under any other appropriate provision of Federal law;

(5) provides that the State will, in the administration of its programs under this part, use such methods relating to the establishment and maintenance of personnel standards on a merit basis as are found by the Secretary to be necessary for the proper and efficient operation of the programs, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods;

(6) provides that the State agency referred to in paragraph (2) (hereinafter in this part referred to as 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) provides that the State agency will monitor and conduct periodic evaluations of activities carried out under this part;

(8) provides safeguards which restrict the use of or disclosure of information concerning individuals assisted under the State plan to purposes directly connected with (A) the administration of the plan of the State approved under this part, the plan or program of the State under part A, B, or D of this title or under title I, V, X, XIV, XVI (as in effect in Puerto Rico, Guam, and the Virgin Islands), XIX, or XX, or the supplemental security income program established by title XVI, (B) any investigation, prosecution, or criminal or civil proceeding, conducted in connection with the administration of any such plan or program, (C) the administration of any other Federal or federally assisted program which provides assistance, in cash or in kind, or services, directly to individuals on the basis of need, (D) any audit or similar activity conducted in connection with the administration of any such plan or program by any governmental agency which is authorized by law to conduct such audit or activity, and (E) reporting and providing information pursuant to paragraph (9) to appropriate authorities with respect to known or suspected child abuse or neglect; and the safeguards so provided shall prohibit disclosure, to any committee or legislative body (other than an agency referred to in clause (D) with respect to an activity referred to in such clause), of any information which identifies by name or address any such applicant or recipient; except that nothing contained herein shall preclude a State from providing standards which restrict disclosures to purposes more limited than those specified herein, or which, in the case of adoptions, prevent disclosure entirely;

(9) provides that the State agency will—

(A) report to an appropriate agency or official, known or suspected instances of physical or mental injury, sexual abuse or exploitation, or negligent treatment or maltreatment of a child receiving aid under part B or this part under circumstances which indicate that the child's health or welfare is threatened thereby; and

(B) provide such information with respect to a situation described in subparagraph (A) as the State agency may have;

(10) provides for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for foster family homes and child care institutions which are reasonably in accord with recommended standards of national organizations concerned with standards for such institutions or homes, including standards related to admission policies, safety, sanitation, and protection of civil rights, and provides that the standards so established shall be applied by the State to any foster family home or child

care institution receiving funds under this part or part B of this title;

(11) provides for periodic review of the standards referred to in the preceding paragraph and amounts paid as foster care maintenance payments and adoption assistance to assure their continuing appropriateness;

(12) provides for granting an opportunity for a fair hearing before the State agency to any individual whose claim for benefits available pursuant to this part is denied or is not acted upon with reasonable promptness;

(13) provides that the State shall arrange for a periodic and independently conducted audit of the programs assisted under this part and part B of this title, which shall be conducted no less frequently than once every three years;

(14) provides (A) specific goals (which shall be established by State law on or before October 1, 1982) for each fiscal year (commencing with the fiscal year which begins on October 1, 1983) as to the maximum number of children (in absolute numbers or as a percentage of all children in foster care with respect to whom assistance under the plan is provided during such year) who, at any time during such year, will remain in foster care after having been in such care for a period in excess of twenty-four months, and (B) a description of the steps which will be taken by the State to achieve such goals;

(15) provides that—

(A) in determining reasonable efforts to be made with respect to a child, as described in this paragraph, and in making such reasonable efforts, the child's health and safety shall be the paramount concern;

(B) except as provided in subparagraph (D), reasonable efforts shall be made to preserve and reunify families—

(i) prior to the placement of a child in foster care, to prevent or eliminate the need for removing the child from the child's home; and

(ii) to make it possible for a child to safely return to the child's home;

(C) if continuation of reasonable efforts of the type described in subparagraph (B) is determined to be inconsistent with the permanency plan for the child, reasonable efforts shall be made to place the child in a timely manner in accordance with the permanency plan, and to complete whatever steps are necessary to finalize the permanent placement of the child;

(D) reasonable efforts of the type described in subparagraph (B) shall not be required to be made with respect to a parent of a child if a court of competent jurisdiction has determined that—

(i) the parent has subjected the child to aggravated circumstances (as defined in State law, which definition may include but need not be limited to abandonment, torture, chronic abuse, and sexual abuse);

(ii) the parent has—

(I) committed murder (which would have been an offense under section 1111(a) of title 18, United

States Code [101], if the offense had occurred in the special maritime or territorial jurisdiction of the United States) of another child of the parent;

(II) committed voluntary manslaughter (which would have been an offense under section 1112(a) of title 18, United States Code, if the offense had occurred in the special maritime or territorial jurisdiction of the United States) of another child of the parent;

(III) aided or abetted, attempted, conspired, or solicited to commit such a murder or such a voluntary manslaughter; or

(IV) committed a felony assault that results in serious bodily injury to the child or another child of the parent; or

(iii) the parental rights of the parent to a sibling have been terminated involuntarily;

(E) if reasonable efforts of the type described in subparagraph (B) are not made with respect to a child as a result of a determination made by a court of competent jurisdiction in accordance with subparagraph (D)—

(i) a permanency hearing (as described in section 475(5)(C)) shall be held for the child within 30 days after the determination; and

(ii) reasonable efforts shall be made to place the child in a timely manner in accordance with the permanency plan, and to complete whatever steps are necessary to finalize the permanent placement of the child; and

(F) reasonable efforts to place a child for adoption or with a legal guardian may be made concurrently with reasonable efforts of the type described in subparagraph (B);

(16) provides for the development of a case plan (as defined in section 475(1)) for each child receiving foster care maintenance payments under the State plan and provides for a case review system which meets the requirements described in section 475(5)(B) with respect to each such child;

(17) provides that, where appropriate, all steps will be taken, including cooperative efforts with the State agencies administering the program funded under part A and plan approved under part D, to secure an assignment to the State of any rights to support on behalf of each child receiving foster care maintenance payments under this part;

(18) not later than January 1, 1997, provides that neither the State nor any other entity in the State that receives funds from the Federal Government and is involved in adoption or foster care placements may—

(A) deny to any person the opportunity to become an adoptive or a foster parent, on the basis of the race, color, or national origin of the person, or of the child, involved; or

(B) delay or deny the placement of a child for adoption or into foster care, on the basis of the race, color, or na-

[101] See Vol. II, 18 U.S.C. 1112(a).

tional origin of the adoptive or foster parent, or the child, involved;

(19) provides that the State shall consider giving preference to an adult relative over a non–related caregiver when determining a placement for a child, provided that the relative caregiver meets all relevant State child protection standards;

(20)(A) unless an election provided for in subparagraph (B) is made with respect to the State, provides procedures for criminal records checks for any prospective foster or adoptive parent before the foster or adoptive parent may be finally approved for placement of a child on whose behalf foster care maintenance payments or adoption assistance payments are to be made under the State plan under this part, including procedures requiring that—

(i) in any case in which a record check reveals a felony conviction for child abuse or neglect, for spousal abuse, for a crime against children (including child pornography), or for a crime involving violence, including rape, sexual assault, or homicide, but not including other physical assault or battery, if a State finds that a court of competent jurisdiction has determined that the felony was committed at any time, such final approval shall not be granted; and

(ii) in any case in which a record check reveals a felony conviction for physical assault, battery, or a drug–related offense, if a State finds that a court of competent jurisdiction has determined that the felony was committed within the past 5 years, such final approval shall not be granted; and

(B) subparagraph (A) shall not apply to a State plan if the Governor of the State has notified the Secretary in writing that the State has elected to make subparagraph (A) inapplicable to the State, or if the State legislature, by law, has elected to make subparagraph (A) inapplicable to the State;

(21) provides for health insurance coverage (including, at State option, through the program under the State plan approved under title XIX) for any child who has been determined to be a child with special needs, for whom there is in effect an adoption assistance agreement (other than an agreement under this part) between the State and an adoptive parent or parents, and who the State has determined cannot be placed with an adoptive parent or parents without medical assistance because such child has special needs for medical, mental health, or rehabilitative care, and that with respect to the provision of such health insurance coverage—

(A) such coverage may be provided through 1 or more State medical assistance programs;

(B) the State, in providing such coverage, shall ensure that the medical benefits, including mental health benefits, provided are of the same type and kind as those that would be provided for children by the State under title XIX;

(C) in the event that the State provides such coverage through a State medical assistance program other than the program under title XIX, and the State exceeds its funding

for services under such other program, any such child shall be deemed to be receiving aid or assistance under the State plan under this part for purposes of section 1902(a)(10)(A)(i)(I); and

(D) in determining cost–sharing requirements, the State shall take into consideration the circumstances of the adopting parent or parents and the needs of the child being adopted consistent, to the extent coverage is provided through a State medical assistance program, with the rules under such program;

(22) provides that, not later than January 1, 1999, the State shall develop and implement standards to ensure that children in foster care placements in public or private agencies are provided quality services that protect the safety and health of the children;

(23) provides that the State shall not—

(A) deny or delay the placement of a child for adoption when an approved family is available outside of the jurisdiction with responsibility for handling the case of the child; or

(B) fail to grant an opportunity for a fair hearing, as described in paragraph (12), to an individual whose allegation of a violation of subparagraph (A) of this paragraph is denied by the State or not acted upon by the State with reasonable promptness, and

(24) include a certification that, before a child in foster care under the responsibility of the State is placed with prospective foster parents, the prospective foster parents will be prepared adequately with the appropriate knowledge and skills to provide for the needs of the child and that such preparation will be continued, as necessary, after the placement of the child.

(b) The Secretary shall approve any plan which complies with the provisions of subsection (a) of this section.

FOSTER CARE MAINTENANCE PAYMENTS PROGRAM [102]

SEC. 472. [42 U.S.C. 672] (a) Each State with a plan approved under this part shall make foster care maintenance payments (as defined in section 475(4)) under this part with respect to a child who would have met the requirements of section 406(a) or of section 407 (as such sections were in effect on July 16, 1996) but for his removal from the home of a relative (specified in section 406(a) (as so in effect)), if—

(1) the removal from the home occurred pursuant to a voluntary placement agreement entered into by the child's parent or legal guardian, or was the result of a judicial determination to the effect that continuation therein would be contrary to the welfare of such child and (effective October 1, 1983) that reasonable efforts of the type described in section 471(a)(15) for a child have been made;

(2) such child's placement and care are the responsibility of (A) the State agency administering the State plan approved under section 471, or (B) any other public agency with whom the State agency administering or supervising the administra-

[102] See Vol. II, P.L. 96–272, §102(e), with respect to the Secretary's report to Congress on the placement of children in foster care pursuant to certain voluntary agreements.

tion of the State plan approved under section 471 has made an agreement which is still in effect;

(3) such child has been placed in a foster family home or child-care institution as a result of the voluntary placement agreement or judicial determination referred to in paragraph (1); and

(4) such child—

(A) would have received aid under the State plan approved under section 402 (as in effect on July 16, 1996) in or for the month in which such agreement was entered into or court proceedings leading to the removal of such child from the home were initiated, or

(B)(i) would have received such aid in or for such month if application had been made therefor, or (ii) had been living with a relative specified in section 406(a) (as in effect on July 16, 1996) within six months prior to the month in which such agreement was entered into or such proceedings were initiated, and would have received such aid in or for such month if in such month he had been living with such a relative and application therefor had been made.

In any case where the child is an alien disqualified under section 245A(h), 210(f), or 210A(d)(7) of the Immigration and Nationality Act [103] from receiving aid under the State plan approved under section 402 in or for the month in which such agreement was entered into or court proceedings leading to the removal of the child from the home were instituted, such child shall be considered to satisfy the requirements of paragraph (4) (and the corresponding requirements of section 473(a)(2)(B)), with respect to that month, if he or she would have satisfied such requirements but for such disqualification. In determining whether a child would have received aid under a State plan approved under section 402 (as in effect on July 16, 1996), a child whose resources (determined pursuant to section 402(a)(7)(B), as so in effect) have a combined value of not more than $10,000 shall be considered to be a child whose resources have a combined value of not more than $1,000 (or such lower amount as the State may determine for purposes of such section 402(a)(7)(B)).

(b) Foster care maintenance payments may be made under this part only on behalf of a child described in subsection (a) of this section who is—

(1) in the foster family home of an individual, whether the payments therefor are made to such individual or to a public or nonprofit private child-placement or child-care agency, or

(2) in a child-care institution, whether the payments therefor are made to such institution or to a public or nonprofit private child-placement or child-care agency, which payments shall be limited so as to include in such payments only those items which are included in the term "foster care maintenance payments" (as defined in section 475(4)).

(c) For the purposes of this part, (1) the term "foster family home" means a foster family home for children which is licensed by the State in which it is situated or has been approved, by the agency of such State having responsibility for licensing homes of this type, as meeting the standards established for such licensing;

[103] See Vol. II, P.L. 82–414. P.L. 103–416, §219(ee)(1), repealed §210A of P.L. 82–414.

and (2) the term "child-care institution" means a private child-care institution, or a public child-care institution which accommodates no more than twenty-five children, which is licensed by the State in which it is situated or has been approved, by the agency of such State responsible for licensing or approval of institutions of this type, as meeting the standards established for such licensing, but the term shall not include detention facilities, forestry camps, training schools, or any other facility operated primarily for the detention of children who are determined to be delinquent.

(d) Notwithstanding any other provision of this title, Federal payments may be made under this part with respect to amounts expended by any State as foster care maintenance payments under this section, in the case of children removed from their homes pursuant to voluntary placement agreements as described in subsection (a), only if (at the time such amounts were expended) the State has fulfilled all of the requirements of section 422(b)(10).

(e) No Federal payment may be made under this part with respect to amounts expended by any State as foster care maintenance payments under this section, in the case of any child who was removed from his or her home pursuant to a voluntary placement agreement as described in subsection (a) and has remained in voluntary placement for a period in excess of 180 days, unless there has been a judicial determination by a court of competent jurisdiction (within the first 180 days of such placement) to the effect that such placement is in the best interests of the child.

(f) For the purposes of this part and part B of this title, (1) the term "voluntary placement" means an out-of-home placement of a minor, by or with participation of a State agency, after the parents or guardians of the minor have requested the assistance of the agency and signed a voluntary placement agreement; and (2) the term "voluntary placement agreement" means a written agreement, binding on the parties to the agreement, between the State agency, any other agency acting on its behalf, and the parents or guardians of a minor child which specifies, at a minimum, the legal status of the child and the rights and obligations of the parents or guardians, the child, and the agency while the child is in placement.

(g) In any case where—

(1) the placement of a minor child in foster care occurred pursuant to a voluntary placement agreement entered into by the parents or guardians of such child as provided in subsection (a), and

(2) such parents or guardians request (in such manner and form as the Secretary may prescribe) that the child be returned to their home or to the home of a relative,

the voluntary placement agreement shall be deemed to be revoked unless the State agency opposes such request and obtains a judicial determination, by a court of competent jurisdiction, that the return of the child to such home would be contrary to the child's best interests.

(h)(1) For purposes of titles XIX, any child with respect to whom foster care maintenance payments are made under this section is deemed to be a dependent child as defined in section 406 (as in effect as of July 16, 1996) and deemed to be a recipient of aid to families with dependent children under part A of this title (as so in effect). For purposes of title XX, any child with respect to whom foster care maintenance payments are made under this section is

deemed to be a minor child in a needy family under a State program funded under part A of this title and is deemed to be a recipient of assistance under such part.

(2) For purposes of paragraph (1), a child whose costs in a foster family home or child care institution are covered by the foster care maintenance payments being made with respect to the child's minor parent, as provided in section 475(4)(B), shall be considered a child with respect to whom foster care maintenance payments are made under this section.

ADOPTION ASSISTANCE PROGRAM

SEC. 473. [42 U.S.C. 673] (a)(1)(A) Each State having a plan approved under this part shall enter into adoption assistance agreements (as defined in section 475(3)) with the adoptive parents of children with special needs.

(B) Under any adoption assistance agreement entered into by a State with parents who adopt a child with special needs, the State—

(i) shall make payments of nonrecurring adoption expenses incurred by or on behalf of such parents in connection with the adoption of such child, directly through the State agency or through another public or nonprofit private agency, in amounts determined under paragraph (3), and

(ii) in any case where the child meets the requirements of paragraph (2), may make adoption assistance payments to such parents, directly through the State agency or through another public or nonprofit private agency, in amounts so determined.

(2) For purposes of paragraph (1)(B)(ii), a child meets the requirements of this paragraph if such child—

(A)(i) at the time adoption proceedings were initiated, met the requirements of section 406(a) or section 407 (as such sections were in effect on July 16, 1996) or would have met such requirements except for his removal from the home of a relative (specified in section 406(a) (as so in effect)), either pursuant to a voluntary placement agreement with respect to which Federal payments are provided under section 474 (or 403 (as such section was in effect on July 16, 1996)) or as a result of a judicial determination to the effect that continuation therein would be contrary to the welfare of such child,

(ii) meets all of the requirements of title XVI with respect to eligibility for supplemental security income benefits, or

(iii) is a child whose costs in a foster family home or child-care institution are covered by the foster care maintenance payments being made with respect to his or her minor parent as provided in section 475(4)(B),

(B)(i) would have received aid under the State plan approved under section 402 (as in effect on July 16, 1996) in or for the month in which such agreement was entered into or court proceedings leading to the removal of such child from the home were initiated, or

(ii)(I) would have received such aid in or for such month if application had been made therefor, or (II) had been living with a relative specified in section 406(a) (as in effect on July 16, 1996) within six months prior to the month in which such

agreement was entered into or such proceedings were initiated, and would have received such aid in or for such month if in such month he had been living with such a relative and application therefor had been made, or

(iii) is a child described in subparagraph (A)(ii) or (A)(iii), and

(C) has been determined by the State, pursuant to subsection (c) of this section, to be a child with special needs.

The last sentence of section 472(a) shall apply, for purposes of subparagraph (B), in any case where the child is an alien described in that sentence. Any child who meets the requirements of subparagraph (C), who was determined eligible for adoption assistance payments under this part with respect to a prior adoption, who is available for adoption because the prior adoption has been dissolved and the parental rights of the adoptive parents have been terminated or because the child's adoptive parents have died, and who fails to meet the requirements of subparagraphs (A) and (B) but would meet such requirements if the child were treated as if the child were in the same financial and other circumstances the child was in the last time the child was determined eligible for adoption assistance payments under this part and the prior adoption were treated as never having occurred, shall be treated as meeting the requirements of this paragraph for purposes of paragraph (1)(B)(ii).

(3) The amount of the payments to be made in any case under clauses (i) and (ii) of paragraph (1)(B) shall be determined through agreement between the adoptive parents and the State or local agency administering the program under this section, which shall take into consideration the circumstances of the adopting parents and the needs of the child being adopted, and may be readjusted periodically, with the concurrence of the adopting parents (which may be specified in the adoption assistance agreement), depending upon changes in such circumstances. However, in no case may the amount of the adoption assistance payment made under clause (ii) of paragraph (1)(B) exceed the foster care maintenance payment which would have been paid during the period if the child with respect to whom the adoption assistance payment is made had been in a foster family home.

(4) Notwithstanding the preceding paragraph, (A) no payment may be made to parents with respect to any child who has attained the age of eighteen (or, where the State determines that the child has a mental or physical handicap which warrants the continuation of assistance, the age of twenty-one), and (B) no payment may be made to parents with respect to any child if the State determines that the parents are no longer legally responsible for the support of the child or if the State determines that the child is no longer receiving any support from such parents. Parents who have been receiving adoption assistance payments under this section shall keep the State or local agency administering the program under this section informed of circumstances which would, pursuant to this subsection, make them ineligible for such assistance payments, or eligible for assistance payments in a different amount.

(5) For purposes of this part, individuals with whom a child (who has been determined by the State, pursuant to subsection (c), to be a child with special needs) is placed for adoption in accordance with applicable State and local law shall be eligible for such pay-

ments, during the period of the placement, on the same terms and subject to the same conditions as if such individuals had adopted such child.

(6)(A) For purposes of paragraph (1)(B)(i), the term "nonrecurring adoption expenses" means reasonable and necessary adoption fees, court costs, attorney fees, and other expenses which are directly related to the legal adoption of a child with special needs and which are not incurred in violation of State or Federal law.

(B) A State's payment of nonrecurring adoption expenses under an adoption assistance agreement shall be treated as an expenditure made for the proper and efficient administration of the State plan for purposes of section 474(a)(3)(E).

(b)(1) For purposes of title XIX, any child who is described in paragraph (3) is deemed to be a dependent child as defined in section 406 (as in effect as of July 16, 1996) and deemed to be a recipient of aid to families with dependent children under part A of this title (as so in effect) in the State where such child resides.

(2) For purposes of title XX, any child who is described in paragraph (3) is deemed to be a minor child in a needy family under a State program funded under part A of this title and deemed to be a recipient of assistance under such part.

(3) A child described in this paragraph is any child—

(A)(i) who is a child described in subsection (a)(2), and

(ii) with respect to whom an adoption assistance agreement is in effect under this section (whether or not adoption assistance payments are provided under the agreement or are being made under this section), including any such child who has been placed for adoption in accordance with applicable State and local law (whether or not an interlocutory or other judicial decree of adoption has been issued), or

(B) with respect to whom foster care maintenance payments are being made under section 472.

(4) For purposes of paragraphs (1) and (2), a child whose costs in a foster family home or child–care institution are covered by the foster care maintenance payments being made with respect to the child's minor parent, as provided in section 475(4)(B), shall be considered a child with respect to whom foster care maintenance payments are being made under section 472.

(c) For purposes of this section, a child shall not be considered a child with special needs unless—

(1) the State has determined that the child cannot or should not be returned to the home of his parents; and

(2) the State had first determined (A) that there exists with respect to the child a specific factor or condition (such as his ethnic background, age, or membership in a minority or sibling group, or the presence of factors such as medical conditions or physical, mental, or emotional handicaps) because of which it is reasonable to conclude that such child cannot be placed with adoptive parents without providing adoption assistance under this section or medical assistance under title XIX, and (B) that, except where it would be against the best interests of the child because of such factors as the existence of significant emotional ties with prospective adoptive parents while in the care of such parents as a foster child, a reasonable, but unsuccessful, effort

has been made to place the child with appropriate adoptive parents without providing adoption assistance under this section or medical assistance under title XIX.

ADOPTION INCENTIVE PAYMENTS [104]

SEC. 473A. [42 U.S.C. 673b] (a) GRANT AUTHORITY.—Subject to the availability of such amounts as may be provided in advance in appropriations Acts for this purpose, the Secretary shall make a grant to each State that is an incentive–eligible State for a fiscal year in an amount equal to the adoption incentive payment payable to the State under this section for the fiscal year, which shall be payable in the immediately succeeding fiscal year.

(b) INCENTIVE–ELIGIBLE STATE.—A State is an incentive–eligible State for a fiscal year if—

(1) the State has a plan approved under this part for the fiscal year;

(2) [105] (A) the number of foster child adoptions in the State during the fiscal year exceeds the base number of foster child adoptions for the State for the fiscal year; or

(B) the number of older child adoptions in the State during the fiscal year exceeds the base number of older child adoptions for the State for the fiscal year;

(3) the State is in compliance with subsection (c) for the fiscal year;

(4) in the case of fiscal years 2001 through 2007 [106], the State provides health insurance coverage to any child with special needs (as determined under section 473(c)) for whom there is in effect an adoption assistance agreement between a State and an adoptive parent or parents; and

(5) the fiscal year is any of fiscal years 1998 through 2007 [107].

(c) DATA REQUIREMENTS.—

(1) IN GENERAL.—A State is in compliance with this subsection for a fiscal year if the State has provided to the Secretary the data described in paragraph (2)—

(A) for fiscal years 1995 through 1997 (or, if the first fiscal year for which the State seeks a grant under this section is after fiscal year 1998, the fiscal year that precedes such first fiscal year); and

(B) for each succeeding fiscal year that precedes the fiscal year.

(2) [108] DETERMINATION OF NUMBERS OF ADOPTIONS BASED ON AFCARS DATA.—The Secretary shall determine the numbers of foster child adoptions, of special needs adoptions that are not older child adoptions, and of older child adoptions in a State during each of fiscal years 2002 through 2007, for purposes of

[104] See Vol. II, P.L. 108-145, §2, with respect to Congressional findings regarding adoptions and §3(b), with respect to a report on adoption and other permanency options for children in foster care.

[105] P.L. 108-145, §3(a)(1)(A), amended paragraph (2) in its entirety, effective October 1, 2003. For paragraph (2) as it formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L. 108-145.

[106] P.L. 108-145, §3(a)(1)(B), struck out "and 2002" and substituted "through 2007", effective October 1, 2003.

[107] P.L. 108-145, §3(a)(1)(C), struck out "2002" and substituted "2007", effective October 1, 2003. For paragraph (2) as it formerly read, see Vol. II, Appendix J, superseded Provisions, P.L. 108-145.

[108] P.L. 108-145, §3(a)(2), amended paragraph (2) in its entirety, effective October 1, 2003.

this section, on the basis of data meeting the requirements of the system established pursuant to section 479, as reported by the State and approved by the Secretary by August 1 of the succeeding fiscal year.

(3) NO WAIVER OF AFCARS REQUIREMENTS.—This section shall not be construed to alter or affect any requirement of section 479 or of any regulation prescribed under such section with respect to reporting of data by States, or to waive any penalty for failure to comply with such a requirement.

(d) ADOPTION INCENTIVE PAYMENT.—

(1) IN GENERAL.—Except as provided in paragraph (2), the adoption incentive payment payable to a State for a fiscal year under this section shall be equal to the sum of—

(A) $4,000, multiplied by the amount (if any) by which the number of foster child adoptions in the State during the fiscal year exceeds the base number of foster child adoptions for the State for the fiscal year;[109]

(B) $2,000, multiplied by the amount (if any) by which the number of special needs adoptions that are not older child adoptions[110] in the State during the fiscal year exceeds the base number of special needs adoptions that are not older child adoptions[111] for the State for the fiscal year; and[112]

(C)[113] $4,000, multiplied by the amount (if any) by which the number of older child adoptions in the State during the fiscal year exceeds the base number of older child adoptions for the State for the fiscal year.

(2) PRO RATA ADJUSTMENT IF INSUFFICIENT FUNDS AVAILABLE.— For any fiscal year, if the total amount of adoption incentive payments otherwise payable under this section for a fiscal year exceeds the amount appropriated pursuant to subsection (h) for the fiscal year, the amount of the adoption incentive payment payable to each State under this section for the fiscal year shall be—

(A) the amount of the adoption incentive payment that would otherwise be payable to the State under this section for the fiscal year; multiplied by

(B) the percentage represented by the amount so appropriated for the fiscal year, divided by the total amount of adoption incentive payments otherwise payable under this section for the fiscal year.

(e) 2–YEAR AVAILABILITY OF INCENTIVE PAYMENTS.—Payments to a State under this section in a fiscal year shall remain available for use by the State through the end of the succeeding fiscal year.

(f) LIMITATIONS ON USE OF INCENTIVE PAYMENTS.—A State shall not expend an amount paid to the State under this section except to provide to children or families any service (including post–adoption services) that may be provided under part B or E. Amounts expended by a State in accordance with the preceding sentence shall

[109] P.L. 108-145, §3(a)(3)(A), struck out "and".

[110] P.L. 108-145, §3(a)(3)(B)(i), inserted "that are not older children adoptions", effective October 1, 2003.

[111] P.L. 108-145, §3(a)(3)(B)(i), inserted "that are not older children adoptions", effective October 1, 2003.

[112] P.L. 108-145, §3(a)(3)(B)(ii), struck out the period and substituted "; and".

[113] P.L. 108-145, §3(a)(3)(C), added subparagraph (C), effective October 1, 2003.

be disregarded in determining State expenditures for purposes of Federal matching payments under sections 423, 434, and 474.

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

(1) FOSTER CHILD ADOPTION.—The term "foster child adoption" means the final adoption of a child who, at the time of adoptive placement, was in foster care under the supervision of the State.

(2) SPECIAL NEEDS ADOPTION.—The term "special needs adoption" means the final adoption of a child for whom an adoption assistance agreement is in effect under section 473.

(3) BASE NUMBER OF FOSTER CHILD ADOPTIONS.—The term "base number of foster child adoptions for a State" means—

(A)[114] with respect to fiscal year 2003, the number of foster child adoptions in the State in fiscal year 2002; and

(B) with respect to any subsequent fiscal year, the number of foster child adoptions in the State in the fiscal year for which the number is the greatest in the period that begins with fiscal year 2002 and ends with the fiscal year preceding that subsequent fiscal year.

(4) BASE NUMBER OF SPECIAL NEEDS ADOPTIONS THAT ARE NOT OLDER CHILD ADOPTIONS[115].—The term "base number of special needs adoptions for a State" means—

(A)[116] with respect to fiscal year 2003, the number of special needs adoptions that are not older child adoptions in the State in fiscal year 2002; and

(B) with respect to any subsequent fiscal year, the number of special needs adoptions that are not older child adoptions in the State in the fiscal year for which the number is the greatest in the period that begins with fiscal year 2002 and ends with the fiscal year preceding that subsequent fiscal year.

(5)[117] Base number of older child adoptions.—The term "base number of older child adoptions for a State" means—

(A) with respect to fiscal year 2003, the number of older child adoptions in the State in fiscal year 2002; and

(B) with respect to any subsequent fiscal year, the number of older child adoptions in the State in the fiscal year for which the number is the greatest in the period that begins with fiscal year 2002 and ends with the fiscal year preceding that subsequent fiscal year.

(6) Older child adoptions.—The term "older child adoptions" means the final adoption of a child who has attained 9 years of age if—

(A) at the time of the adoptive placement, the child was in foster care under the supervision of the State; or (B) an adoption assistance agreement was in effect under section 473 with respect to the child.

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[114] P.L. 108-145, §3(a)(4)(A), amended subparagraphs (A) and (B) in their entirety, effective October 1, 2003. For subparagraph (A) and (B) as they formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L. 108-145.

[115] P.L. 108-145, §3(a)(4)(B)(i), inserted "THAT ARE NOT OLDER CHILD ADOPTIONS", effective October 1, 2003.

[116] P.L. 108-145, §3(a)(4)(b)(ii), amended subparagraphs (A) and (B) in their entirety, effective October 1, 2003. For subparagraphs (A) and (B) as they formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L. 108-145.

[117] P.L. 108-145, §3(a)(4)(C), added subparagraphs (5) and (6), effective October 1, 2003.

(h) LIMITATIONS ON AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—For grants under subsection (a), there are authorized to be appropriated to the Secretary—

(A) $20,000,000 for fiscal year 1999;

(B) $43,000,000 for fiscal year 2000;[118]

(C) $20,000,000 for each of fiscal years 2001 through 2003, and[119]

(D)[120] $43,000,000 for each of fiscal years 2004 through 2008.

(2) AVAILABILITY.—Amounts appropriated under paragraph (1), or under any other law for grants under subsection (a)[121], are authorized to remain available until expended, but not after fiscal year 2006[122].

(i) TECHNICAL ASSISTANCE.—

(1) IN GENERAL.—The Secretary may, directly or through grants or contracts, provide technical assistance to assist States and local communities to reach their targets for increased numbers of adoptions and, to the extent that adoption is not possible, alternative permanent placements, for children in foster care.

(2) DESCRIPTION OF THE CHARACTER OF THE TECHNICAL ASSISTANCE.—The technical assistance provided under paragraph (1) may support the goal of encouraging more adoptions out of the foster care system, when adoptions promote the best interests of children, and may include the following:

(A) The development of best practice guidelines for expediting termination of parental rights.

(B) Models to encourage the use of concurrent planning.

(C) The development of specialized units and expertise in moving children toward adoption as a permanency goal.

(D) The development of risk assessment tools to facilitate early identification of the children who will be at risk of harm if returned home.

(E) Models to encourage the fast tracking of children who have not attained 1 year of age into pre–adoptive placements.

(F) Development of programs that place children into pre–adoptive families without waiting for termination of parental rights.

(3) TARGETING OF TECHNICAL ASSISTANCE TO THE COURTS.—Not less than 50 percent of any amount appropriated pursuant to paragraph (4) shall be used to provide technical assistance to the courts.

(4) LIMITATIONS ON AUTHORIZATION OF APPROPRIATIONS.—To carry out this subsection, there are authorized to be appropriated to the Secretary of Health and Human Services not to exceed $10,000,000 for each of fiscal years 2004 through 2006[123].

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[118] P.L. 108-145, §3(a)(5)(A)(i), struck out "and".

[119] P.L. 108-145, §3(a)(5)(A)(ii), struck out the period and substituted "; and".

[120] P.L. 108-145, §3(a)(5)(A)(iii), added subparagraph (D), effective October 1, 2003.

[121] P.L. 108-145, §3(a)(5)(B)(i), inserted ", or under any other law for grants under subsection (a),", effective October 1, 2003.

[122] P.L. 108-145, §3(a)(5)(B)(ii), struck out "2003" and substituted "2008", effective October 1, 2003.

[123] P.L. 108-145, §3(a)(6), struck out 1998 through 2000 and substituted "2008", effective October 1, 2003.

[(j) Stricken.[124]]

PAYMENTS TO STATES; ALLOTMENTS TO STATES[125]

SEC. 474. [42 U.S.C. 674] (a) For each quarter beginning after September 30, 1980, each State which has a plan approved under this part shall be entitled to a payment equal to the sum of—

(1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b) of this Act) of the total amount expended during such quarter as foster care maintenance payments under section 472 for children in foster family homes or child-care institutions; plus

(2) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b) of this Act) of the total amount expended during such quarter as adoption assistance payments under section 473 pursuant to adoption assistance agreements; plus

(3) an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary for the provision of child placement services and for the proper and efficient administration of the State plan—

(A) 75 per centum of so much of such expenditures as are for the training (including both short-and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions) of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision,

(B) 75 percent of so much of such expenditures (including travel and per diem expenses) as are for the short-term training of current or prospective foster or adoptive parents and the members of the staff of State-licensed or State-approved child care institutions providing care to foster and adopted children receiving assistance under this part, in ways that increase the ability of such current or prospective parents, staff members, and institutions to provide support and assistance to foster and adopted children, whether incurred directly by the State or by contract,

(C) 50 percent of so much of such expenditures as are for the planning, design, development, or installation of statewide mechanized data collection and information retrieval systems (including 50 percent of the full amount of expenditures for hardware components for such systems) but only to the extent that such systems—

(i) meet the requirements imposed by regulations promulgated pursuant to section 479(b)(2);

(ii) to the extent practicable, are capable of interfacing with the State data collection system that collects information relating to child abuse and neglect;

[124] P.L. 108-203, §3(a)(7), struck out subsection (j), effective October 1, 2003. For subsection (j) as it formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L. 108-145.

[125] See Vol. II, P.L. 99–177, §256, with respect to treatment of foster care and adoption assistance programs.

(iii) to the extent practicable, have the capability of interfacing with, and retrieving information from, the State data collection system that collects information relating to the eligibility of individuals under part A (for the purposes of facilitating verification of eligibility of foster children); and

(iv) are determined by the Secretary to be likely to provide more efficient, economical, and effective administration of the programs carried out under a State plan approved under part B or this part; and

(D) 50 percent of so much of such expenditures as are for the operation of the statewide mechanized data collection and information retrieval systems referred to in subparagraph (C); and

(E) one-half of the remainder of such expenditures; plus

(4) an amount equal to the amount (if any) by which—

(A) the lesser of—

(i) 80 percent of the amount expended by the State during the fiscal year in which the quarter occurs to carry out programs in accordance with the State application approved under section 477(b) for the period in which the quarter occurs (including any amendment that meets the requirements of section 477(b)(5)); or

(ii) the amount allotted to the State under section 477(c)(1) for the fiscal year in which the quarter occurs, reduced by the total of the amounts payable to the State under this paragraph for all prior quarters in the fiscal year; exceeds

(B) the total amount of any penalties assessed against the State under section 477(e) during the fiscal year in which the quarter occurs.

(b) (1) The Secretary shall, prior to the beginning of each quarter, estimate the amount to which a State will be entitled under subsection (a) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with subsection (a), and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, (B) records showing the number of children in the State receiving assistance under this part, and (C) such other investigation as the Secretary may find necessary.

(2) The Secretary shall then pay to the State, in such installments as he may determine, the amounts so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

(3) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to foster care and adoption

assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.

(4)(A) Within 60 days after receipt of a State claim for expenditures pursuant to subsection (a), the Secretary shall allow, disallow, or defer such claim.

(B) Within 15 days after a decision to defer such a State claim, the Secretary shall notify the State of the reasons for the deferral and of the additional information necessary to determine the allowability of the claim.

(C) Within 90 days after receiving such necessary information (in readily reviewable form), the Secretary shall—

(i) disallow the claim, if able to complete the review and determine that the claim is not allowable, or

(ii) in any other case, allow the claim, subject to disallowance (as necessary)—

(I) upon completion of the review, if it is determined that the claim is not allowable; or

(II) on the basis of findings of an audit or financial management review.

(c) AUTOMATED DATA COLLECTION EXPENDITURES.—The Secretary shall treat as necessary for the proper and efficient administration of the State plan all expenditures of a State necessary in order for the State to plan, design, develop, install, and operate data collection and information retrieval systems described in subsection (a)(3)(C), without regard to whether the systems may be used with respect to foster or adoptive children other than those on behalf of whom foster care maintenance payments or adoption assistance payments may be made under this part.

(d)(1) If, during any quarter of a fiscal year, a State's program operated under this part is found, as a result of a review conducted under section 1123A, or otherwise, to have violated paragraph (18) or (23) of section 471(a) with respect to a person or to have failed to implement a corrective action plan within a period of time not to exceed 6 months with respect to such violation, then, notwithstanding subsection (a) of this section and any regulations promulgated under section 1123A(b)(3), the Secretary shall reduce the amount otherwise payable to the State under this part, for that fiscal year quarter and for any subsequent quarter of such fiscal year, until the State program is found, as a result of a subsequent review under section 1123A, to have implemented a corrective action plan with respect to such violation, by—

(A) 2 percent of such otherwise payable amount, in the case of the 1st such finding for the fiscal year with respect to the State;

(B) 3 percent of such otherwise payable amount, in the case of the 2nd such finding for the fiscal year with respect to the State; or

(C) 5 percent of such otherwise payable amount, in the case of the 3rd or subsequent such finding for the fiscal year with respect to the State.

In imposing the penalties described in this paragraph, the Secretary shall not reduce any fiscal year payment to a State by more than 5 percent.

(2) Any other entity which is in a State that receives funds under this part and which violates paragraph (18) or (23) of section 471(a) during a fiscal year quarter with respect to any

person shall remit to the Secretary all funds that were paid by the State to the entity during the quarter from such funds.

(3)(A) Any individual who is aggrieved by a violation of section 471(a)(18) by a State or other entity may bring an action seeking relief from the State or other entity in any United States district court.

(B) An action under this paragraph may not be brought more than 2 years after the date the alleged violation occurred.

(4) This subsection shall not be construed to affect the application of the Indian Child Welfare Act of 1978.

(e) DISCRETIONARY GRANTS FOR EDUCATIONAL AND TRAINING VOUCHERS FOR YOUTHS AGING OUT OF FOSTER CARE.—From amounts appropriated pursuant to section 477(h)(2), the Secretary may make a grant to a State with a plan approved under this part, for a calendar quarter, in an amount equal to the lesser of—

(1) 80 percent of the amounts expended by the State during the quarter to carry out programs for the purposes described in section 477(a)(6); or

(2) the amount, if any, allotted to the State under section 477(c)(3) for the fiscal year in which the quarter occurs, reduced by the total of the amounts payable to the State under this subsection for such purposes for all prior quarters in the fiscal year.

(f)[126] (1) If the Secretary finds that a State has failed to submit to the Secretary data, as required by regulation, for the data collection system implemented under section 479, the Secretary shall, within 30 days after the date by which the data was due to be so submitted, notify the State of the failure and that payments to the State under this part will be reduced if the State fails to submit the data, as so required, within 6 months after the date the data was originally due to be so submitted.

(2) If the Secretary finds that the State has failed to submit the data, as so required, by the end of the 6-month period referred to in paragraph (1) of this subsection, then, notwithstanding subsection (a) of this section and any regulations promulgated under section 1123A(b)(3), the Secretary shall reduce the amounts otherwise payable to the State under this part, for each quarter ending in the 6-month period (and each quarter ending in each subsequent consecutively occurring 6-month period until the Secretary finds that the State has submitted the data, as so required), by—

(A) ⅙ of 1 percent of the total amount expended by the State for administration of foster care activities under the State plan approved under this part in the quarter so ending, in the case of the 1st 6-month period during which the failure continues; or

(B) ¼ of 1 percent of the total amount so expended, in the case of the 2nd or any subsequent such 6-month period.

[126] P.L. 108-145, §4, added subsection (f), effective October 1, 2003.

DEFINITIONS

SEC. 475. [42 U.S.C. 675] As used in this part or part B of this title:

(1) The term "case plan" means a written document which includes at least the following:

(A) A description of the type of home or institution in which a child is to be placed, including a discussion of the safety and appropriateness of the placement and how the agency which is responsible for the child plans to carry out the voluntary placement agreement entered into or judicial determination made with respect to the child in accordance with section 472(a)(1).

(B) A plan for assuring that the child receives safe and proper care and that services are provided to the parents, child, and foster parents in order to improve the conditions in the parents' home, facilitate return of the child to his own safe home or the permanent placement of the child, and address the needs of the child while in foster care, including a discussion of the appropriateness of the services that have been provided to the child under the plan.

(C) To the extent available and accessible, the health and education records of the child, including—

(i) the names and addresses of the child's health and educational providers;

(ii) the child's grade level performance;

(iii) the child's school record;

(iv) assurances that the child's placement in foster care takes into account proximity to the school in which the child is enrolled at the time of placement;

(v) a record of the child's immunizations;

(vi) the child's known medical problems;

(vii) the child's medications; and

(viii) any other relevant health and education information concerning the child determined to be appropriate by the State agency.

(D) Where appropriate, for a child age 16 or over, a written description of the programs and services which will help such child prepare for the transition from foster care to independent living.

(E) In the case of a child with respect to whom the permanency plan is adoption or placement in another permanent home, documentation of the steps the agency is taking to find an adoptive family or other permanent living arrangement for the child, to place the child with an adoptive family, a fit and willing relative, a legal guardian, or in another planned permanent living arrangement, and to finalize the adoption or legal guardianship. At a minimum, such documentation shall include child specific recruitment efforts such as the use of State, regional, and national adoption exchanges including electronic exchange systems.

(2) The term "parents" means biological or adoptive parents or legal guardians, as determined by applicable State law.

(3) The term "adoption assistance agreement" means a written agreement, binding on the parties to the agreement, between the State agency, other relevant agencies, and the pro-

spective adoptive parents of a minor child which at a minimum (A) specifies the nature and amount of any payments, services, and assistance to be provided under such agreement, and (B) stipulates that the agreement shall remain in effect regardless of the State of which the adoptive parents are residents at any given time. The agreement shall contain provisions for the protection (under an interstate compact approved by the Secretary or otherwise) of the interests of the child in cases where the adoptive parents and child move to another State while the agreement is effective.

(4)(A) The term "foster care maintenance payments" means payments to cover the cost of (and the cost of providing) food, clothing, shelter, daily supervision, school supplies, a child's personal incidentals, liability insurance with respect to a child, and reasonable travel to the child's home for visitation. In the case of institutional care, such term shall include the reasonable costs of administration and operation of such institution as are necessarily required to provide the items described in the preceding sentence.

(B) In cases where—

(i) a child placed in a foster family home or child-care institution is the parent of a son or daughter who is in the same home or institution, and

(ii) payments described in subparagraph (A) are being made under this part with respect to such child,

the foster care maintenance payments made with respect to such child as otherwise determined under subparagraph (A) shall also include such amounts as may be necessary to cover the cost of the items described in that subparagraph with respect to such son or daughter.

(5) The term "case review system" means a procedure for assuring that—

(A) each child has a case plan designed to achieve placement in a safe setting that is the least restrictive (most family like) and most appropriate setting available and in close proximity to the parents' home, consistent with the best interest and special needs of the child, which—

(i) if the child has been placed in a foster family home or child-care institution a substantial distance from the home of the parents of the child, or in a State different from the State in which such home is located, sets forth the reasons why such placement is in the best interests of the child, and

(ii) if the child has been placed in foster care outside the State in which the home of the parents of the child is located, requires that, periodically, but not less frequently than every 12 months, a caseworker on the staff of the State agency of the State in which the home of the parents of the child is located, or of the State in which the child has been placed, visit such child in such home or institution and submit a report on such visit to the State agency of the State in which the home of the parents of the child is located,

(B) the status of each child is reviewed periodically but no less frequently than once every six months by either a court or by administrative review (as defined in paragraph

(6)) in order to determine the safety of the child, the continuing necessity for and appropriateness of the placement, the extent of compliance with the case plan, and the extent of progress which has been made toward alleviating or mitigating the causes necessitating placement in foster care, and to project a likely date by which the child may be returned to and safely maintained in the home or placed for adoption or legal guardianship,

(C) with respect to each such child, procedural safeguards will be applied, among other things, to assure each child in foster care under the supervision of the State of a permanency hearing to be held, in a family or juvenile court or another court (including a tribal court) of competent jurisdiction, or by an administrative body appointed or approved by the court, no later than 12 months after the date the child is considered to have entered foster care (as determined under subparagraph (F)) (and not less frequently than every 12 months thereafter during the continuation of foster care), which hearing shall determine the permanency plan for the child that includes whether, and if applicable when, the child will be returned to the parent, placed for adoption and the State will file a petition for termination of parental rights, or referred for legal guardianship, or (in cases where the State agency has documented to the State court a compelling reason for determining that it would not be in the best interests of the child to return home, be referred for termination of parental rights, or be placed for adoption, with a fit and willing relative, or with a legal guardian) placed in another planned permanent living arrangement and, in the case of a child described in subparagraph (A)(ii), whether the out-of-State placement continues to be appropriate and in the best interests of the child, and, in the case of a child who has attained age 16, the services needed to assist the child to make the transition from foster care to independent living; and procedural safeguards shall also be applied with respect to parental rights pertaining to the removal of the child from the home of his parents, to a change in the child's placement, and to any determination affecting visitation privileges of parents;

(D) a child's health and education record (as described in paragraph (1)(A)) is reviewed and updated, and supplied to the foster parent or foster care provider with whom the child is placed, at the time of each placement of the child in foster care;

(E) in the case of a child who has been in foster care under the responsibility of the State for 15 of the most recent 22 months, or, if a court of competent jurisdiction has determined a child to be an abandoned infant (as defined under State law) or has made a determination that the parent has committed murder of another child of the parent, committed voluntary manslaughter of another child of the parent, aided or abetted, attempted, conspired, or solicited to commit such a murder or such a voluntary manslaughter, or committed a felony assault that has resulted in serious bodily injury to the child or to another child of

the parent, the State shall file a petition to terminate the parental rights of the child's parents (or, if such a petition has been filed by another party, seek to be joined as a party to the petition), and, concurrently, to identify, recruit, process, and approve a qualified family for an adoption, unless—

(i) at the option of the State, the child is being cared for by a relative;

(ii) a State agency has documented in the case plan (which shall be available for court review) a compelling reason for determining that filing such a petition would not be in the best interests of the child; or

(iii) the State has not provided to the family of the child, consistent with the time period in the State case plan, such services as the State deems necessary for the safe return of the child to the child's home, if reasonable efforts of the type described in section 471(a)(15)(B)(ii) are required to be made with respect to the child;

(F) a child shall be considered to have entered foster care on the earlier of—

(i) the date of the first judicial finding that the child has been subjected to child abuse or neglect; or

(ii) the date that is 60 days after the date on which the child is removed from the home; and

(G) the foster parents (if any) of a child and any preadoptive parent or relative providing care for the child are provided with notice of, and an opportunity to be heard in, any review or hearing to be held with respect to the child, except that this subparagraph shall not be construed to require that any foster parent, preadoptive parent, or relative providing care for the child be made a party to such a review or hearing solely on the basis of such notice and opportunity to be heard.

(6) The term "administrative review" means a review open to the participation of the parents of the child, conducted by a panel of appropriate persons at least one of whom is not responsible for the case management of, or the delivery of services to, either the child or the parents who are the subject of the review.

(7) The term "legal guardianship" means a judicially created relationship between child and caretaker which is intended to be permanent and self–sustaining as evidenced by the transfer to the caretaker of the following parental rights with respect to the child: protection, education, care and control of the person, custody of the person, and decisionmaking. The term "legal guardian" means the caretaker in such a relationship.

TECHNICAL ASSISTANCE; DATA COLLECTION AND EVALUATION

SEC. 476. [42 U.S.C. 676] (a) The Secretary may provide technical assistance to the States to assist them to develop the programs authorized under this part and shall periodically (1) evaluate the programs authorized under this part and part B of this title and (2) collect and publish data pertaining to the incidence and characteristics of foster care and adoptions in this country.

(b) Each State shall submit statistical reports as the Secretary may require with respect to children for whom payments are made under this part containing information with respect to such children including legal status, demographic characteristics, location, and length of any stay in foster care.

JOHN H. CHAFEE FOSTER CARE INDEPENDENCE PROGRAM

SEC. 477. [42 U.S.C. 677] (a) PURPOSE.—The purpose of this section is to provide States with flexible funding that will enable programs to be designed and conducted—

(1) to identify children who are likely to remain in foster care until 18 years of age and to help these children make the transition to self-sufficiency by providing services such as assistance in obtaining a high school diploma, career exploration, vocational training, job placement and retention, training in daily living skills, training in budgeting and financial management skills, substance abuse prevention, and preventive health activities (including smoking avoidance, nutrition education, and pregnancy prevention);

(2) to help children who are likely to remain in foster care until 18 years of age receive the education, training, and services necessary to obtain employment;

(3) to help children who are likely to remain in foster care until 18 years of age prepare for and enter postsecondary training and education institutions;

(4) to provide personal and emotional support to children aging out of foster care, through mentors and the promotion of interactions with dedicated adults;

(5) to provide financial, housing, counseling, employment, education, and other appropriate support and services to former foster care recipients between 18 and 21 years of age to complement their own efforts to achieve self-sufficiency and to assure that program participants recognize and accept their personal responsibility for preparing for and then making the transition from adolescence to adulthood; and

(6) to make available vouchers for education and training, including postsecondary training and education, to youths who have aged out of foster care.

(b) APPLICATIONS.—

(1) IN GENERAL.—A State may apply for funds from its allotment under subsection (c) for a period of five consecutive fiscal years by submitting to the Secretary, in writing, a plan that meets the requirements of paragraph (2) and the certifications required by paragraph (3) with respect to the plan.

(2) STATE PLAN.—

A plan meets the requirements of this paragraph if the plan specifies which State agency or agencies will administer, supervise, or oversee the programs carried out under the plan, and describes how the State intends to do the following:

(A) Design and deliver programs to achieve the purposes of this section.

(B) Ensure that all political subdivisions in the State are served by the program, though not necessarily in a uniform manner.

(C) Ensure that the programs serve children of various ages and at various stages of achieving independence.

(D) Involve the public and private sectors in helping adolescents in foster care achieve independence.

(E) Use objective criteria for determining eligibility for benefits and services under the programs, and for ensuring fair and equitable treatment of benefit recipients.

(F) Cooperate in national evaluations of the effects of the programs in achieving the purposes of this section.

(3) CERTIFICATIONS.—

The certifications required by this paragraph with respect to a plan are the following:

(A) A certification by the chief executive officer of the State that the State will provide assistance and services to children who have left foster care because they have attained 18 years of age, and who have not attained 21 years of age.

(B) A certification by the chief executive officer of the State that not more than 30 percent of the amounts paid to the State from its allotment under subsection (c) for a fiscal year will be expended for room or board for children who have left foster care because they have attained 18 years of age, and who have not attained 21 years of age.

(C) A certification by the chief executive officer of the State that none of the amounts paid to the State from its allotment under subsection (c) will be expended or room or board for any child who has not attained 18 years of age.

(D) A certification by the chief executive officer of the State that the State will use training funds provided under the program of Federal payments for foster care and adoption assistance to provide training to help foster parents, adoptive parents, workers in group homes, and case managers understand and address the issues confronting adolescents preparing for independent living, and will, to the extent possible, coordinate such training with the independent living program conducted for adolescents.

(E) A certification by the chief executive officer of the State that the State has consulted widely with public and private organizations in developing the plan and that the State has given all interested members of the public at least 30 days to submit comments on the plan.

(F) A certification by the chief executive officer of the State that the State will make every effort to coordinate the State programs receiving funds provided from an allotment made to the State under subsection (c) with other Federal and State programs for youth (especially transitional living youth projects funded under part B of title III of the Juvenile Justice and Delinquency Prevention Act of 1974), abstinence education programs, local housing programs, programs for disabled youth (especially sheltered workshops), and school-to-work programs offered by high schools or local workforce agencies.

(G) A certification by the chief executive officer of the State that each Indian tribe in the State has been consulted about the programs to be carried out under the plan; that there have been efforts to coordinate the pro-

grams with such tribes; and that benefits and services under the programs will be made available to Indian children in the State on the same basis as to other children in the State.

(H) A certification by the chief executive officer of the State that the State will ensure that adolescents participating in the program under this section participate directly in designing their own program activities that prepare them for independent living and that the adolescents accept personal responsibility for living up to their part of the program.

(I) A certification by the chief executive officer of the State that the State has established and will enforce standards and procedures to prevent fraud and abuse in the programs carried out under the plan.

(J) A certification by the chief executive officer of the State that the State educational and training voucher program under this section is in compliance with the conditions specified in subsection (i), including a statement describing methods the State will use—

(i) to ensure that the total amount of educational assistance to a youth under this section and under other Federal and Federally supported programs does not exceed the limitation specified in subsection (i)(5); and

(ii) to avoid duplication of benefits under this and any other Federal or Federally assisted benefit program.

(4) APPROVAL.—The Secretary shall approve an application submitted by a State pursuant to paragraph (1) for a period if—

(A) the application is submitted on or before June 30 of the calendar year in which such period begins; and

(B) the Secretary finds that the application contains the material required by paragraph (1).

(5) AUTHORITY TO IMPLEMENT CERTAIN AMENDMENTS; NOTIFICATION.—A State with an application approved under paragraph (4) may implement any amendment to the plan contained in the application if the application, incorporating the amendment, would be approvable under paragraph (4). Within 30 days after a State implements any such amendment, the State shall notify the Secretary of the amendment.

(6) AVAILABILITY.—The State shall make available to the public any application submitted by the State pursuant to paragraph (1), and a brief summary of the plan contained in the application.

(c) ALLOTMENTS TO STATES.—

(1) GENERAL PROGRAM ALLOTMENT.—From the amount specified in subsection (h)(1) that remains after applying subsection (g)(2) for a fiscal year, the Secretary shall allot to each State with an application approved under subsection (b) for the fiscal year the amount which bears the ratio to such remaining amount equal to the State foster care ratio, as adjusted in accordance with paragraph (2).

(2) HOLD HARMLESS PROVISION.—

(A) IN GENERAL.—The Secretary shall allot to each State whose allotment for a fiscal year under paragraph (1) is

less than the greater of $500,000 or the amount payable to the State under this section for fiscal year 1998, an additional amount equal to the difference between such allotment and such greater amount.

(B) RATABLE REDUCTION OF CERTAIN ALLOTMENTS.—In the case of a State not described in subparagraph (A) of this paragraph for a fiscal year, the Secretary shall reduce the amount allotted to the State for the fiscal year under paragraph (1) by the amount that bears the same ratio to the sum of the differences determined under subparagraph (A) of this paragraph for the fiscal year as the excess of the amount so allotted over the greater of $500,000 or the amount payable to the State under this section for fiscal year 1998 bears to the sum of such excess amounts determined for all such States.

(3) VOUCHER PROGRAM ALLOTMENT.—From the amount, if any, appropriated pursuant to subsection (h)(2) for a fiscal year, the Secretary may allot to each State with an application approved under subsection (b) for the fiscal year an amount equal to the State foster care ratio multiplied by the amount so specified.

(4) STATE FOSTER CARE RATIO.—In this subsection, the term "State foster care ratio"means the ratio of the number of children in foster care under a program of the State in the most recent fiscal year for which the information is available to the total number of children in foster care in all States for the most recent fiscal year.

(d) IN GENERAL.—

(1) IN GENERAL.—A State to which an amount is paid from its allotment under subsection (c) may use the amount in any manner that is reasonably calculated to accomplish the purposes of this section.

(2) NO SUPPLANTATION OF OTHER FUNDS AVAILABLE FOR SAME GENERAL PURPOSES.—The amounts paid to a State from its allotment under subsection (c) shall be used to supplement and not supplant any other funds which are available for the same general purposes in the State.

(3) TWO-YEAR AVAILABILITY OF FUNDS.—Payments made to a State under this section for a fiscal year shall be expended by the State in the fiscal year or in the succeeding fiscal year.

(4) REALLOCATION OF UNUSED FUNDS.—If a State does not apply for funds under this section for a fiscal year within such time as may be provided by the Secretary, the funds to which the State would be entitled for the fiscal year shall be reallocated to 1 or more other States on the basis of their relative need for additional payments under this section, as determined by the Secretary.

(e) PENALTIES.—

(1) USE OF GRANT IN VIOLATION OF THIS PART.—If the Secretary is made aware, by an audit conducted under chapter 75 of title 31, United States Code, or by any other means, that a program receiving funds from an allotment made to a State under subsection (c) has been operated in a manner that is inconsistent with, or not disclosed in the State application approved under subsection (b), the Secretary shall assess a penalty against the State in an amount equal to not less than 1

percent and not more than 5 percent of the amount of the allotment.

(2) FAILURE TO COMPLY WITH DATA REPORTING REQUIREMENT.—The Secretary shall assess a penalty against a State that fails during a fiscal year to comply with an information collection plan implemented under subsection (f) in an amount equal to not less than 1 percent and not more than 5 percent of the amount allotted to the State for the fiscal year.

(3) PENALTIES BASED ON DEGREE OF NONCOMPLIANCE.—The Secretary shall assess penalties under this subsection based on the degree of noncompliance.

(f) DATA COLLECTION AND PERFORMANCE MEASUREMENT.—

(1) IN GENERAL.—The Secretary, in consultation with State and local public officials responsible for administering independent living and other child welfare programs, child welfare advocates, Members of Congress, youth service providers, and researchers, shall—

(A) develop outcome measures (including measures of educational attainment, high school diploma, employment, avoidance of dependency, homelessness, nonmarital childbirth, incarceration, and high-risk behaviors) that can be used to assess the performance of States in operating independent living programs;

(B) identify data elements needed to track—

(i) the number and characteristics of children receiving services under this section;

(ii) the type and quantity of services being provided; and

(iii) State performance on the outcome measures; and

(C) develop and implement a plan to collect the needed information beginning with the second fiscal year beginning after the date of the enactment of this section.

(2) REPORT TO THE CONGRESS.—Within 12 months after the date of the enactment of this section, the Secretary shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report detailing the plans and timetable for collecting from the States the information described in paragraph (1) and a proposal to impose penalties consistent with paragraph (e)(2) on States that do not report data.

(g) EVALUATIONS.—

(1) GENERAL.—The Secretary shall conduct evaluations of such State programs funded under this section as the Secretary deems to be innovative or of potential national significance. The evaluation of any such program shall include information on the effects of the program on education, employment, and personal development. To the maximum extent practicable, the evaluations shall be based on rigorous scientific standards including random assignment to treatment and control groups. The Secretary is encouraged to work directly with State and local governments to design methods for conducting the evaluations, directly or by grant, contract, or cooperative agreement.

(2) FUNDING OF EVALUATIONS.—The Secretary shall reserve 1.5 percent of the amount specified in subsection (h) for a fiscal

year to carry out, during the fiscal year, evaluation, technical assistance, performance measurement, and data collection activities related to this section, directly or through grants, contracts, or cooperative agreements with appropriate entities.

(h) LIMITATION ON AUTHORIZATION OF APPROPRIATIONS.—To carry out this section and for payments to States under section 474(a)(4), there are authorized to be appropriated to the Secretary for each fiscal year—

(1) $140,000,000, which shall be available for all purposes under this section; and

(2) an additional $60,000,000, which are authorized to be available for payments to States for education and training vouchers for youths who age out of foster care, to assist the youths to develop skills necessary to lead independent and productive lives.

(i) EDUCATIONAL AND TRAINING VOUCHERS.—The following conditions shall apply to a State educational and training voucher program under this section:

(1) Vouchers under the program may be available to youths otherwise eligible for services under the State program under this section.

(2) For purposes of the voucher program, youths adopted from foster care after attaining age 16 may be considered to be youths otherwise eligible for services under the State program under this section.

(3) The State may allow youths participating in the voucher program on the date they attain 21 years of age to remain eligible until they attain 23 years of age, as long as they are enrolled in a postsecondary education or training program and are making satisfactory progress toward completion of that program.

(4) The voucher or vouchers provided for an individual under this section—

(A) may be available for the cost of attendance at an institution of higher education, as defined in section 102 of the Higher Education Act of 1965 [127]; and

(B) shall not exceed the lesser of $5,000 per year or the total cost of attendance, as defined in section 472 of that Act.

(5) The amount of a voucher under this section may be disregarded for purposes of determining the recipient's eligibility for, or the amount of, any other Federal or Federally supported assistance, except that the total amount of educational assistance to a youth under this section and under other Federal and Federally supported programs shall not exceed the total cost of attendance, as defined in section 472 of the Higher Education Act of 1965, and except that the State agency shall take appropriate steps to prevent duplication of benefits under this and other Federal or Federally supported programs.

(6) The program is coordinated with other appropriate education and training programs.

[127] See Vol. II, P.L. 89-329.

RULE OF CONSTRUCTION

SEC. 478. [42 U.S.C. 678] Nothing in this part shall be construed as precluding State courts from exercising their discretion to protect the health and safety of children in individual cases, including cases other than those described in section 471(a)(15)(D).

COLLECTION OF DATA RELATING TO ADOPTION AND FOSTER CARE [128]

SEC. 479. [42 U.S.C. 679] (a)(1) Not later than 90 days after the date of the enactment of this subsection [129], the Secretary shall establish an Advisory Committee on Adoption and Foster Care Information (in this section referred to as the "Advisory Committee") to study the various methods of establishing, administering, and financing a system for the collection of data with respect to adoption and foster care in the United States.

(2) The study required by paragraph (1) shall—

(A) identify the types of data necessary to—

(i) assess (on a continuing basis) the incidence, characteristics, and status of adoption and foster care in the United States, and

(ii) develop appropriate national policies with respect to adoption and foster care;

(B) evaluate the feasibility and appropriateness of collecting data with respect to privately arranged adoptions and adoptions arranged through private agencies without assistance from public child welfare agencies;

(C) assess the validity of various methods of collecting data with respect to adoption and foster care; and

(D) evaluate the financial and administrative impact of implementing each such method.

(3) Not later than October 1, 1987, the Advisory Committee shall submit to the Secretary and the Congress a report setting forth the results of the study required by paragraph (1) and evaluating and making recommendations with respect to the various methods of establishing, administering, and financing a system for the collection of data with respect to adoption and foster care in the United States.

(4)(A) Subject to subparagraph (B), the membership and organization of the Advisory Committee shall be determined by the Secretary.

(B) The membership of the Advisory Committee shall include representatives of—

(i) private, nonprofit organizations with an interest in child welfare (including organizations that provide foster care and adoption services),

(ii) organizations representing State and local governmental agencies with responsibility for foster care and adoption services,

(iii) organizations representing State and local governmental agencies with responsibility for the collection of health and social statistics,

(iv) organizations representing State and local judicial bodies with jurisdiction over family law,

[128] See Vol. II, P.L. 99–509, §9442, with respect to the maternal and child health and adoption clearinghouse.

[129] October 21, 1986. [P.L. 99–509, §9443; 100 Stat. 2073]

(v) Federal agencies responsible for the collection of health and social statistics, and

(vi) organizations and agencies involved with privately arranged or international adoptions.

(5) After the date of the submission of the report required by paragraph (3), the Advisory Committee shall cease to exist.

(b)(1)(A) Not later than July 1, 1988, the Secretary shall submit to the Congress a report that—

(i) proposes a method of establishing, administering, and financing a system for the collection of data relating to adoption and foster care in the United States,

(ii) evaluates the feasibility and appropriateness of collecting data with respect to privately arranged adoptions and adoptions arranged through private agencies without assistance from public child welfare agencies, and

(iii) evaluates the impact of the system proposed under clause (i) on the agencies with responsibility for implementing it.

(B) The report required by subparagraph (A) shall—

(i) specify any changes in law that will be necessary to implement the system proposed under subparagraph (A)(i), and

(ii) describe the type of system that will be implemented under paragraph (2) in the absence of such changes.

(2) Not later than December 31, 1988, the Secretary shall promulgate final regulations providing for the implementation of—

(A) the system proposed under paragraph (1)(A)(i), or

(B) if the changes in law specified pursuant to paragraph (1)(B)(i) have not been enacted, the system described in paragraph (1)(B)(ii).

Such regulations shall provide for the full implementation of the system not later than October 1, 1991.

(c) Any data collection system developed and implemented under this section shall—

(1) avoid unnecessary diversion of resources from agencies responsible for adoption and foster care;

(2) assure that any data that is collected is reliable and consistent over time and among jurisdictions through the use of uniform definitions and methodologies;

(3) provide comprehensive national information with respect to—

(A) the demographic characteristics of adoptive and foster children and their biological and adoptive or foster parents,

(B) the status of the foster care population (including the number of children in foster care, length of placement, type of placement, availability for adoption, and goals for ending or continuing foster care),

(C) the number and characteristics of—

(i) children placed in or removed from foster care,

(ii) children adopted or with respect to whom adoptions have been terminated, and

(iii) children placed in foster care outside the State which has placement and care responsibility, and

(D) the extent and nature of assistance provided by Federal, State, and local adoption and foster care programs

and the characteristics of the children with respect to whom such assistance is provided; and

(4) utilize appropriate requirements and incentives to ensure that the system functions reliably throughout the United States.

ANNUAL REPORT

SEC. 479A. [42 U.S.C. 679b] The Secretary, in consultation with Governors, State legislatures, State and local public officials responsible for administering child welfare programs, and child welfare advocates, shall—

(1) develop a set of outcome measures (including length of stay in foster care, number of foster care placements, and number of adoptions) that can be used to assess the performance of States in operating child protection and child welfare programs pursuant to parts B and E to ensure the safety of children;

(2) to the maximum extent possible, the outcome measures should be developed from data available from the Adoption and Foster Care Analysis and Reporting System;

(3) develop a system for rating the performance of States with respect to the outcome measures, and provide to the States an explanation of the rating system and how scores are determined under the rating system;

(4) prescribe such regulations as may be necessary to ensure that States provide to the Secretary the data necessary to determine State performance with respect to each outcome measure, as a condition of the State receiving funds under this part; and

(5) on May 1, 1999, and annually thereafter, prepare and submit to the Congress a report on the performance of each State on each outcome measure, which shall examine the reasons for high performance and low performance and, where possible, make recommendations as to how State performance could be improved.

TITLE V—MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT [1]

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AUTHORIZATION OF APPROPRIATIONS

SEC. 501. [42 U.S.C. 701] (a) To improve the health of all mothers and children consistent with the applicable health status goals and national health objectives established by the Secretary under the Public Health Service Act for the year 2000, there are authorized to be appropriated $850,000,000 for fiscal year 2001 and each fiscal year thereafter—

(1) for the purpose of enabling each State—

(A) to provide and to assure mothers and children (in particular those with low income or with limited availability of health services) access to quality maternal and child health services;

(B) to reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children, to reduce the need for inpatient and long-term care services, to increase the number of children (especially preschool children) appropriately immunized against disease and the number of low income children receiving health assessments and follow-up diagnostic and treatment services, and otherwise to promote the health of mothers and infants by providing prenatal, delivery, and postpartum

[1] Title V of the Social Security Act is administered by the Health Resources and Services Administration, Public Health Service, Department of Health and Human Services.

Title V appears in the United States Code as §§701–710, subchapter V, chapter 7, Title 42.

Regulations of the Secretary of Health and Human Services relating to Title V are contained in chapter I, Title 42, and in subtitle A, Title 45, Code of Federal Regulations.

See Vol. II, P.L. 78–410, §317A(a) and (d), with respect to coordination required in lead poisoning prevention.

See Vol. II, P.L. 88–352, §601, with respect to prohibition against discrimination in federally assisted programs.

See Vol. II, P.L. 95–521, §102(i), with respect to reporting of benefits received under the Social Security Act.

See Vol. II, P.L. 101–239, §6509, with respect to a maternal and child health handbook.

[2] This table of contents does not appear in the law.

care for low income, at-risk pregnant women, and to promote the health of children by providing preventive and primary care services for low income children;

(C) to provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under title XVI, to the extent medical assistance for such services is not provided under title XIX; and

(D) to provide and to promote family-centered, community-based, coordinated care (including care coordination services, as defined in subsection (b)(3)) for children with special health care needs and to facilitate the development of community-based systems of services for such children and their families;

(2) for the purpose of enabling the Secretary (through grants, contracts, or otherwise) to provide for special projects of regional and national significance, research, and training with respect to maternal and child health and children with special health care needs (including early intervention training and services development), for genetic disease testing, counseling, and information development and dissemination programs, for grants (including funding for comprehensive hemophilia diagnostic treatment centers) relating to hemophilia without regard to age, and for the screening of newborns for sickle cell anemia, and other genetic disorders and follow-up services; and

(3) subject to section 502(b) for the purpose of enabling the Secretary (through grants, contracts, or otherwise) to provide for developing and expanding the following—

(A) maternal and infant health home visiting programs in which case management services as defined in subparagraphs (A) and (B) of subsection (b)(4), health education services, and related social support services are provided in the home to pregnant women or families with an infant up to the age one by an appropriate health professional or by a qualified nonprofessional acting under the supervision of a health care professional,

(B) projects designed to increase the participation of obstetricians and pediatricians under the program under this title and under state plans approved under title XIX,

(C) integrated maternal and child health service delivery systems (of the type described in section 1136 and using, once developed, the model application form developed under section 6506(a) of the Omnibus Budget Reconciliation Act of 1989),

(D) maternal and child health centers which (i) provide prenatal, delivery, and postpartum care for pregnant women and preventive and primary care services for infants up to age one, and (ii) operate under the direction of a not-for-profit hospital,

(E) maternal and child health projects to serve rural populations, and

(F) outpatient and community based services programs (including day care services) for children with special health care needs whose medical services are provided primarily through inpatient institutional care.

Funds appropriated under this section may only be used in a manner consistent with the Assisted Suicide Funding Restriction Act of 1997.

(b) For purposes of this title:

(1) The term "consolidated health programs" means the programs administered under the provisions of—

(A) this title (relating to maternal and child health and services for children with special health care needs),

(B) section 1615(c) of this Act (relating to supplemental security income for disabled children),

(C) sections 316 (relating to lead-based paint poisoning prevention programs), 1101 (relating to genetic disease programs), 1121 (relating to sudden infant death syndrome programs) and 1131 (relating to hemophilia treatment centers) of the Public Health Service Act[3], and

(D) title VI[4] of the Health Services and Centers Amendments of 1978 (Public Law 95–626; relating to adolescent pregnancy grants),

as such provisions were in effect before the date of the enactment of the Maternal and Child Health Services Block Grant Act[5].

(2) The term "low income" means, with respect to an individual or family, such an individual or family with an income determined to be below the income official poverty line 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[6].

(3) The term "care coordination services" means services to promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families.

(4) The term "case management services" means—

(A) with respect to pregnant women, services to assure access to quality prenatal, delivery, and postpartum care; and

(B) with respect to infants up to age one, services to assure access to quality preventive and primary care services.

ALLOTMENTS TO STATES AND FEDERAL SET-ASIDE

SEC. 502. [42 U.S.C. 702] (a)(1) Of the amounts appropriated under section 501(a) for a fiscal year that are not in excess of $600,000,000, the Secretary shall retain an amount equal to 15 percent for the purpose of carrying out activities described in section 501(a)(2). The authority of the Secretary to enter into any contracts under this title is effective for any fiscal year only to such extent or in such amounts as are provided in appropriations Acts.

(2) For purposes of paragraph (1)—

(A) amounts retained by the Secretary for training shall be used to make grants to public or nonprofit private insti-

[3] P.L. 78–410. P.L. 97–35, §2193(b)(1), 95 Stat. 827, repealed §§316, 1101, 1121, and 1131 of the PHSA.

[4] P.L. 95–626, Title VI, was repealed by P.L. 97–35, §955(b); 95 Stat. 592.

[5] P.L. 97–35, Title XXI, subtitle D [95 Stat. 818].

[6] See Vol. II, P.L. 97–35.

tutions of higher learning for training personnel for health care and related services for mothers and children; and

(B) amounts retained by the Secretary for research shall be used to make grants to, contracts with, or jointly financed cooperative agreements with, public or nonprofit institutions of higher learning and public or nonprofit private agencies and organizations engaged in research or in maternal and child health or programs for children with special health care needs for research projects relating to maternal and child health services or services for children with special health care needs which show promise of substantial contribution to the advancement thereof.

(3) No funds may be made available by the Secretary under this subsection or subsection (b) unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, be submitted in such manner, and contain and be accompanied by such information as the Secretary may specify. No such application may be approved unless it contains assurances that the applicant will use the funds provided only for the purposes specified in the approved application and will establish such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement and accounting of Federal funds paid to the applicant under this title.

(b)(1)(A) Of the amounts appropriated under section 501(a) for a fiscal year in excess of $600,000,000 the Secretary shall retain an amount equal to 12 ¾ percent thereof for the projects described in subparagraphs (A) through (F) of section 501(a)(3).

(B) Any amount appropriated under section 501(a) for a fiscal year in excess of $600,000,000 that remains after the Secretary has retained the applicable amount (if any) under subparagraph (A) shall be retained by the Secretary in accordance with subsection (a) and allocated to the States in accordance with subsection (c).

(2)(A) Of the amounts retained for the purpose of carrying out activities described in section 501(a)(3)(A), (B), (C), (D) and (E), the Secretary shall provide preference to qualified applicants which demonstrate that the activities to be carried out with such amounts shall be in areas with a high infant mortality rate (relative to the average infant mortality rate in the United States or in the State in which the area is located).

(B) In carrying out activities described in section 501(a)(3)(D), the Secretary shall not provide for developing or expanding a maternal and child health center unless the Secretary has received satisfactory assurances that there will be applied, towards the costs of such development or expansion, non-Federal funds in an amount at least equal to the amount of funds provided under this title toward such development or expansion.

(c) From the remaining amounts appropriated under section 501(a) for any fiscal year that are not in excess of $600,000,000, the Secretary shall allot to each State which has transmitted an application for the fiscal year under section 505(a), an amount determined as follows:

(1) The Secretary shall determine, for each State—

(A)(i) the amount provided or allotted by the Secretary to the State and to entities in the State under the provisions of the consolidated health programs (as defined in section 501(b)(1)), other than for any of the projects or programs described in subsection (a), from appropriations for fiscal year 1981,

(ii) the proportion that such amount for that State bears to the total of such amounts for all the States, and

(B)(i) the number of low income children in the State, and

(ii) the proportion that such number of children for that State bears to the total of such numbers of children for all the States.

(2) Each such State shall be allotted for each fiscal year an amount equal to the sum of—

(A) the amount of the allotment to the State under this subsection in fiscal year 1983, and

(B) the State's proportion (determined under paragraph (1)(B)(ii)) of the amount by which the allotment available under this subsection for all the States for that fiscal year exceeds the amount that was available under this subsection for allotment for all the States for fiscal year 1983.

(d)(1) To the extent that all the funds appropriated under this title for a fiscal year are not otherwise allotted to States either because all the States have not qualified for such allotments under section 505(a) for the fiscal year or because some States have indicated in their descriptions of activities under section 505(a) that they do not intend to use the full amount of such allotments, such excess shall be allotted among the remaining States in proportion to the amount otherwise allotted to such States for the fiscal year without regard to this paragraph.

(2) To the extent that all the funds appropriated under this title for a fiscal year are not otherwise allotted to States because some State allotments are offset under section 506(b)(2), such excess shall be allotted among the remaining States in proportion to the amount otherwise allotted to such States for the fiscal year without regard to this paragraph.

PAYMENTS TO STATES

SEC. 503. [42 U.S.C. 703] (a) From the sums appropriated therefor and the allotments available under section 502(c), the Secretary shall make payments as provided by section 6503(a) of title 31, United States Code to each State provided such an allotment under section 502(c), for each quarter, of an amount equal to four-sevenths of the total of the sums expended by the State during such quarter in carrying out the provisions of this title.

(b) Any amount payable to a State under this title from allotments for a fiscal year which remains unobligated at the end of such year shall remain available to such State for obligation during the next fiscal year. No payment may be made to a State under this title from allotments for a fiscal year for expenditures made after the following fiscal year.

(c) The Secretary, at the request of a State, may reduce the amount of payments under subsection (a) by—

(1) the fair market value of any supplies or equipment furnished the State, and

(2) the amount of the pay, allowances, and travel expenses of any officer or employee of the Government when detailed to the State and the amount of any other costs incurred in connection with the detail of such officer or employee,

when the furnishing of supplies or equipment or the detail of an officer or employee is for the convenience of and at the request of the State and for the purpose of conducting activities described in section 505(a) on a temporary basis. The amount by which any payment is so reduced shall be available for payment by the Secretary of the costs incurred in furnishing the supplies or equipment or in detailing the personnel, on which the reduction of the payment is based, and the amount shall be deemed to be part of the payment and shall be deemed to have been paid to the State.

USE OF ALLOTMENT FUNDS

SEC. 504. **[**42 U.S.C. 704**]** (a) Except as otherwise provided under this section, a State may use amounts paid to it under section 503 for the provision of health services and related activities (including planning, administration, education, and evaluation and including payment of salaries and other related expenses of National Health Service Corps personnel) consistent with its application transmitted under section 505(a).

(b) Amounts described in subsection (a) may not be used for—

(1) inpatient services, other than inpatient services provided to children with special health care needs or to high-risk pregnant women and infants and such other inpatient services as the Secretary may approve;

(2) cash payments to intended recipients of health services;

(3) the purchase or improvement of land, the purchase, construction, or permanent improvement (other than minor remodeling) of any building or other facility, or the purchase of major medical equipment;

(4) satisfying any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds;

(5) providing funds for research or training to any entity other than a public or nonprofit private entity; or

(6) payment for any item or service (other than an emergency item or service) furnished—

(A) by an individual or entity during the period when such individual or entity is excluded under this title or title XVIII, XIX, or XX pursuant to section 1128, 1128A, 1156, or 1842(j)(2), or

(B) at the medical direction or on the prescription of a physician during the period when the physician is excluded under this title or title XVIII, XIX, or XX pursuant to section 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

The Secretary may waive the limitation contained in paragraph (3) upon the request of a State if the Secretary finds that there are extraordinary circumstances to justify the waiver and that granting the waiver will assist in carrying out this title.

(c) A State may use a portion of the amounts described in subsection (a) for the purpose of purchasing technical assistance from public or private entities if the State determines that such assistance is required in developing, implementing, and administering programs funded under this title.

(d) Of the amounts paid to a State under section 503 from an allotment for a fiscal year under section 502(c), not more than 10 percent may be used for administering the funds paid under such section.

APPLICATION FOR BLOCK GRANT FUNDS

SEC. 505. [42 U.S.C. 705] (a) In order to be entitled to payments for allotments under section 502 for a fiscal year, a State must prepare and transmit to the Secretary an application (in a standardized form specified by the Secretary) that—

(1) contains a statewide needs assessment (to be conducted every 5 years) that shall identify (consistent with the health status goals and national health objectives referred to in section 501(a)) the need for—

(A) preventive and primary care services for pregnant women, mothers, and infants up to age one;

(B) preventive and primary care services for children; and

(C) services for children with special health care needs (as specified in section 501(a)(1)(D));

(2) includes for each fiscal year—

(A) a plan for meeting the needs identified by the statewide needs assessment under paragraph (1); and

(B) a description of how the funds allotted to the State under section 502(c) will be used for the provision and coordination of services to carry out such plan that shall include—

(i) subject to paragraph (3), a statement of the goals and objectives consistent with the health status goals and national health objectives referred to in section 501(a) for meeting the needs specified in the State plan described in subparagraph (A);

(ii) an identification of the areas and localities in the State in which services are to be provided and coordinated;

(iii) an identification of the types of services to be provided and the categories or characteristics of individuals to be served; and

(iv) information the State will collect in order to prepare reports required under section 506(a);

(3) except as provided under subsection (b), provides that the State will use—

(A) at least 30 percent of such payment amounts for preventive and primary care services for children, and

(B) at least 30 percent of such payment amounts for services for children with special health care needs (as specified in section 501(a)(1)(D));

(4) provides that a State receiving funds for maternal and child health services under this title shall maintain the level of funds being provided solely by such State for maternal and

child health programs at a level at least equal to the level that such State provided for such programs in fiscal year 1989; and

(5) provides that—

(A) the State will establish a fair method (as determined by the State) for allocating funds allotted to the State under this title among such individuals, areas, and localities identified under paragraph (1)(A) as needing maternal and child health services, and the State will identify and apply guidelines for the appropriate frequency and content of, and appropriate referral and followup with respect to, health care assessments and services financially assisted by the State under this title and methods for assuring quality assessments and services;

(B) funds allotted to the State under this title will only be used, consistent with section 508, to carry out the purposes of this title or to continue activities previously conducted under the consolidated health programs (described in section 501(b)(1));

(C) the State will use—

(i) special consideration (where appropriate) for the continuation of the funding of special projects in the State previously funded under this title (as in effect before August 31, 1981), and

(ii) a reasonable proportion (based upon the State's previous use of funds under this title) of such sums to carry out the purposes described in subparagraphs (A) through (D) of section 501(a)(1);

(D) if any charges are imposed for the provision of health services assisted by the State under this title, such charges (i) will be pursuant to a public schedule of charges, (ii) will not be imposed with respect to services provided to low income mothers or children, and (iii) will be adjusted to reflect the income, resources, and family size of the individual provided the services;

(E) the State agency (or agencies) administering the State's program under this title will provide for a toll-free telephone number (and other appropriate methods) for the use of parents to access information about health care providers and practitioners who provide health care services under this title and title XIX and about other relevant health and health-related providers and practitioners; and

(F) the State agency (or agencies) administering the State's program under this title will—

(i) participate in the coordination of activities between such program and the early and periodic screening, diagnostic, and treatment program under section 1905(a)(4)(B) (including the establishment of periodicity and content standards for early and periodic screening, diagnostic, and treatment services), to ensure that such programs are carried out without duplication of effort,

(ii) participate in the arrangement and carrying out of coordination agreements described in section 1902(a)(11) (relating to coordination of care and services available under this title and title XIX),

(iii) participate in the coordination of activities within the State with programs carried out under this title and related Federal grant programs (including supplemental food programs for mothers, infants, and children, related education programs, and other health, developmental disability, and family planning programs), and

(iv) provide, directly and through their providers and institutional contractors, for services to identify pregnant women and infants who are eligible for medical assistance under subparagraph (A) or (B) of section 1902(l)(1) and, once identified, to assist them in applying for such assistance.

The application shall be developed by, or in consultation with, the State maternal and child health agency and shall be made public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during its development and after its transmittal.

(b) The Secretary may waive the requirements under subsection (a)(3) that a State's application for a fiscal year provide for the use of funds for specific activities if for that fiscal year—

(1) the Secretary determines—

(A) on the basis of information provided in the State's most recent annual report submitted under section 506(a)(1), that the State has demonstrated an extraordinary unmet need for one of the activities described in subsection (a)(3), and

(B) that the granting of the waiver is justified and will assist in carrying out the purposes of this title; and

(2) the State provides assurances to the Secretary that the State will provide for the use of some amounts paid to it under section 503 for the activities described in subparagraphs (A) and (B) of subsection (a)(3) and specifies the percentages to be substituted in each of such subparagraphs.

REPORTS AND AUDITS

SEC. 506. [42 U.S.C. 706] (a)(1) Each State shall prepare and submit to the Secretary annual reports on its activities under this title. Each such report shall be prepared by, or in consultation with, the State maternal and child health agency. In order properly to evaluate and to compare the performance of different States assisted under this title and to assure the proper expenditure of funds under this title, such reports shall be in such standardized form and contain such information (including information described in paragraph (2)) as the Secretary determines (after consultation with the States) to be necessary (A) to secure an accurate description of those activities, (B) to secure a complete record of the purposes for which funds were spent, of the recipients of such funds,,[7] (C) to describe the extent to which the State has met the goals and objectives it set forth under section 505(a)(2)(B)(i) and the national health objectives referred to in section 501(a) and (D) to determine the extent to which funds were expended consistent with the State's application transmitted under section 505(a). Copies of the report shall be provided, upon request, to any interested public

[7] As in original.

agency, and each such agency may provide its views on these reports to the Congress.

(2) Each annual report under paragraph (1) shall include the following information:

(A)(i) The number of individuals served by the State under this title (by class of individuals).

(ii) The proportion of each class of such individuals which has health coverage.

(iii) The types (as defined by the Secretary) of services provided under this title to individuals within each such class.

(iv) The amounts spent under this title on each type of services, by class of individuals served.

(B) Information on the status of maternal and child health in the State, including—

(i) information (by county and by racial and ethnic group) on—

(I) the rate of infant mortality, and

(II) the rate of low-birth-weight births;

(ii) information (on a State-wide basis) on—

(I) the rate of maternal mortality,

(II) the rate of neonatal death,

(III) the rate of perinatal death,

(IV) the number of children with chronic illness and the type of illness,

(V) the proportion of infants born with fetal alcohol syndrome,

(VI) the proportion of infants born with drug dependency,

(VII) the proportion of women who deliver who do not receive prenatal care during the first trimester of pregnancy, and

(VIII) the proportion of children, who at their second birthday, have been vaccinated against each of measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Hib meningitis, and hepatitis B; and

(iii) information on such other indicators of maternal, infant, and child health care status as the Secretary may specify.

(C) Information (by racial and ethnic group) on—

(i) the number of deliveries in the State in the year, and

(ii) the number of such deliveries to pregnant women who were provided prenatal, delivery, or postpartum care under this title or were entitled to benefits with respect to such deliveries under the State plan under title XIX in the year.

(D) Information (by racial and ethnic group) on—

(i) the number of infants under one year of age who were in the State in the year, and

(ii) the number of such infants who were provided services under this title or were entitled to benefits under the State plan under title XIX or the State plan under title XXI at any time during the year.

(E) Information on the number of—

(i) obstetricians,

(ii) family practitioners,

(iii) certified family nurse practitioners,

(iv) certified nurse midwives,

(v) pediatricians, and

(vi) certified pediatric nurse practitioners,

who were licensed in the State in the year.

For purposes of subparagraph (A), each of the following shall be considered to be a separate class of individuals: pregnant women, infants up to age one, children with special health care needs, other children under age 22, and other individuals.

(3) The Secretary shall annually transmit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report that includes—

(A) a description of each project receiving funding under paragraph (2) or (3) of section 502(a), including the amount of Federal funds provided, the number of individuals served or trained, as appropriate, under the project, and a summary of any formal evaluation conducted with respect to the project;

(B) a summary of the information described in paragraph (2)(A) reported by States;

(C) based on information described in paragraph (2)(B) supplied by the States under paragraph (1), a compilation of the following measures of maternal and child health in the United States and in each State:

(i) Information on—

(I) the rate of infant mortality, and

(II) the rate of low-birth-weight births.

Information under this clause shall also be compiled by racial and ethnic group.

(ii) Information on—

(I) the rate of maternal mortality,

(II) the rate of neonatal death,

(III) the rate of perinatal death,

(IV) the proportion of infants born with fetal alcohol syndrome,

(V) the proportion of infants born with drug dependency,

(VI) the proportion of women who deliver who do not receive prenatal care during the first trimester of pregnancy, and

(VII) the proportion of children, who at their second birthday, have been vaccinated against each of measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Hib meningitis, and hepatitis B.

(iii) Information on such other indicators of maternal, infant, and child health care status as the Secretary has specified under paragraph (2)(B)(iii).

(iv) Information (by racial and ethnic group) on—

(I) the number of deliveries in the State in the year, and

(II) the number of such deliveries to pregnant women who were provided prenatal, delivery, or postpartum care under this title or were entitled to benefits with respect to such deliveries under the State plan under title XIX in the year;

(D) based on information described in subparagraphs (C), (D), and (E) of paragraph (2) supplied by the States under

paragraph (1), a compilation of the following information in the United States and in each State:

(i) Information on—

(I) the number of deliveries in the year, and

(II) the number of such deliveries to pregnant women who were provided prenatal, delivery, or postpartum care under this title or were entitled to benefits with respect to such deliveries under a State plan under title XIX or the State plan under title XXI in the year.

Information under this clause shall also be compiled by racial and ethnic group.

(ii) Information on—

(I) the number of infants under one year of age in the year, and

(II) the number of such infants who were provided services under this title or were entitled to benefits under a State plan under title XIX at any time during the year.

Information under this clause shall also be compiled by racial and ethnic group.

(iii) Information on the number of—

(I) obstetricians,

(II) family practitioners,

(III) certified family nurse practitioners,

(IV) certified nurse midwives,

(V) pediatricians, and

(VI) certified pediatric nurse practitioners,

who were licensed in a State in the year; and

(E) an assessment of the progress being made to meet the health status goals and national health objectives referred to in section 501(a).

(b)(1) Each State shall, not less often than once every two years, audit its expenditures from amounts received under this title. Such State audits shall be conducted by an entity independent of the State agency administering a program funded under this title in accordance with the Comptroller General's standards for auditing governmental organizations, programs, activities, and functions and generally accepted auditing standards. Within 30 days following the completion of each audit report, the State shall submit a copy of that audit report to the Secretary.

(2) Each State shall repay to the United States amounts found by the Secretary, after notice and opportunity for a hearing to the State, not to have been expended in accordance with this title and, if such repayment is not made, the Secretary may offset such amounts against the amount of any allotment to which the State is or may become entitled under this title or may otherwise recover such amounts.

(3) The Secretary may, after notice and opportunity for a hearing, withhold payment of funds to any State which is not using its allotment under this title in accordance with this title. The Secretary may withhold such funds until the Secretary finds that the reason for the withholding has been removed and there is reasonable assurance that it will not recur.

(c) The State shall make copies of the reports and audits required by this section available for public inspection within the State.

(d)(1) For the purpose of evaluating and reviewing the block grant established under this title, the Secretary and the Comptroller General shall have access to any books, accounts, records, correspondence, or other documents that are related to such block grant, and that are in the possession, custody, or control of States, political subdivisions thereof, or any of their grantees.

(2) In conjunction with an evaluation or review under paragraph (1), no State or political subdivision thereof (or grantee of either) shall be required to create or prepare new records to comply with paragraph (1).

(3) For other provisions relating to deposit, accounting, reports, and auditing with respect to Federal grants to States, see section 6503(b) of title 31, United States Code.

CRIMINAL PENALTY FOR FALSE STATEMENTS

SEC. 507. [42 U.S.C. 707] (a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in connection with the furnishing of items or services for which payment may be made by a State from funds allotted to the State under this title, or

(2) having knowledge of the occurrence of any event affecting his initial or continued right to any such payment conceals or fails to disclose such event with an intent fraudulently to secure such payment either in a greater amount than is due or when no such payment is authorized,

shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(b) For civil monetary penalties for certain submissions of false claims, see section 1128A of this Act.

NONDISCRIMINATION

SEC. 508. [42 U.S.C. 708] (a)(1) For the purpose of applying the prohibitions against discrimination on the basis of age under the Age Discrimination Act of 1975[8], on the basis of handicap under section 504 of the Rehabilitation Act of 1973[9], on the basis of sex under title IX of the Education Amendments of 1972[10], or on the basis of race, color, or national origin under title VI of the Civil Rights Act of 1964[11], programs and activities funded in whole or in part with funds made available under this title are considered to be programs and activities receiving Federal financial assistance.

(2) No person shall on the ground of sex or religion be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity funded in whole or in part with funds made available under this title.

(b) Whenever the Secretary finds that a State, or an entity that has received a payment from an allotment to a State under section

[8] See Vol. II, P.L. 94–135, Title III [89 Stat. 728].
[9] See Vol. II, P.L. 93–112.
[10] See Vol. II, P.L. 92–318.
[11] See Vol. II, P.L. 88–352.

502(c), has failed to comply with a provision of law referred to in subsection (a)(1), with subsection (a)(2), or with an applicable regulation (including one prescribed to carry out subsection (a)(2)), he shall notify the chief executive officer of the State and shall request him to secure compliance. If within a reasonable period of time, not to exceed sixty days, the chief executive officer fails or refuses to secure compliance, the Secretary may—

(1) refer the matter to the Attorney General with a recommendation that an appropriate civil action be instituted,

(2) exercise the powers and functions provided by title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, or section 504 of the Rehabilitation Act of 1973, as may be applicable, or

(3) take such other action as may be provided by law.

(c) When a matter is referred to the Attorney General pursuant to subsection (b)(1), or whenever he has reason to believe that the entity is engaged in a pattern or practice in violation of a provision of law referred to in subsection (a)(1) or in violation of subsection (a)(2), the Attorney General may bring a civil action in any appropriate district court of the United States for such relief as may be appropriate, including injunctive relief.

ADMINISTRATION OF TITLE AND STATE PROGRAMS

SEC. 509. [42 U.S.C. 709] (a) The Secretary shall designate an identifiable administrative unit with expertise in maternal and child health within the Department of Health and Human Services, which unit shall be responsible for—

(1) the Federal program described in section 502(a);

(2) promoting coordination at the Federal level of the activities authorized under this title and under title XIX of this Act, especially early and periodic screening, diagnosis and treatment, related activities funded by the Departments of Agriculture and Education, and under health block grants and categorical health programs, such as immunizations, administered by the Secretary;

(3) disseminating information to the States in such areas as preventive health services and advances in the care and treatment of mothers and children;

(4) providing technical assistance, upon request, to the States in such areas as program planning, establishment of goals and objectives, standards of care, and evaluation and in developing consistent and accurate data collection mechanisms in order to report the information required under section 506(a)(2);

(5) in cooperation with the National Center for Health Statistics and in a manner that avoids duplication of data collection, collection, maintenance, and dissemination of information relating to the health status and health service needs of mothers and children in the United States;

(6) assisting in the preparation of reports to the Congress on the activities funded and accomplishments achieved under this title from the information required to be reported by the States under sections 505(a) and 506; and [12]

[12] As in original. "and" should probably not appear.

(7) assisting States in the development of care coordination services (as defined in section 501(b)(3)); and

(8) developing and making available to the State agency (or agencies) administering the State's program under this title a national directory listing by State the toll-free numbers described in section 505(a)(5)(E).

(b) The State health agency of each State shall be responsible for the administration (or supervision of the administration) of programs carried out with allotments made to the State under this title, except that, in the case of a State which on July 1, 1967, provided for administration (or supervision thereof) of the State plan under this title (as in effect on such date) by a State agency other than the State health agency, that State shall be considered to comply [13] the requirement of this subsection if it would otherwise comply but for the fact that such other State agency administers (or supervises the administration of) any such program providing services for children with special health care needs.

SEPARATE PROGRAM FOR ABSTINENCE EDUCATION [14]

SEC. 510. [42 U.S.C. 710] (a) For the purpose described in subsection (b), the Secretary shall, for fiscal year 1998 and each subsequent fiscal year, allot to each State which has transmitted an application for the fiscal year under section 505(a) an amount equal to the product of—

(1) the amount appropriated in subsection (d) for the fiscal year; and

(2) the percentage determined for the State under section 502(c)(1)(B)(ii).

(b)(1) The purpose of an allotment under subsection (a) to a State is to enable the State to provide abstinence education, and at the option of the State, where appropriate, mentoring, counseling, and adult supervision to promote abstinence from sexual activity, with a focus on those groups which are most likely to bear children out–of–wedlock.

(2) For purposes of this section, the term "abstinence education" means an educational or motivational program which—

(A) has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;

(B) teaches abstinence from sexual activity outside marriage as the expected standard for all school age children;

(C) teaches that abstinence from sexual activity is the only certain way to avoid out–of–wedlock pregnancy, sexually transmitted diseases, and other associated health problems;

(D) teaches that a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity;

(E) teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;

[13] As in original. Probably should be "comply with".

[14] See Vol. II, P.L. 108-89, §101(a), P.L. 108-262, §2(a), and P.L. 108-308, §2(a), with respect to the extension of the temporary assistance for needy families block grant program.

(F) teaches that bearing children out–of–wedlock is likely to have harmful consequences for the child, the child's parents, and society;

(G) teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and

(H) teaches the importance of attaining self–sufficiency before engaging in sexual activity.

(c)(1) Sections 503, 507, and 508 apply to allotments under subsection (a) to the same extent and in the same manner as such sections apply to allotments under section 502(c).

(2) Sections 505 and 506 apply to allotments under subsection (a) to the extent determined by the Secretary to be appropriate.

(d) For the purpose of allotments under subsection (a), there is appropriated, out of any money in the Treasury not otherwise appropriated, an additional $50,000,000 for each of the fiscal years 1998 through 2003 [15]. The appropriation under the preceding sentence for a fiscal year is made on October 1 of the fiscal year.

[15] P.L. 108-40, §6, struck out "2002" and substituted "2003", effective July 1, 2003.

TITLE VI—TEMPORARY STATE FISCAL RELIEF [1]

TEMPORARY STATE FISCAL RELIEF

SEC. 601. [42 U.S.C. 801] (a) APPROPRIATION.—There is authorized to be appropriated and is appropriated for making payments to States under this section, $5,000,000,000 for each of fiscal years 2003 and 2004.

(b) PAYMENTS.—

(1) FISCAL YEAR 2003.—From the amount appropriated under subsection (a) for fiscal year 2003, the Secretary of the Treasury shall, not later than the later of the date that is 45 days after the date of enactment of this Act or the date that a State provides the certification required by subsection (e) for fiscal year 2003, pay each State the amount determined for the State for fiscal year 2003 under subsection (c).

(2) FISCAL YEAR 2004.—From the amount appropriated under subsection (a) for fiscal year 2004, the Secretary of the Treasury shall, not later than the later of October 1, 2003, or the date that a State provides the certification required by subsection (e) for fiscal year 2004, pay each State the amount determined for the State for fiscal year 2004 under subsection (c).

(c) PAYMENTS BASED ON POPULATION.—

(1) IN GENERAL.—Subject to paragraph (2), the amount appropriated under subsection (a) for each of fiscal years 2003 and 2004 shall be used to pay each State an amount equal to the relative population proportion amount described in paragraph (3) for such fiscal year.

(2) MINIMUM PAYMENT.—

(A) IN GENERAL.—No State shall receive a payment under this section for a fiscal year that is less than—

(i) in the case of 1 of the 50 States or the District of Columbia, ½ of 1 percent of the amount appropriated for such fiscal year under subsection (a); and

(ii) in the case of the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands, or American Samoa, 1/10 of 1 percent of the amount appropriated for such fiscal year under subsection (a).

(B) PRO RATA ADJUSTMENTS.—The Secretary of the Treasury shall adjust on a pro rata basis the amount of the payments to States determined under this section without regard to this subparagraph to the extent necessary to comply with the requirements of subparagraph (A).

[1] P.L. 108-27, §401(b), added this Title VI, effective May 28, 2003.
Title VI appears in the United States Code as §801 of subchapter VI, chapter 7, Title 42.
Subsection (g) provides that effective October 1, 2004, this title is repealed.

(3) RELATIVE POPULATION PROPORTION AMOUNT.—The relative population proportion amount described in this paragraph is the product of—

(A) the amount described in subsection (a) for a fiscal year; and

(B) the relative State population proportion (as defined in paragraph (4)).

(4) RELATIVE STATE POPULATION PROPORTION DEFINED.—For purposes of paragraph (3)(B), the term "relative State population proportion" means, with respect to a State, the amount equal to the quotient of—

(A) the population of the State (as reported in the most recent decennial census); and

(B) the total population of all States (as reported in the most recent decennial census).

(d) USE OF PAYMENT.—

(1) IN GENERAL.—Subject to paragraph (2), a State shall use the funds provided under a payment made under this section for a fiscal year to—

(A) provide essential government services; or

(B) cover the costs to the State of complying with any Federal intergovernmental mandate (as defined in section 421(5) of the Congressional Budget Act of 1974) to the extent that the mandate applies to the State, and the Federal Government has not provided funds to cover the costs.

(2) LIMITATION.—A State may only use funds provided under a payment made under this section for types of expenditures permitted under the most recently approved budget for the State.

(e) CERTIFICATION.—In order to receive a payment under this section for a fiscal year, the State shall provide the Secretary of the Treasury with a certification that the State's proposed uses of the funds are consistent with subsection (d).

(f) DEFINITION OF STATE.—In this section, the term "State" means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands, and American Samoa.

(g) REPEAL.—Effective as of October 1, 2004, this title is repealed.

TITLE VII—ADMINISTRATION [1]

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SOCIAL SECURITY ADMINISTRATION

SEC. 701. [42 U.S.C. 901] (a) There is hereby established, as an independent agency in the executive branch of the Government, a Social Security Administration (in this title referred to as the "Administration").

(b) It shall be the duty of the Administration to administer the old-age, survivors, and disability insurance program under title II and the supplemental security income program under title XVI.

COMMISSIONER; DEPUTY COMMISSIONER; OTHER OFFICERS

Commissioner of Social Security [3]

SEC. 702. [42 U.S.C. 902] (a)(1) There shall be in the Administration a Commissioner of Social Security (in this title referred to as the "Commissioner") who shall be appointed by the President, by and with the advice and consent of the Senate.

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[1] Title VII of the Social Security Act is administered by the Office of the Commissioner of Social Security.

Title VII appears in the United States Code as §§901–912 of subchapter VII, chapter 7, Title 42.

Regulations of the Social Security Administration relating to Title VII are contained in subtitle A and chapter II, Title 45, Code of Federal Regulations.

See Vol. II, 31 U.S.C. 6504–6505, with respect to intergovernmental cooperation.

See Vol. II, P.L. 88–352, §601, for prohibition against discrimination in federally assisted programs.

[2] This table of contents does not appear in the law.

[3] See Vol. II, P.L. 108-203, §202, with respect to the issuance by The Commissioner of Social Security of receipts acknowledging the submission of reports 4 changes in work or earnings status of disabled beneficiaries.

(2) The Commissioner shall be compensated at the rate provided for level I of the Executive Schedule.

(3) The Commissioner shall be appointed for a term of 6 years, except that the initial term of office for Commissioner shall terminate January 19, 2001. In any case in which a successor does not take office at the end of a Commissioner's term of office, such Commissioner may continue in office until the entry upon office of such a successor. A Commissioner appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term. An individual serving in the the office of Commissioner may be removed from office only pursuant to a finding by the President of neglect of duty or malfeasance in office.

(4) The Commissioner shall be responsible for the exercise of all powers and the discharge of all duties of the Administration, and shall have authority and control over all personnel and activities thereof.

(5) The Commissioner may prescribe such rules and regulations as the Commissioner determines necessary or appropriate to carry out the functions of the Administration. The regulations prescribed by the Commissioner shall be subject to the rulemaking procedures established under section 553 of title 5, United States Code.

(6) The Commissioner may establish, alter, consolidate, or discontinue such organizational units or components within the Administration as the Commissioner considers necessary or appropriate, except that this paragraph shall not apply with respect to any unit, component, or provision provided for by this Act.

(7) The Commissioner may assign duties, and delegate, or authorize successive redelegations of, authority to act and to render decisions, to such officers and employees of the Administration as the Commissioner may find necessary. Within the limitations of such delegations, redelegations, or assignments, all official acts and decisions of such officers and employees shall have the same force and effect as though performed or rendered by the Commissioner.

(8) The Commissioner and the Secretary of Health and Human Services (in this title referred to as the "Secretary") shall consult, on an ongoing basis, to ensure—

(A) the coordination of the programs administered by the Commissioner, as described in section 701, with the programs administered by the Secretary under titles XVIII and XIX of this Act; and

(B) that adequate information concerning benefits under such titles XVIII and XIX is available to the public.

Deputy Commissioner of Social Security

(b)(1) There shall be in the Administration a Deputy Commissioner of Social Security (in this title referred to as the Deputy Commissioner) who shall be appointed by the President, by and with the advice and consent of the Senate.

(2) The Deputy Commissioner shall be appointed for a term of 6 years, except that the initial term of office for the Deputy

Commissioner shall terminate January 19, 2001. In any case in which a successor does not take office at the end of a Deputy Commissioner's term of office, such Deputy Commissioner may continue in office until the entry upon office of such a successor. A Deputy Commissioner appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

(3) The Deputy Commissioner shall be compensated at the rate provided for level II of the Executive Schedule.

(4) The Deputy Commissioner shall perform such duties and exercise such powers as the Commissioner shall from time to time assign or delegate. The Deputy Commissioner shall be Acting Commissioner of the Administration during the absence or disability of the Commissioner and, unless the President designates another officer of the Government as Acting Commissioner, in the event of a vacancy in the office of the Commissioner.

Chief Actuary

(c)(1) There shall be in the Administration a Chief Actuary, who shall be appointed by, and in direct line of authority to, the Commissioner. The Chief Actuary shall be appointed from individuals who have demonstrated, by their education and experience, superior expertise in the actuarial sciences. The Chief Actuary shall serve as the chief actuarial officer of the Administration, and shall exercise such duties as are appropriate for the office of the Chief Actuary and in accordance with professional standards of actuarial independence. The Chief Actuary may be removed only for cause.

(2) The Chief Actuary shall be compensated at the highest rate of basic pay for the Senior Executive Service under section 5382(b) of title 5, United States Code.

Chief Financial Officer

(d) There shall be in the Administration a Chief Financial Officer appointed by the Commissioner in accordance with section 901(a)(2) of title 31, United States Code.

Inspector General

(e) There shall be in the Administration an Inspector General appointed by the President, by and with the advice and consent of the Senate, in accordance with section 3(a) of the Inspector General Act of 1978.

SOCIAL SECURITY ADVISORY BOARD

Establishment of Board

SEC. 703. [42 U.S.C. 903] (a) There shall be established a Social Security Advisory Board (in this section referred to as the "Board").

(b) On and after the date the Commissioner takes office, the Board shall advise the Commissioner on policies related to the old-age, survivors, and disability insurance program under title II, the program of special benefits for certain World War II veterans under title VIII, and the supplemental security income program under

title XVI. Specific functions of the Board of the Board shall include—

(1) analyzing the Nation's retirement and disability systems and making recommendations with respect to how the old-age, survivors, and disability insurance program and the supplemental security income program, supported by other public and private systems, can most effectively assure economic security;

(2) studying and making recommendations relating to the coordination of programs that provide health security with programs described in paragraph (1);

(3) making recommendations to the President and to the Congress with respect to policies that will ensure the solvency of the old-age, survivors, and disability insurance program, both in the short-term and the long-term;

(4) making recommendations with respect to the quality of service that the Administration provides to the public;

(5) making recommendations with respect to policies and regulations regarding the old-age, survivors, and disability insurance program and the supplemental security income program;

(6) increasing public understanding of the social security system;

(7) making recommendations with respect to a long-range research program evaluation plan for the Administration;

(8) reviewing and assessing any major studies of social security as may come to the attention of the Board; and

(9) making recommendations with respect to such other matters as the Board determines to be appropriate.

Structure and Membership of the Board

(c)(1) The Board shall be composed of 7 members who shall be appointed as follows:

(A) 3 members shall be appointed by the President, by and with the advice and consent of the Senate. Not more than 2 of such members shall be from the same political party.

(B) 2 members (each member from a different political party) shall be appointed by the President pro tempore of the Senate with the advice of the Chairman and the Ranking Minority Member of the Senate Committee on Finance.

(C) 2 members (each member from a different political party) shall be appointed by the Speaker of the House of Representatives, with the advice of the Chairman and the Ranking Minority Member of the House Committee on Ways and Means.

(2) The members shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education, experience, and attainments, exceptionally qualified to perform the duties of members of the Board.

Terms of Appointment

(d) Each member of the Board shall serve for a term of 6 years, except that—

(1) a member appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term; and

(2) the terms of service of the members initially appointed under this section shall begin on October 1, 1994, and expire as follows:

(A) The terms of service of the members initially appointed by the President shall expire as designated by the President at the time of nomination, 1 each at the end of—

(i) 2 years;

(ii) 4 years; and

(iii) 6 years.

(B) The terms of service of members initially appointed by the President pro tempore of the Senate shall expire as designated by the President pro tempore of the Senate at the time of nomination, 1 each at the end of—

(i) 3 years; and

(ii) 6 years.

(C) The terms of service of members initially appointed by the Speaker of the House of Representatives shall expire as designated by the Speaker of the House of Representatives at the time of nomination, 1 each at the end of—

(i) 4 years; and

(ii) 5 years.

Chairman

(e) A member of the Board shall be designated by the President to serve as Chairman for a term of 4 years, coincident with the term of the President, or until the designation of a successor.

Compensation, Expenses and Per Diem

(f)[4] A member of the Board shall, for each day (including travel-time) during which the member is attending meetings or conferences of the Board or otherwise engaged in the business of the Board, be compensated at the daily rate of basic pay for level IV of the Executive Schedule. While serving on business of the Board away from their homes or regular places of business, members may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government employed intermittently.

Meeting

(g)(1) The Board shall meet at the call of the Chairman (in consultation with the other members of the Board) not less than 4 times each year to consider a specific agenda of issues, as determined by the Chairman in consultation with the other members of the Board.

(2) Four members of the Board (not more than 3 of whom may be of the same political party) shall constitute a quorum for purposes of conducting business.

[4] P.L. 108-203, §417, amended subsection (f) in its entirety, effective as of January 1, 2003. For subsection (f) as it formerly read, See Vol. II, Appendix J, Superseded Provisions, P.L. 108-203.

Federal Advisory Committee Act

(h) The Board shall be exempt from the provisions of the Federal Advisory Committee Act (5 U.S.C. App.).

Personnel

(i) The Board shall, without regard to the provisions of title 5, United States Code, relating to the competitive service, appoint a Staff Director who are not members of the political party represented by the majority of the Board,who shall be paid at a rate equivalent to a rate established for the Senior Executive Service under section 5382 of title 5, United States Code. The Board shall appoint such additional personnel as the Board determines to be necessary to provide adequate support for the Board, and may compensate such additional personnel without regard to the provisions of title 5, United States Code, relating to the competitive service.

Authorization of Appropriations

(j) There are authorized to be appropriated, out of the Federal Disability Insurance Trust Fund, the Federal Old-Age and Survivors Insurance Trust Fund, and the general fund of the Treasury, such sums as are necessary to carry out the purposes of this section.

ADMINISTRATIVE DUTIES OF THE COMMISSIONER

Personnel

SEC. 704. [42 U.S.C. 904] (a)(1) The Commissioner shall appoint such additional officers and employees as the Commissioner considers necessary to carry out the functions of the Administration under this Act, and attorneys and experts may be appointed without regard to the civil service laws. Except as otherwise provided in the preceding sentence or in any other provision of law, such officers and employees shall be appointed, and their compensation shall be fixed, in accordance with title 5, United States Code.

(2) The Commissioner may procure the services of experts and consultants in accordance with the provisions of section 3109 of title 5, United States Code.

(3) Notwithstanding any requirements of section 3133 of title 5, United States Code, the Director of the Office of Personnel Management shall authorize for the Administration a total number of Senior Executive Service positions which is substantially greater than the number of such positions authorized in the Social Security Administration in the Department of Health and Human Services as of immediately before the date of the enactment of the Social Security Independence Program Improvements Act of 1994[5] to the extent that the greater number of such authorized positions is specified in the comprehensive work force plan as established and revised by the Commissioner under subsection (b)(2). The total number of such positions authorized for the Administration shall not at any time

[5] August 15, 1994 [P.L. 103–296; 108 Stat. 1464].

be less than the number of such authorized positions as of immediately before such date.

Budgetary Matters

(b)(1)(A) The Commissioner shall prepare an annual budget for the Administration, which shall be submitted by the President to the Congress without revision, together with the President's annual budget for the Administration.

(B) The Commissioner shall include in the annual budget prepared pursuant to subparagraph (A) an itemization of the amount of funds required by the Social Security Administration for the fiscal year covered by the budget to support efforts to combat fraud committed by applicants and beneficiaries.

(2)(A) Appropriations requests for staffing and personnel of the Administration shall be based upon a comprehensive work force plan, which shall be established and revised from time to time by the Commissioner.

(B) Appropriations for administrative expenses of the Administration are authorized to be provided on a biennial basis.

Employment Restriction

(c) The total number of positions in the Administration (other than positions established under section 702) which—

(1) are held by noncareer appointees (within the meaning of section 3132(a)(7) of title 5, United States Code) in the Senior Executive Service, or

(2) have been determined by the President or the Office of Personnel Management to be of a confidential, policy-determining, policy-making, or policy-advocating character and have been excepted from the competitive service thereby,

may not exceed at any time the equivalent of 20 full-time positions.

Seal of Office

(d) The Commissioner shall cause a seal of office to be made for the Administration of such design as the Commissioner shall approve. Judicial notice shall be taken of such seal.

Data Exchanges

(e)(1) Notwithstanding any other provision of law (including subsection (b), (o), (p), (q), (r), and (u) of section 552a of title 5, United States Code)—

(A) the Secretary shall disclose to the Commissioner any record or information requested in writing by the Commissioner for the purpose of administering any program administered by the Commissioner, if records or information of such type were disclosed to the Commissioner of Social Security in the Department of Health and Human Services under applicable rules, regulations, and procedures in effect before the date of the enactment of the Social Security Independence and Program Improvements Act of 1994; and

(B) the Commissioner shall disclose to the Secretary or to any State any record or information requested in writing by the Secretary to be so disclosed for the purpose of administering any program administered by the Secretary, if records or information of such type were so disclosed under applicable rules, regulations, and procedures in effect before the date of the enactment of the Social Security Independence and Program Improvements Act of 1994.

(2) The Commissioner and the Secretary shall enter into an agreement under which the Commissioner provides the Secretary data concerning the quality of the services and information provided to beneficiaries of the programs under titles XVIII and XIX and the administrative services provided by the Social Security Administration in support of such programs. Such agreement shall stipulate the type of data to be provided and the terms and conditions under which the data are to be provided.

(3) The Commissioner and the Secretary shall periodically review the need for exchanges of information not referred to in paragraph (1) or (2) and shall enter into such agreements as may be necessary and appropriate to provide information to each other or to States in order to meet the programmatic needs of the requesting agencies.

(4)(A) Any disclosure from a system of records (as defined in section 552a(a)(5) of title 5, United States Code) pursuant to this subsection shall be made as a routine use under subsection (b)(3) of section 552a of such title (unless otherwise authorized under such section 552a).

(B) Any computerized comparison of records, including matching programs, between the Commissioner and the Secretary shall be conducted in accordance with subsections (o), (p), (q), (r), and (u) of section 552a of title 5, United States Code.

(5) The Commissioner and the Secretary shall each ensure that timely action is taken to establish any necessary routine uses for disclosures required under paragraph (1) or agreed to pursuant to paragraph (3).

TRAINING GRANTS FOR PUBLIC WELFARE PERSONNEL

SEC. 705. [42 U.S.C. 906] (a) In order to assist in increasing the effectiveness and efficiency of administration of public assistance programs by increasing the number of adequately trained public welfare personnel available for work in public assistance programs, there are hereby authorized to be appropriated for the fiscal year ending June 30, 1963, the sum of $3,500,000, and for each fiscal year thereafter the sum of $5,000,000.

(b) Such portion of the sums appropriated pursuant to subsection (a) for any fiscal year as the Secretary may determine, but not in excess of $1,000,000 in the case of the fiscal year ending June 30, 1963, and $2,000,000 in the case of any fiscal year thereafter, shall be available for carrying out subsection (f). From the remainder of the sums so appropriated for any fiscal year, the Secretary shall make allotments to the States on the basis of (1) population, (2) relative need for trained public welfare personnel, particularly for per-

sonnel to provide self-support and self-care services, and (3) financial need.

(c) From each State's allotment under subsection (b), the Secretary shall from time to time pay to such State its costs of carrying out the purposes of this section through (1) grants to public or other nonprofit institutions of higher learning for training personnel employed or preparing for employment in public assistance programs, (2) special courses of study or seminars of short duration conducted for such personnel by experts hired on a temporary basis for the purpose, and (3) establishing and maintaining, directly or through grants to such institutions, fellowships or traineeships for such personnel at such institutions, with such stipends and allowances as may be permitted under regulations of the Secretary.

(d) Payments pursuant to subsection (c) shall be made in advance on the basis of estimates by the Secretary and adjustments may be made in future payments under this section to take account of overpayments or underpayments in amounts previously paid.

(e) The amount of any allotment to a State under subsection (b) for any fiscal year which the State certifies to the Secretary will not be required for carrying out the purposes of this section in such State shall be available for reallotment from time to time, on such dates as the Secretary may fix, to other States which the Secretary determines have need in carrying out such purposes for sums in excess of those previously allotted to them under this section and will be able to use such excess amounts during such fiscal year; such reallotments to be made on the basis provided in subsection (b) for the initial allotments to the States. Any amount so reallotted to a State shall be deemed part of its allotment under such subsection.

(f)(1) The portion of the sums appropriated for any fiscal year which is determined by the Secretary under the first sentence of subsection (b) to be available for carrying out this subsection shall be available to enable him to provide (A) directly or through grants to or contracts with public or nonprofit private institutions of higher learning, for training personnel who are employed or preparing for employment in the administration of public assistance programs, (B) directly or through grants to or contracts with public or nonprofit private agencies or institutions, for special courses of study or seminars of short duration (not in excess of one year) for training of such personnel, and (C) directly or through grants to or contracts with public or nonprofit private institutions of higher learning, for establishing and maintaining fellowships or traineeships for such personnel at such institutions, with such stipends and allowances as may be permitted by the Secretary.

(2) Payments under paragraph (1) may be made in advance on the basis of estimates by the Secretary, or may be made by way of reimbursement, and adjustments may be made in future payments under this subsection to take account of overpayments or underpayments in amounts previously paid.

(3) The Secretary may, to the extent he finds such action to be necessary, prescribe requirements to assure that any individual will repay the amount of his fellowship or traineeship received under this subsection to the extent such individual fails to serve, for the period prescribed by the Secretary, with a State or political subdivision thereof, or with the Federal Government, in connection with administration of any State or local public assistance program. The Secretary may relieve any

individual of his obligation to so repay, in whole or in part, whenever and to the extent that requirement of such repayment would, in his judgment, be inequitable or would be contrary to the purposes of any of the public welfare programs established by this Act.

SEC. 706. [Repealed.][6]

GRANTS FOR EXPANSION AND DEVELOPMENT OF UNDERGRADUATE AND GRADUATE PROGRAMS

SEC. 707. [42 U.S.C. 908] (a) There is authorized to be appropriated $5,000,000 for the fiscal year ending June 30, 1969, and $5,000,000 for each of the three succeeding fiscal years, for grants by the Secretary to public or nonprofit private colleges and universities and to accredited graduate schools of social work or an association of such schools to meet part of the costs of development, expansion, or improvement of (respectively) undergraduate programs in social work and programs for the graduate training of professional social work personnel, including the costs of compensation of additional faculty and administrative personnel and minor improvements of existing facilities. Not less than one-half of the sums appropriated for any fiscal year under the authority of this subsection shall be used by the Secretary for grants with respect to undergraduate programs.

(b) In considering applications for grants under this section, the Secretary shall take into account the relative need in the States for personnel trained in social work and the effect of the grants thereon.

(c) Payment of grants under this section may be made (after necessary adjustments on account of previously made overpayments or underpayments) in advance or by way of reimbursement, and on such terms and conditions and in such installments, as the Secretary may determine.

(d) For purposes of this section—

(1) the term "graduate school of social work" means a department, school, division, or other administrative unit, in a public or nonprofit private college or university, which provides, primarily or exclusively, a program of education in social work and allied subjects leading to a graduate degree in social work;

(2) the term "accredited" as applied to a graduate school of social work refers to a school which is accredited by a body or bodies approved for the purpose by the Commissioner of Education or with respect to which there is evidence satisfactory to the Secretary that it will be so accredited within a reasonable time; and

(3) the term "nonprofit" as applied to any college or university refers to a college or university which is a corporation or association, or is owned and operated by one or more corporations or associations, no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

[6] P.L. 103–296, §108(a)(2); 108 Stat. 1481.

DELIVERY OF BENEFIT CHECKS

SEC. 708. [42 U.S.C. 909] (a) If the day regularly designated for the delivery of benefit checks under title II, title VIII or title XVI falls on a Saturday, Sunday, or legal public holiday (as defined in section 6103 of title 5, United States Code[7] in any month, the benefit checks which would otherwise be delivered on such day shall be mailed for delivery on the first day preceding such day which is not a Saturday, Sunday, or legal public holiday (as so defined), without regard to whether the delivery of such checks would as a result have to be made before the end of the month for which such checks are issued.

(b) If more than the correct amount of payment under title II, title VIII or XVI is made to any individual as a result of the receipt of a benefit check pursuant to subsection (a) before the end of the month for which such check is issued, no action shall be taken (under section 204 or 1631(b) or otherwise) to recover such payment or the incorrect portion thereof.

(c) For purposes of computing the "OASDI trust fund ratio" under section 201(l), the "OASDI fund ratio" under section 215(i), and the "balance ratio" under section 709(b), benefit checks delivered before the end of the month for which they are issued by reason of subsection (a) of this section shall be deemed to have been delivered on the regularly designated delivery date.

RECOMMENDATIONS BY BOARD OF TRUSTEES TO REMEDY INADEQUATE BALANCES IN THE SOCIAL SECURITY TRUST FUNDS

SEC. 709. [42 U.S.C. 910] (a) If the Board of Trustees of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, the Federal Hospital Insurance Trust Fund, or the Federal Supplementary Medical Insurance Trust Fund determines at any time that the balance ratio of any such Trust Fund for any calendar year may become less than 20 percent, the Board shall promptly submit to each House of the Congress a report setting forth its recommendations for statutory adjustments affecting the receipts and disbursements of such Trust Fund necessary to maintain the balance ratio of such Trust Fund at not less than 20 percent, with due regard to the economic conditions which created such inadequacy in the balance ratio and the amount of time necessary to alleviate such inadequacy in a prudent manner. The report shall set forth specifically the extent to which benefits would have to be reduced, taxes under section 1401, 3101, or 3111 of the Internal Revenue Code of 1954[8] would have to be increased, or a combination thereof, in order to obtain the objectives referred to in the preceding sentence.

(b) For purposes of this section, the term "balance ratio" means, with respect to any calendar year in connection with any Trust Fund referred to in subsection (a), the ratio of—

(1) the balance in such Trust Fund as of the beginning of such year, including the taxes transferred under section 201(a) on the first day of such year and reduced by the outstanding amount of any loan (including interest thereon) theretofore made to such Trust Fund under section 201(l) or 1817(j), to

[7] Legal public holidays which may affect check delivery are (1) New Year's Day [January 1], (2) Independence Day [July 4], and (3) Labor Day [first Monday in September]).

[8] See P.L. 83–591, (this volume).

(2) the total amount which (for amounts which will be paid from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, as estimated by the Commissioner, and for amounts which will be paid from the Federal Hospital Insurance Trust and the Federal Supplementary Medical Insurance Trust Fund, as estimated by the Secretary) will be paid from such Trust Fund during such calendar year for all purposes authorized by section 201, 1817, or 1841 (as applicable), other than payments of interest on, or repayments of, loans under section 201(l) or 1817(j), but excluding any transfer payments between such Trust Fund and any other Trust Fund referred to in subsection (a) and reducing the amount of any transfers to the Railroad Retirement Account by the amount of any transfers into such Trust Fund from that Account.

BUDGETARY TREATMENT OF TRUST FUND OPERATIONS[9]

SEC. 710. [42 U.S.C. 911] (a) The receipts and disbursements of the Federal Old–Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund and the taxes imposed under sections 1401 and 3101 of the Internal Revenue Code of 1986[10] shall not be included in the totals of the budget of the United States Government as submitted by the President or of the congressional budget and shall be exempt from any general budget limitation imposed by statute on expenditures and net lending (budget outlays) of the United States Government.

(b) No provision of law enacted after the date of enactment of the Balanced Budget and Emergency Deficit Control Act of 1985[11] (other than a provision of an appropriation Act that appropriated funds authorized under the Social Security Act as in effect on the date of the enactment of the Balanced Budget and Emergency Deficit Control Act of 1985) may provide for payments from the general fund of the Treasury to any Trust Fund specified in subsection (a) or for payments from any such Trust Fund to the general fund of the Treasury.

OFFICE OF RURAL HEALTH POLICY

SEC. 711. [42 U.S.C. 912] (a) There shall be established in the Department of Health and Human Services (in this section referred to as the "Department") an Office of Rural Health Policy (in this section referred to as the "Office"). The Office shall be headed by a Director, who shall advise the Secretary on the effects of current policies and proposed statutory, regulatory, administrative, and budgetary changes in the programs established under titles XVIII and XIX on the financial viability of small rural hospitals, the ability of rural areas (and rural hospitals in particular) to attract and retain physicians and other health professionals, and access to (and the quality of) health care in rural areas.

(b) In addition to advising the Secretary with respect to the matters specified in subsection (a), the Director, through the Office, shall—

[9] See Vol. II, P.L. 93–344, §3(2), with respect to budget authority for fiscal year 1992 and subsequent fiscal years.
[10] See P.L. 83–591 (this volume).
[11] December 12, 1985 [P.L. 99–177; 99 Stat. 1037].

(1) oversee compliance with the requirements of section 1102(b) of this Act and section 4403 of the Omnibus Budget Reconciliation Act of 1987 [12] (as such section pertains to rural health issues),

(2) establish and maintain a clearinghouse for collecting and disseminating information on—

(A) rural health care issues, including rural mental health, rural infant mortality prevention, and rural occupational safety and preventive health promotion,

(B) research findings relating to rural health care, and

(C) innovative approaches to the delivery of health care in rural area, including programs providing community-based mental health services, pre-natal and infant care services, and rural occupational safety and preventive health education and promotion,

(3) coordinate the activities within the Department that relate to rural health care, [13]

(4) provide information to the Secretary and others in the Department with respect to the activities, of other Federal departments and agencies, that relate to rural health care, including activities relating to rural mental health, rural infant mortality, and rural occupational safety and preventive health promotion, and [14]

(5) administer grants, cooperative agreements, and contracts to provide technical assistance and other activities as necessary to support activities related to improving health care in rural areas. [15]

DUTIES AND AUTHORITY OF SECRETARY

SEC. 712. [42 U.S.C. 913] The Secretary shall perform the duties imposed upon the Secretary by this Act. The Secretary is authorized to appoint and fix the compensation of such officers and employees, and to make such expenditures as may be necessary for carrying out the functions of the Secretary under this Act. The Secretary may appoint attorneys and experts without regard to the civil service laws.

[12] See Vol. II, 100–203.
[13] P.L. 108-173, §432(1), struck out "and".
[14] P.L. 108-173, §432(2), struck out the period substituted ", and".
[15] P.L. 108-173, §432(3), added paragraph (5), effective December 8, 2003.

TITLE VIII—SPECIAL BENEFITS FOR CERTAIN WORLD WAR II VETERANS [1]

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BASIC ENTITLEMENT TO BENEFITS

SEC. 801. [42 U.S.C. 1001] Every individual who is a qualified individual under section 802 shall, in accordance with and subject to the provisions of this title, be entitled to a monthly benefit paid by the Commissioner of Social Security for each month after September 2000 (or such earlier month, if the Commissioner determines is administratively feasible) the individual resides outside the United States.

QUALIFIED INDIVIDUALS

SEC. 802. [42 U.S.C. 1002] Except as otherwise provided in this title, an individual—

(1) who has attained the age of 65 on or before the date of the enactment of this title;

(2) who is a World War II veteran;

(3) who is eligible for a supplemental security income benefit under title XVI for—

(A) the month in which this title is enacted; and

(B) the month in which the individual files an application for benefits under this title;

(4) whose total benefit income is less than 75 percent of the Federal benefit rate under title XVI;

[1] Title VIII of the Social Security Act is administered by the Social Security Administration. Title VIII appears in the United States Code, §§1001–1013, subchapter VIII, chapter 7, Title 42.

[2] This table of contents does not appear in the law.

(5) who has filed an application for benefits under this title; and

(6) who is in compliance with all requirements imposed by the Commissioner of Social Security under this title,

shall be a qualified individual for purposes of this title.

RESIDENCE OUTSIDE THE UNITED STATES

SEC. 803. [42 U.S.C. 1003] For purposes of section 801, with respect to any month, an individual shall be regarded as residing outside the United States if, on the first day of the month, the individual so resides outside the United States.

DISQUALIFICATIONS

SEC. 804. [42 U.S.C. 1004] (a) IN GENERAL.—Notwithstanding section 802, an individual may not be a qualified individual for any month—

(1) that begins after the month in which the Commissioner of Social Security is notified by the Attorney General that the individual has been removed from the United States pursuant to section 237(a) or 212(a)(6)(A) of the Immigration and Nationality Act and before the month in which the individual is lawfully admitted to the United States for permanent residence;

(2) during any part of which the individual is fleeing to avoid prosecution, or custody or confinement after conviction, under the laws of the United States or the jurisdiction within the United States from which the person has fled, for a crime, or an attempt to commit a crime, that is a felony under the laws of the place from which the individual has fled or, in jurisdictions that do not define crimes as felonies, is punishable by death or imprisonment for a term exceeding 1 year regardless of the actual sentence imposed[3] ;

(3) during any part of which the individual violates a condition of probation or parole imposed under Federal or State law; or

(4) during which the individual resides in a foreign country and is not a citizen or national of the United States if payments for such month to individuals residing in such country are withheld by the Treasury Department under section 3329 of title 31, United States Code.

(b) REQUIREMENT FOR ATTORNEY GENERAL.—For the purpose of carrying out subsection (a)(1), the Attorney General shall notify the Commissioner of Social Security as soon as practicable after the removal of any individual under section 237(a) or 212(a)(6)(A) of the Immigration and Nationality Act.

BENEFIT AMOUNT

SEC. 805. [42 U.S.C. 1005] The benefit under this title payable to a qualified individual for any month shall be in an amount equal to 75 percent of the Federal benefit rate under title XVI for the

[3] P.L. 108-203, §203(c), struck out "or which, in the case of the State of New Jersey, is a high misdemeanor under the laws of such State" and substituted "or, in jurisdictions that do not define crimes as felonies, is punishable by death or imprisonment for a term exceeding 1 year regardless of the actual sentence imposed", effective December 1, 2004.

month, reduced by the amount of the qualified individual's benefit income for the month.

APPLICATIONS AND FURNISHING OF INFORMATION

SEC. 806. [42 U.S.C. 1006] (a) IN GENERAL.—The Commissioner of Social Security shall, subject to subsection (b), prescribe such requirements with respect to the filing of applications, the furnishing of information and other material, and the reporting of events and changes in circumstances, as may be necessary for the effective and efficient administration of this title.

(b) VERIFICATION REQUIREMENT.—The requirements prescribed by the Commissioner of Social Security under subsection (a) shall preclude any determination of entitlement to benefits under this title solely on the basis of declarations by the individual concerning qualifications or other material facts, and shall provide for verification of material information from independent or collateral sources, and the procurement of additional information as necessary in order to ensure that the benefits are provided only to qualified individuals (or their representative payees) in correct amounts.

REPRESENTATIVE PAYEES[4]

SEC. 807. [42 U.S.C. 1007] (a) IN GENERAL.—If the Commissioner of Social Security determines that the interest of any qualified individual under this title would be served thereby, payment of the qualified individual's benefit under this title may be made, regardless of the legal competency or incompetency of the qualified individual, either directly to the qualified individual, or for his or her use and benefit[5], to another person (the meaning of which term, for purposes of this section, includes an organization) with respect to whom the requirements of subsection (b) have been met (in this section referred to as the qualified individual's "representative payee"). If the Commissioner of Social Security determines that a representative payee has misused any benefit paid to the representative payee pursuant to this section, section 205(j), or section 1631(a)(2), the Commissioner of Social Security shall promptly revoke the person's designation as the qualified individual's representative payee under this subsection, and shall make payment to an alternative representative payee or, if the interest of the qualified individual under this title would be served thereby, to the qualified individual.

(b) EXAMINATION OF FITNESS OF PROSPECTIVE REPRESENTATIVE PAYEE.—

(1) Any determination under subsection (a) to pay the benefits of a qualified individual to a representative payee shall be made on the basis of—

(A) an investigation by the Commissioner of Social Security of the person to serve as representative payee, which shall be conducted in advance of the determination and

[4] See Vol. II, P.L. 108-203, §103(a), with respect to a report evaluating existing procedures and reviews for the qualification of representative payees.

P.L. 108-203, §103(b), amends §807 further in subsections (b) and (d). These amendments shall take effect on April 1, 2005.

[5] P.L. 108-203, §101(b)(3), struck out "for his or her benefit" and substituted "for his or her use and benefit", applicable to any case of benefit misuse by a representative payee with respect to which the Commissioner of Social Security makes the determination of misuse on or after January 1, 1995.

shall, to the extent practicable, include a face–to–face interview with the person (or, in the case of an organization, a representative of the organization); and

(B) adequate evidence that the arrangement is in the interest of the qualified individual.

(2) As part of the investigation referred to in paragraph (1), the Commissioner of Social Security shall—

(A) require the person being investigated to submit documented proof of the identity of the person;

(B) in the case of a person who has a social security account number issued for purposes of the program under title II or an employer identification number issued for purposes of the Internal Revenue Code of 1986, verify the number;

(C) determine whether the person has been convicted of a violation of section 208, 811, or 1632; and

(D) determine whether payment of benefits to the person in the capacity as representative payee has been revoked or terminated pursuant to this section, section 205(j), or section 1631(a)(2)(A)(iii) by reason of misuse of funds paid as benefits under this title, title II, or XVI, respectively.

(c) REQUIREMENT FOR MAINTAINING LISTS OF UNDESIRABLE PAYEES.—The Commissioner of Social Security shall establish and maintain lists which shall be updated periodically and which shall be in a form that renders such lists available to the servicing offices of the Social Security Administration. The lists shall consist of—

(1) the names and (if issued) social security account numbers or employer identification numbers of all persons with respect to whom, in the capacity of representative payee, the payment of benefits has been revoked or terminated under this section, section 205(j), or section 1631(a)(2)(A)(iii) by reason of misuse of funds paid as benefits under this title, title II, or XVI, respectively; and

(2) the names and (if issued) social security account numbers or employer identification numbers of all persons who have been convicted of a violation of section 208, 811, or 1632.

(d) PERSONS INELIGIBLE TO SERVE AS REPRESENTATIVE PAYEES.—

(1) IN GENERAL.—The benefits of a qualified individual may not be paid to any other person pursuant to this section if—

(A) the person has been convicted of a violation of section 208, 811, or 1632;

(B) except as provided in paragraph (2), payment of benefits to the person in the capacity of representative payee has been revoked or terminated under this section, section 205(j), or section 1631(a)(2)(A)(ii) by reason of misuse of funds paid as benefits under this title, title II, or title XVI, respectively; or

(C) except as provided in paragraph (2)(B), the person is a creditor of the qualified individual and provides the qualified individual with goods or services for consideration.

(2) EXEMPTIONS.—

(A) The Commissioner of Social Security may prescribe circumstances under which the Commissioner of Social Security may grant an exemption from paragraph (1) to any

person on a case–by–case basis if the exemption is in the best interest of the qualified individual whose benefits would be paid to the person pursuant to this section.

(B) Paragraph (1)(C) shall not apply with respect to any person who is a creditor referred to in such paragraph if the creditor is—

(i) a relative of the qualified individual and the relative resides in the same household as the qualified individual;

(ii) a legal guardian or legal representative of the individual;

(iii) a facility that is licensed or certified as a care facility under the law of the political jurisdiction in which the qualified individual resides;

(iv) a person who is an administrator, owner, or employee of a facility referred to in clause (iii), if the qualified individual resides in the facility, and the payment to the facility or the person is made only after the Commissioner of Social Security has made a good faith effort to locate an alternative representative payee to whom payment would serve the best interests of the qualified individual; or

(v) a person who is determined by the Commissioner of Social Security, on the basis of written findings and pursuant to procedures prescribed by the Commissioner of Social Security, to be acceptable to serve as a representative payee.

(C) The procedures referred to in subparagraph (B)(v) shall require the person who will serve as representative payee to establish, to the satisfaction of the Commissioner of Social Security, that—

(i) the person poses no risk to the qualified individual;

(ii) the financial relationship of the person to the qualified individual poses no substantial conflict of interest; and

(iii) no other more suitable representative payee can be found.

(e) DEFERRAL OF PAYMENT PENDING APPOINTMENT OF REPRESENTATIVE PAYEE.—

(1) IN GENERAL.—Subject to paragraph (2), if the Commissioner of Social Security makes a determination described in the first sentence of subsection (a) with respect to any qualified individual's benefit and determines that direct payment of the benefit to the qualified individual would cause substantial harm to the qualified individual, the Commissioner of Social Security may defer (in the case of initial entitlement) or suspend (in the case of existing entitlement) direct payment of the benefit to the qualified individual, until such time as the selection of a representative payee is made pursuant to this section.

(2) TIME LIMITATION.—

(A) IN GENERAL.—Except as provided in subparagraph (B), any deferral or suspension of direct payment of a benefit pursuant to paragraph (1) shall be for a period of not more than 1 month.

(B) EXCEPTION IN THE CASE OF INCOMPETENCY.—Subparagraph (A) shall not apply in any case in which the qualified individual is, as of the date of the Commissioner of Social Security's determination, legally incompetent under the laws of the jurisdiction in which the individual resides.

(3) PAYMENT OF RETROACTIVE BENEFITS.—Payment of any benefits which are deferred or suspended pending the selection of a representative payee shall be made to the qualified individual or the representative payee as a single sum or over such period of time as the Commissioner of Social Security determines is in the best interest of the qualified individual.

(f) HEARING.—Any qualified individual who is dissatisfied with a determination by the Commissioner of Social Security to make payment of the qualified individual's benefit to a representative payee under subsection (a) of this section or with the designation of a particular person to serve as representative payee shall be entitled to a hearing by the Commissioner of Social Security to the same extent as is provided in section 809(a), and to judicial review of the Commissioner of Social Security's final decision as is provided in section 809(b).

(g) NOTICE REQUIREMENTS.—

(1) IN GENERAL.—In advance, to the extent practicable, of the payment of a qualified individual's benefit to a representative payee under subsection (a), the Commissioner of Social Security shall provide written notice of the Commissioner's initial determination to so make the payment. The notice shall be provided to the qualified individual, except that, if the qualified individual is legally incompetent, then the notice shall be provided solely to the legal guardian or legal representative of the qualified individual.

(2) SPECIFIC REQUIREMENT.—Any notice required by paragraph (1) shall be clearly written in language that is easily understandable to the reader, shall identify the person to be designated as the qualified individual's representative payee, and shall explain to the reader the right under subsection (f) of the qualified individual or of the qualified individual's legal guardian or legal representative—

(A) to appeal a determination that a representative payee is necessary for the qualified individual;

(B) to appeal the designation of a particular person to serve as the representative payee of the qualified individual; and

(C) to review the evidence upon which the designation is based and to submit additional evidence.

(h) ACCOUNTABILITY MONITORING.—

(1) IN GENERAL.—In any case where payment under this title is made to a person other than the qualified individual entitled to the payment, the Commissioner of Social Security shall establish a system of accountability monitoring under which the person shall report not less often than annually with respect to the use of the payments. The Commissioner of Social Security shall establish and implement statistically valid procedures for reviewing the reports in order to identify instances in which persons are not properly using the payments.

(2) SPECIAL REPORTS.—Notwithstanding paragraph (1), the Commissioner of Social Security may require a report at any time from any person receiving payments on behalf of a qualified individual, if the Commissioner of Social Security has reason to believe that the person receiving the payments is misusing the payments.

(3)[6] AUTHORITY TO REDIRECT DELIVERY OF BENEFIT PAYMENTS WHEN A REPRESENTATIVE PAYEE FAILS TO PROVIDE REQUIRED ACCOUNTING.—In any case in which the person described in paragraph (1) or (2) receiving benefit payments on behalf of a qualified individual fails to submit a report required by the Commissioner of Social Security under paragraph (1) or (2), the Commissioner may, after furnishing notice to such person and the qualified individual, require that such person appear in person at a United States Government facility designated by the Social Security Administration as serving the area in which the qualified individual resides in order to receive such benefit payments.

(4)[7] MAINTAINING LISTS OF PAYEES.—The Commissioner of Social Security shall maintain lists which shall be updated periodically of—

(A) the name, address, and (if issued) the social security account number or employer identification number of each representative payee who is receiving benefit payments pursuant to this section, section 205(j), or section 1631(a)(2); and

(B) the name, address, and social security account number of each individual for whom each representative payee is reported to be providing services as representative payee pursuant to this section, section 205(j), or section 1631(a)(2).

(5)[8] MAINTAINING LISTS OF AGENCIES.—The Commissioner of Social Security shall maintain lists, which shall be updated periodically, of public agencies and community–based nonprofit social service agencies which are qualified to serve as representative payees pursuant to this section and which are located in the jurisdiction in which any qualified individual resides.

(i) RESTITUTION.—In any case where the negligent failure of the Commissioner of Social Security to investigate or monitor a representative payee results in misuse of benefits by the representative payee, the Commissioner of Social Security shall make payment to the qualified individual or the individual's alternative representative payee of an amount equal to the misused benefits. In any case in which a representative payee that—

(A) is not an individual; or

(B) is an individual who, for any month during a period when misuse occurs, serves 15 or more individuals who are beneficiaries under this title, title II, title XVI, or any combination of such titles;

misuses all or part of an individual's benefit paid to such representative payee, the Commissioner of Social Security shall pay to the beneficiary or the beneficiary's alternative representative payee

[6] P.L. 108-203, §106(b)(2), added this paragraph (3), effective September, 2004.
[7] P.L. 108-203, §106(b)(1), redesignated the former paragraph (3) as paragraph (4).
[8] P.L. 108-203, §106(b)(1), redesignated the former paragraph (4) as paragraph (5).

an amount equal to the amount of such benefit so misused. The provisions of this paragraph are subject to the limitations of subsection (l)(2).[9] The Commissioner of Social Security shall make a good faith effort to obtain restitution from the terminated representative payee.

(j)[10] MISUSE OF BENEFITS.—For purposes of this title, misuse of benefits by a representative payee occurs in any case in which the representative payee receives payment under this title for the use and benefit of another person under this title and converts such payment, or any part thereof, to a use other than for the use and benefit of such person. The Commissioner of Social Security may prescribe by regulation the meaning of the term "use and benefit" for purposes of this subsection.

(k)[11] PERIODIC ONSITE REVIEW.—

(1) IN GENERAL.—In addition to such other reviews of representative payees as the Commissioner of Social Security may otherwise conduct, the Commissioner may provide for the periodic onsite review of any person or agency that receives the benefits payable under this title (alone or in combination with benefits payable under title II or title XVI) to another individual pursuant to the appointment of such person or agency as a representative payee under this section, section 205(j), or section 1631(a)(2) in any case in which—

(A) the representative payee is a person who serves in that capacity with respect to 15 or more such individuals; or

(B) the representative payee is an agency that serves in that capacity with respect to 50 or more such individuals.

(2) REPORT.—Within 120 days after the end of each fiscal year, the Commissioner shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report on the results of periodic onsite reviews conducted during the fiscal year pursuant to paragraph (1) and of any other reviews of representative payees conducted during such fiscal year in connection with benefits under this title. Each such report shall describe in detail all problems identified in such reviews and any corrective action taken or planned to be taken to correct such problems, and shall include—

(A) the number of such reviews;

(B) the results of such reviews;

(C) the number of cases in which the representative payee was changed and why;

(D) the number of cases involving the exercise of expedited, targeted oversight of the representative payee by the Commissioner conducted upon receipt of an allegation of misuse of funds, failure to pay a vendor, or a similar irregularity;

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[9] P.L. 108-203, §101(b)(1), added the prior two sentences beginning with "In any case in which..." through 50 misused. The provisions... to the limitations of subsection (1)(2).", applicable to any case of benefit misuse by a representative payee with respect to which the Commissioner of Social Security makes the determination of misuse on or after January 1, 1995.

[10] P.L. 108-203, §101(b)(2), added subsection (j), applicable to any case of benefit misuse by a representative payee with respect to which the Commissioner of Social Security makes the determination of misuse on or after January 1, 1995.

[11] P.L. 108-203, §102(b)(2), added subsection (k), effective March 2, 2004.

(E) the number of cases discovered in which there was a misuse of funds;

(F) how any such cases of misuse of funds were dealt with by the Commissioner;

(G) the final disposition of such cases of misuse of funds, including any criminal penalties imposed; and

(H) such other information as the Commissioner deems appropriate.

(l)[12] LIABILITY FOR MISUSED AMOUNTS.—

(1) IN GENERAL.—In addition to such other reviews of representative payees as the Commissioner of Social Security may otherwise conduct, the Commissioner may provide for the periodic onsite review of any person or agency that receives the benefits payable under this title (alone or in combination with benefits payable under title II or title XVI) to another individual pursuant to the appointment of such person or agency as a representative payee under this section, section 205(j), or section 1631(a)(2) in any case in which—

(A) the representative payee is a person who serves in that capacity with respect to 15 or more such individuals; or

(B) the representative payee is an agency that serves in that capacity with respect to 50 or more such individuals.

(2) REPORT.—Within 120 days after the end of each fiscal year, the Commissioner shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report on the results of periodic onsite reviews conducted during the fiscal year pursuant to paragraph (1) and of any other reviews of representative payees conducted during such fiscal year in connection with benefits under this title. Each such report shall describe in detail all problems identified in such reviews and any corrective action taken or planned to be taken to correct such problems, and shall include—

(A) the number of such reviews;

(B) the results of such reviews;

(C) the number of cases in which the representative payee was changed and why;

(D) the number of cases involving the exercise of expedited, targeted oversight of the representative payee by the Commissioner conducted upon receipt of an allegation of misuse of funds, failure to pay a vendor, or a similar irregularity;

(E) the number of cases discovered in which there was a misuse of funds;

(F) how any such cases of misuse of funds were dealt with by the Commissioner;

(G) the final disposition of such cases of misuse of funds, including any criminal penalties imposed; and

(H) such other information as the Commissioner deems appropriate.

[12] P.L. 108-203, §105(b), added subsection (l), applicable to benefit misuse by a representative in any case with respect to which the Commissioner of Social Security or a court of competent jurisdiction makes the determination of misuse after September 2004.

OVERPAYMENTS AND UNDERPAYMENTS

SEC. 808. [42 U.S.C. 1008] (a) IN GENERAL.—Whenever the Commissioner of Social Security finds that more or less than the correct amount of payment has been made to any person under this title, proper adjustment or recovery shall be made, as follows:

(1) With respect to payment to a person of more than the correct amount, the Commissioner of Social Security shall decrease any payment under this title[13].[14]

(2) With respect to payment of less than the correct amount to a qualified individual who, at the time the Commissioner of Social Security is prepared to take action with respect to the underpayment—

(A) is living, the Commissioner of Social Security shall make payment to the qualified individual (or the qualified individual's representative payee designated under section 807) of the balance of the amount due the underpaid qualified individual.

(B) is deceased, the balance of the amount due shall revert to the general fund of the Treasury.

(b)[15] WAIVER OF RECOVERY OF OVERPAYMENT.—In any case in which more than the correct amount of payment has been made, there shall be no adjustment of payments to, or recovery by the United States from, any person who is without fault if the Commissioner of Social Security determines that the adjustment or recovery would defeat the purpose of this title or would be against equity and good conscience.

(c)[16] LIMITED IMMUNITY FOR DISBURSING OFFICERS.—A disbursing officer may not be held liable for any amount paid by the officer if the adjustment or recovery of the amount is waived under subsection (b), or adjustment under subsection (a) is not completed before the death of the qualified individual against whose benefits deductions are authorized.

(d)[17] AUTHORIZED COLLECTION PRACTICES.—

(1) IN GENERAL.—With respect to any delinquent amount, the Commissioner of Social Security may use the collection practices described in sections 3711(e), 3716, and 3718 of title 31, United States Code, as in effect on October 1, 1994.

(2) DEFINITION.—For purposes of paragraph (1), the term "delinquent amount" means an amount—

(A) in excess of the correct amount of the payment under this title; and

(B) determined by the Commissioner of Social Security to be otherwise unrecoverable under this section from a person who is not a qualified individual under this title.

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[13] P.L. 108-203, §210(b)(2)(A)(ii), struck out "any payment—" and subparagraph (A) and substituted "any payment under this title", effective March 2, 2004 with respect to overpayments under titles II, VIII, and XVI that are outstanding on or after March 2, 2004. For subparagraph (A) as it formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L. 108-203.

[14] P.L. 108-203, §210(b)(2)(A)(iii), struck out "; or" and substituted a period.

P.L. 108-203, §210(b)(2)(A)(i), struck out subparagraph (B), effective March 2, 2004 with respect to overpayments under titles II, VIII, and XVI that are outstanding on or after March 2, 2004. For subparagraph (B) as it formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L. 108-203.

[15] P.L. 108-203, §210(b)(2)(B), struck out the former subsection (b), and redesignated the former subsection (c) as subsection (b), for subsection (b) as it formerly read, see Vol. II, Supersided Provisions, Appendix J, P.L. 108-203, effective March 2, 2004 with respect to overpayments under titles II, VIII, and XVI that are outstanding on or after March 2, 2004.

[16] P.L. 108-203, §210(b)(2)(B), redesignated the former subsection (d) as subsection (c).

[17] P.L. 108-203, §210(b)(2)(B), redesignated the former subsection (c) as subsection (d).

(e)[18] AUTHORIZED COLLECTION PRACTICES.—For provisions relating to the cross-program recovery of overpayments made under programs administered by the Commissioner of Social Security, see section 1147.

HEARINGS AND REVIEW

SEC. 809. [42 U.S.C. 1009] (a) HEARINGS.—

(1) IN GENERAL.—The Commissioner of Social Security shall make findings of fact and decisions as to the rights of any individual applying for payment under this title. The Commissioner of Social Security shall provide reasonable notice and opportunity for a hearing to any individual who is or claims to be a qualified individual and is in disagreement with any determination under this title with respect to entitlement to, or the amount of, benefits under this title, if the individual requests a hearing on the matter in disagreement within 60 days after notice of the determination is received, and, if a hearing is held, shall, on the basis of evidence adduced at the hearing affirm, modify, or reverse the Commissioner of Social Security's findings of fact and the decision. The Commissioner of Social Security may, on the Commissioner of Social Security's own motion, hold such hearings and conduct such investigations and other proceedings as the Commissioner of Social Security deems necessary or proper for the administration of this title. In the course of any hearing, investigation, or other proceeding, the Commissioner may administer oaths and affirmations, examine witnesses, and receive evidence. Evidence may be received at any hearing before the Commissioner of Social Security even though inadmissible under the rules of evidence applicable to court procedure. The Commissioner of Social Security shall specifically take into account any physical, mental, educational, or linguistic limitation of the individual (including any lack of facility with the English language) in determining, with respect to the entitlement of the individual for benefits under this title, whether the individual acted in good faith or was at fault, and in determining fraud, deception, or intent.

(2) EFFECT OF FAILURE TO TIMELY REQUEST REVIEW.—A failure to timely request review of an initial adverse determination with respect to an application for any payment under this title or an adverse determination on reconsideration of such an initial determination shall not serve as a basis for denial of a subsequent application for any payment under this title if the applicant demonstrates that the applicant failed to so request such a review acting in good faith reliance upon incorrect, incomplete, or misleading information, relating to the consequences of reapplying for payments in lieu of seeking review of an adverse determination, provided by any officer or employee of the Social Security Administration.

(3) NOTICE REQUIREMENTS.—In any notice of an adverse determination with respect to which a review may be requested under paragraph (1), the Commissioner of Social Security shall describe in clear and specific language the effect on possible

[18] P.L. 108-203, §210(b)(2)(C), added this subsection (e), effective March 2, 2004 with respect to overpayments under titles II, VIII, and XVI that are outstanding on or after March 2, 2004.

entitlement to benefits under this title of choosing to reapply in lieu of requesting review of the determination.

(b) JUDICIAL REVIEW.—The final determination of the Commissioner of Social Security after a hearing under subsection (a)(1) shall be subject to judicial review as provided in section 205(g) to the same extent as the Commissioner of Social Security's final determinations under section 205.

OTHER ADMINISTRATIVE PROVISIONS

SEC. 810. [42 U.S.C. 1010] (a) REGULATIONS AND ADMINISTRATIVE ARRANGEMENTS.—The Commissioner of Social Security may prescribe such regulations, and make such administrative and other arrangements, as may be necessary or appropriate to carry out this title.

(b) PAYMENT OF BENEFITS.—Benefits under this title shall be paid at such time or times and in such installments as the Commissioner of Social Security determines are in the interests of economy and efficiency.

(c) ENTITLEMENT REDETERMINATIONS.—An individual's entitlement to benefits under this title, and the amount of the benefits, may be redetermined at such time or times as the Commissioner of Social Security determines to be appropriate.

(d) SUSPENSION AND TERMINATION OF BENEFITS.—Regulations prescribed by the Commissioner of Social Security under subsection (a) may provide for the suspension and termination of entitlement to benefits under this title as the Commissioner determines is appropriate.

OPTIONAL FEDERAL ADMINISTRATION OF STATE RECOGNITION PAYMENTS

SEC. 810A. [42 U.S.C. 1010a] (a) IN GENERAL.—The Commissioner of Social Security may enter into an agreement with any State (or political subdivision thereof) that provides cash payments on a regular basis to individuals entitled to benefits under this title under which the Commissioner of Social Security shall make such payments on behalf of such State (or subdivision).

(b) AGREEMENT TERMS.—

(1) IN GENERAL.—Such agreement shall include such terms as the Commissioner of Social Security finds necessary to achieve efficient and effective administration of both this title and the State program.

(2) FINANCIAL TERMS.—Such agreement shall provide for the State to pay the Commissioner of Social Security, at such times and in such installments as the parties may specify—

(A) an amount equal to the expenditures made by the Commissioner of Social Security pursuant to such agreement as payments to individuals on behalf of such State; and

(B) an administration fee to reimburse the administrative expenses incurred by the Commissioner of Social Security in making payments to individuals on behalf of the State.

(c) SPECIAL DISPOSITION OF ADMINISTRATION FEES.—Administration fees, upon collection, shall be credited to a special fund established in the Treasury of the United States for State recognition

payments for certain World War II veterans. The amounts so credited, to the extent and in the amounts provided in advance in appropriations Acts, shall be available to defray expenses incurred in carrying out this title.

PENALTIES FOR FRAUD

SEC. 811. [42 U.S.C. 1011] (a) IN GENERAL.—Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in an application for benefits under this title;

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining any right to the benefits;

(3) having knowledge of the occurrence of any event affecting—

(A) his or her initial or continued right to the benefits; or

(B) the initial or continued right to the benefits of any other individual in whose behalf he or she has applied for or is receiving the benefit, conceals or fails to disclose the event with an intent fraudulently to secure the benefit either in a greater amount or quantity than is due or when no such benefit is authorized; or

(4) having made application to receive any such benefit for the use and benefit of another and having received it, knowingly and willfully converts the benefit or any part thereof to a use other than for the use and benefit of the other individual,

shall be fined under title 18, United States Code, imprisoned not more than 5 years, or both.

(b)[19] COURT ORDER FOR RESTITUTION.—

(1) IN GENERAL.—Any Federal court, when sentencing a defendant convicted of an offense under subsection (a), may order, in addition to or in lieu of any other penalty authorized by law, that the defendant make restitution to the Commissioner of Social Security, in any case in which such offense results in—

(A) the Commissioner of Social Security making a benefit payment that should not have been made, or

(B) an individual suffering a financial loss due to the defendant's violation of subsection (a) in his or her capacity as the individual's representative payee appointed pursuant to section 807(i).

(2) RELATED PROVISIONS.—Sections 3612, 3663, and 3664 of title 18, United States Code, shall apply with respect to the issuance and enforcement of orders of restitution under this subsection. In so applying such sections, the Commissioner of Social Security shall be considered the victim.

(3) STATED REASONS FOR NOT ORDERING RESTITUTION.—If the court does not order restitution, or orders only partial restitution, under this subsection, the court shall state on the record the reasons therefor.

(4) RECEIPT OF RESTITUTION PAYMENTS.—

[19] P.L. 108-203, §209(b), amended subsection (b) in its entirety, applicable with respect to violations occurring on or after March 2, 2004. For subsection (b) as it formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L. 108-203.

(A) IN GENERAL.—Except as provided in subparagraph (B), funds paid to the Commissioner of Social Security as restitution pursuant to a court order shall be deposited as miscellaneous receipts in the general fund of the Treasury.

(B) PAYMENT TO THE INDIVIDUAL.—In the case of funds paid to the Commissioner of Social Security pursuant to paragraph (1)(B), the Commissioner of Social Security shall certify for payment to the individual described in such paragraph an amount equal to the lesser of the amount of the funds so paid or the individual's outstanding financial loss as described in such paragraph, except that such amount may be reduced by any overpayment of benefits owed under this title, title II, or title XVI by the individual.

DEFINITIONS

SEC. 812. [42 U.S.C. 1012] In this title:

(1) WORLD WAR II VETERAN.—The term "World War II veteran" means a person who—

(A) served during World War II—

(i) in the active military, naval, or air service of the United States during World War II; or

(ii) in the organized military forces of the Government of the Commonwealth of the Philippines, while the forces were in the service of the Armed Forces of the United States pursuant to the military order of the President dated July 26, 1941, including among the military forces organized guerrilla forces under commanders appointed, designated, or subsequently recognized by the Commander in Chief, Southwest Pacific Area, or other competent authority in the Army of the United States, in any case in which the service was rendered before December 31, 1946; and

(B) was discharged or released therefrom under conditions other than dishonorable—

(i) after service of 90 days or more; or

(ii) because of a disability or injury incurred or aggravated in the line of active duty.

(2) WORLD WAR II.—The term "World War II" means the period beginning on September 16, 1940, and ending on July 24, 1947.

(3) SUPPLEMENTAL SECURITY INCOME BENEFIT UNDER TITLE XVI.—The term "supplemental security income benefit under title XVI", except as otherwise provided, includes State supplementary payments which are paid by the Commissioner of Social Security pursuant to an agreement under section 1616(a) of this Act or section 212(b) of Public Law 93–66.

(4) FEDERAL BENEFIT RATE UNDER TITLE XVI.—The term "Federal benefit rate under title XVI" means, with respect to any month, the amount of the supplemental security income cash benefit (not including any State supplementary payment which is paid by the Commissioner of Social Security pursuant to an agreement under section 1616(a) of this Act or section 212(b) of Public Law 93–66) payable under title XVI for the month to an eligible individual with no income.

(5) UNITED STATES.—The term "United States" means, notwithstanding section 1101(a)(1), only the 50 States, the District of Columbia, and the Commonwealth of the Northern Mariana Islands.

(6) BENEFIT INCOME.—The term "benefit income" means any recurring payment received by a qualified individual as an annuity, pension, retirement, or disability benefit (including any veterans' compensation or pension, workmen's compensation payment, old–age, survivors, or disability insurance benefit, railroad retirement annuity or pension, and unemployment insurance benefit), but only if a similar payment was received by the individual from the same (or a related) source during the 12–month period preceding the month in which the individual files an application for benefits under this title.

APPROPRIATIONS

SEC. 813. [42 U.S.C. 1013] There are hereby appropriated for fiscal year 2000 and subsequent fiscal years, out of any funds in the Treasury not otherwise appropriated, such sums as may be necessary to carry out this title.

TITLE IX—MISCELLANEOUS PROVISIONS RELATING TO EMPLOYMENT SECURITY [1]

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EMPLOYMENT SECURITY ADMINISTRATION ACCOUNT

Establishment of Account

SEC. 901. [42 U.S.C. 1101] (a) There is hereby established in the Unemployment Trust Fund an employment security administration account.

Appropriations to Account

(b)(1) There is hereby appropriated to the Unemployment Trust Fund for credit to the employment security administration account, out of any moneys in the Treasury not otherwise appropriated, for the fiscal year ending June 30, 1961, and for each fiscal year thereafter, an amount equal to 100 per centum of the tax (including interest, penalties, and additions to the tax) received during the fiscal year under the Federal Unemployment Tax Act [3] and covered into the Treasury.

(2) The amount appropriated by paragraph (1) shall be transferred at least monthly from the general fund of the

[1] Title IX of the Social Security Act is administered by the Department of Labor.
Title IX appears in the United States Code as §§1101–1110, subchapter IX, chapter 7, Title 42.
Regulations of the Secretary of Labor relating to Title IX are contained in chapter V, Title 20, Code of Federal Regulations.
See Vol. II, 31 U.S.C. 6504–6505, with respect to intergovernmental cooperation.
See Vol. II, P.L. 88–352, §601, for prohibition against discrimination in federally assisted programs.
See Vol. II, P.L. 93–618, §§221–249, with respect to adjustment assistance for workers.
See Vol. II, P.L. 95–521, §102(i), with respect to reporting of benefits received under the Social Security Act.
See Vol. II, P.L. 100–203, §9151, with respect to the determination of the amount of the Federal share of certain extended benefits.
[2] This table of contents does not appear in the law.
[3] The "Federal Unemployment Tax Act" is in §§3301–3311 of P.L. 83–591 (this volume).

Treasury to the Unemployment Trust Fund and credited to the employment security administration account. Each such transfer shall be based on estimates made by the Secretary of the Treasury of the amounts received in the Treasury. Proper adjustments shall be made in the amounts subsequently transferred, to the extent prior estimates (including estimates for the fiscal year ending June 30, 1960) were in excess of or were less than the amounts required to be transferred.

(3) The Secretary of the Treasury is directed to pay from time to time from the employment security administration account into the Treasury, as repayments to the account for refunding internal revenue collections, amounts equal to all refunds made after June 30, 1960, of amounts received as tax under the Federal Unemployment Tax Act (including interest on such refunds).

Administrative Expenditures

(c)(1) There are hereby authorized to be made available for expenditure out of the employment security administration account for the fiscal year ending June 30, 1971, and for each fiscal year thereafter—

(A) such amounts (not in excess of the applicable limit provided by paragraph (3) and, with respect to clause (ii), not in excess of the limit provided by paragraph (4)) as the Congress may deem appropriate for the purpose of—

(i) assisting the States in the administration of their unemployment compensation laws as provided in title III (including administration pursuant to agreements under any Federal unemployment compensation law),

(ii) the establishment and maintenance of systems of public employment offices in accordance with the Act of June 6, 1933,[4] as amended (29 U.S.C., secs. 49–49n), and

(iii) carrying into effect section 4103 of title 38 of the United States Code[5];

(B) such amounts (not in excess of the limit provided by paragraph (4) with respect to clause (iii)) as the Congress may deem appropriate for the necessary expenses of the Department of Labor for the performance of its functions under—

(i) this title and titles III and XII of this Act,

(ii) the Federal Unemployment Tax Act,

(iii) the provisions of the Act of June 6, 1933, as amended,

(iv) chapter 41 (except section 4103) of title 38 of the United States Code, and

(v) any Federal unemployment compensation law.

The term "necessary expenses" as used in this subparagraph (B) shall include the expense of reimbursing a State for salaries and other expenses of employees of such State temporarily assigned or detailed to duty with the Department of Labor and of paying such employees for travel expenses, transportation of household goods, and per diem in lieu of subsistence while away from their regular

[4] See Vol. II, P.L. 73–30.
[5] See Vol. II, Title 38, §4103.

duty stations in the State, at rates authorized by law for civilian employees of the Federal Government.

(2) The Secretary of the Treasury is directed to pay from the employment security administration account into the Treasury as miscellaneous receipts the amount estimated by him which will be expended during a three-month period by the Treasury Department for the performance of its functions under—

(A) this title and titles III and XII of this Act, including the expenses of banks for servicing unemployment benefit payment and clearing accounts which are offset by the maintenance of balances of Treasury funds with such banks,

(B) the Federal Unemployment Tax Act, and

(C) any Federal unemployment compensation law with respect to which responsibility for administration is vested in the Secretary of Labor.

If it subsequently appears that the estimates under this paragraph in any particular period were too high or too low, appropriate adjustments shall be made by the Secretary of the Treasury in future payments.

(3)(A) For purposes of paragraph (1)(A), the limitation on the amount authorized to be made available for any fiscal year after June 30, 1970, is, except as provided in subparagraph (B) and in the second sentence of section 901(f)(3)(A), an amount equal to 95 percent of the amount estimated and set forth in the budget of the United States Government for such fiscal year as the amount by which the net receipts during such year under the Federal Unemployment Tax Act will exceed the amount transferred under section 905(b) during such year to the extended unemployment compensation account.

(B) The limitation established by subparagraph (A) is increased by any unexpended amount retained in the employment security administration account in accordance with section 901(f)(2)(B).

(C) Each estimate of net receipts under this paragraph shall be based upon a tax rate of 0.6 percent.

(4) For purposes of paragraphs (1)(A)(ii) and (1)(B)(iii) the amount authorized to be made available out of the employment security administration account for any fiscal year after June 30, 1972, shall reflect the proportion of the total cost of administering the system of public employment offices in accordance with the Act of June 6, 1933[6], as amended, and of the necessary expenses of the Department of Labor for the performance of its functions under the provisions of such Act, as the President determines is an appropriate charge to the employment security administration account, and reflects in his annual budget for such year. The President's determination, after consultation with the Secretary, shall take into account such factors as the relationship between employment subject to State laws and the total labor force in the United States, the number of claimants and the number of job applicants, and such other factors as he finds relevant.

(5)(A) There are authorized to be appropriated out of the employment security administration account to carry out program

[6] See Vol. II, P.L. 73–30.

integrity activities, in addition to any amounts available under paragraph (1)(A)(i)—

(i) $89,000,000 for fiscal year 1998;
(ii) $91,000,000 for fiscal year 1999;
(iii) $93,000,000 fiscal year 2000;
(iv) $96,000,000 for fiscal year 2001; and
(v) $98,000,000 for fiscal year 2002.

(B) In any fiscal year in which a State receives funds appropriated pursuant to this paragraph, the State shall expend a proportion of the funds appropriated pursuant to paragraph (1)(A)(i) to carry out program integrity activities that is not less than the proportion of the funds appropriated under such paragraph that was expended by the State to carry out program integrity activities in fiscal year 1997.

(C) For purposes of this paragraph, the term "program integrity activities" means initial claims review activities, eligibility review activities, benefit payments control activities, and employer liability auditing activities.

Additional Tax Attributable to Reduced Credits

(d)(1) The Secretary of the Treasury is directed to transfer from the employment security administration account—

(A) To the Federal unemployment account, an amount equal to the amount by which—

(i) 100 per centum of the additional tax received under the Federal Unemployment Tax Act with respect to any State by reason of the reduced credits provisions of section 3302(c)(3) of such Act and covered into the Treasury for the repayment of advances made to the State under section 1201, exceeds

(ii) the amount transferred to the account of such State pursuant to subparagraph (B) of this paragraph.

Any amount transferred pursuant to this subparagraph shall be credited against, and shall operate to reduce, that balance of advances, made under section 1201 to the State, with respect to which employers paid such additional tax.

(B) To the account (in the Unemployment Trust Fund) of the State with respect to which employers paid such additional tax, an amount equal to the amount by which such additional tax received and covered into the Treasury exceeds that balance of advances, made under section 1201 to the State, with respect to which employers paid such additional tax.

(2) Transfers under this subsection shall be as of the beginning of the month succeeding the month in which the moneys were credited to the employment security administration account pursuant to subsection (b)(2).

Revolving Fund

(e)(1) There is hereby established in the Treasury a revolving fund which shall be available to make the advances authorized by this subsection. There are hereby authorized to be appropriated, without fiscal year limitation, to such revolving fund such amounts as may be necessary for the purposes of this section.

(2) The Secretary of the Treasury is directed to advance from time to time from the revolving fund to the employment security administration account such amounts as may be necessary for the purposes of this section. If the net balance in the employment security administration account as of the beginning of any fiscal year equals 40 percent of the amount of the total appropriation by the Congress out of the employment security administration account for the preceding fiscal year, no advance may be made under this subsection during such fiscal year.

(3) Advances to the employment security administration account made under this subsection shall bear interest until repaid at a rate equal to the average rate of interest (computed as of the end of the calendar month next preceding the date of such advance) borne by all interest-bearing obligations of the United States then forming a part of the public debt; except that where such average rate is not a multiple of one-eighth of 1 per centum, the rate of interest shall be the multiple of one-eighth of 1 per centum next lower than such average rate.

(4) Advances to the employment security administration account made under this subsection, plus interest accrued thereon, shall be repaid by the transfer from time to time, from the employment security administration account to the revolving fund, of such amounts as the Secretary of the Treasury, in consultation with the Secretary of Labor, determines to be available in the employment security administration account for such repayment. Any amount transferred as a repayment under this paragraph shall be credited against, and shall operate to reduce, any balance of advances (plus accrued interest) repayable under this subsection.

Determination of Excess and Amount To Be Retained in Employment Security Administration Account

(f)(1) The Secretary of the Treasury shall determine as of the close of each fiscal year (beginning with the fiscal year ending June 30, 1961) the excess in the employment security administration account.

(2) The excess in the employment security administration account as of the close of any fiscal year is the amount by which the net balance in such account as of such time (after the application of section 902(b) and section 901(f)(3)(C)) exceeds the net balance in the employment security administration account as of the beginning of that fiscal year (including the fiscal year for which the excess is being computed) for which the net balance was higher than as of the beginning of any other such fiscal year.

(3)(A) The excess determined as provided in paragraph (2) as of the close of any fiscal year after June 30, 1972, shall be retained (as of the beginning of the succeeding fiscal year) in the employment security administration account until the amount in such account is equal to 40 percent of the amount of the total appropriation by the Congress out of the employment security administration account for the fiscal year for which the excess is determined. Three-eighths of the amount in the employment security administration account as of the beginning

of any fiscal year after June 30, 1972, or $150 million, whichever is the lesser, is authorized to be made available for such fiscal year pursuant to subsection (c)(1) for additional costs of administration due to an increase in the rate of insured unemployment for a calendar quarter of at least 15 percent over the rate of insured unemployment for the corresponding calendar quarter in the immediately preceding year.

(B) If the entire amount of the excess determined as provided in paragraph (2) as of the close of any fiscal year after June 30, 1972, is not retained in the employment security administration account, there shall be transferred (as of the beginning of the succeeding fiscal year) to the extended unemployment compensation account the balance of such excess or so much thereof as is required to increase the amount in the extended unemployment compensation account to the limit provided in section 905(b)(2).

(C) If as of the close of any fiscal year after June 30, 1972, the amount in the extended unemployment compensation account exceeds the limit provided in section 905(b)(2), such excess shall be transferred to the employment security administration account as of the close of such fiscal year.

(4) For the purposes of this section, the net balance in the employment security administration account as of any time is the amount in such account as of such time reduced by the sum of—

(A) the amounts then subject to transfer pursuant to subsection (d), and

(B) the balance of advances (plus interest accrued thereon) then repayable to the revolving fund established by subsection (e).

The net balance in the employment security administration account as of the beginning of any fiscal year shall be determined after the disposition of the excess in such account as of the close of the preceding fiscal year.

Transfers For Calendar Years 1988, 1989, and 1990

(g)(1) With respect to calendar years 1988, 1989, and 1990, the Secretary of the Treasury shall transfer from the employment security administration account—

(A) to the Federal unemployment account an amount equal to 50 percent of the amount of tax received under section 3301(1) of the Federal Unemployment Tax Act which is attributable to the difference in the tax rates between paragraphs (1) and (2) of such section; and

(B) to the extended unemployment compensation account an amount equal to 50 percent of such amount of tax received.

(2) Transfers under this subsection shall be as of the beginning of the month succeeding the month in which the moneys were credited to the employment security administration account pursuant to subsection (b)(2) with respect to wages paid during such calendar years.

TRANSFERS TO FEDERAL UNEMPLOYMENT ACCOUNT AND REPORT TO CONGRESS

Transfers to Federal Unemployment Account

SEC. 902. [42 U.S.C. 1102] (a) Whenever the Secretary of the Treasury determines pursuant to section 901(f) that there is an excess in the employment security administration account as of the close of any fiscal year and the entire amount of such excess is not retained in the employment security administration account or transferred to the extended unemployment compensation account as provided in section 901(f)(3), there shall be transferred (as of the beginning of the succeeding fiscal year) to the Federal unemployment account the balance of such excess or so much thereof as is required to increase the amount in the Federal unemployment account to whichever of the following is the greater:

(1) $550 million, or

(2) the amount (determined by the Secretary of Labor and certified by him to the Secretary of the Treasury) equal to 0.5 percent of the total wages subject (determined without any limitation on amount) to contributions under all State unemployment compensation laws for the calendar year ending during the fiscal year for which the excess is determined.

Transfers to Employment Security Administration Account

(b) The amount, if any, by which the amount in the Federal unemployment account as of the close of any fiscal year exceeds the greater of the amounts specified in paragraphs (1) and (2) of subsection (a) shall be transferred to the employment security administration account as of the close of such fiscal year.

Report to the Congress

(c) Whenever the Secretary of Labor has reason to believe that in the next fiscal year the employment security administration account will reach the limit provided for such account in section 901(f)(3)(A), and the Federal unemployment account will reach the limit provided for such account in section 902(a), and the extended unemployment compensation account will reach the limit provided for such account in section 905(b)(2), he shall, after consultation with the Secretary of the Treasury, so report to the Congress with a recommendation for appropriate action by the Congress.

AMOUNTS TRANSFERRED TO STATE ACCOUNTS

In General

SEC. 903. [42 U.S.C. 1103] (a)(1) If as of the close of any fiscal year after the fiscal year ending June 30, 1972, the amount in the extended unemployment compensation account has reached the limit provided in section 905(b)(2) and the amount in the Federal unemployment account has reached the limit provided in section 902(a) and all advances and interest pursuant to section 905(d) and section 1203 have been repaid, and there remains in the employment security administration account any amount over the amount provided in section 901(f)(3)(A), such excess amount, except as provided in subsection (b), shall be transferred (as of the beginning of

the succeeding fiscal year) to the accounts of the States in the Unemployment Trust Fund.

(2) Each State's share of the funds to be transferred under this subsection as of any October 1—

(A) shall be determined by the Secretary of Labor and certified by such Secretary to the Secretary of the Treasury before such date, and

(B) shall bear the same ratio to the total amount to be so transferred as—

(i) the amount of wages subject to tax under section 3301 of the Internal Revenue Code of 1986 during the preceding calendar year which are determined by the Secretary of Labor to be attributable to the State, bears to

(ii) the total amount of wages subject to such tax during such year.

Limitations on Transfers

(b)(1) If the Secretary of Labor finds that on October 1 of any fiscal year—

(A) a State is not eligible for certification under section 303, or

(B) the law of a State is not approvable under section 3304 of the Federal Unemployment Tax Act,

then the amount available for transfer to such State's account shall, in lieu of being so transferred, be transferred to the Federal unemployment account as of the beginning of such October 1. If, during the fiscal year beginning on such October 1, the Secretary of Labor finds and certifies to the Secretary of the Treasury that such State is eligible for certification under section 303, that the law of such State is approvable under such section 3304, or both, the Secretary of the Treasury shall transfer such amount from the Federal unemployment account to the account of such State. If the Secretary of Labor does not so find and certify to the Secretary of the Treasury before the close of such fiscal year then the amount which was available for transfer to such State's account as of October 1 of such fiscal year shall (as of the close of such fiscal year) become unrestricted as to use as part of the Federal unemployment account.

(2) The amount which, but for this paragraph, would be transferred to the account of a State under subsection (a) or paragraph (1) of this subsection shall be reduced (but not below zero) by the balance of advances made to the State under section 1201. The sum by which such amount is reduced shall—

(A) be transferred to or retained in (as the case may be) the Federal unemployment account, and

(B) be credited against, and operate to reduce—

(i) first, any balance of advances made before the date of the enactment of the Employment Security Act of 1960[7] to the State under section 1201, and

(ii) second, any balance of advances made on or after such date to the State under section 1201.

[7] Enacted on September 13, 1960, [Title V of P.L. 86–778; 74 Stat. 970].

Use of Transferred Amounts

(c)(1) Except as provided in paragraph (2), amounts transferred to the account of a State pursuant to subsections (a) and (b) shall be used only in the payment of cash benefits to individuals with respect to their unemployment, exclusive of expenses of administration.

(2) A State may, pursuant to a specific appropriation made by the legislative body of the State, use money withdrawn from its account in the payment of expenses incurred by it for the administration of its unemployment compensation law and public employment offices if and only if—

(A) the purposes and amounts were specified in the law making the appropriation,

(B) the appropriation law did not authorize the obligation of such money after the close of the two-year period which began on the date of enactment of the appropriation law,

(C) the money is withdrawn and the expenses are incurred after such date of enactment,

(D)(i) the appropriation law limits the total amount which may be obligated under such appropriation at any time to an amount which does not exceed, at any such time, the amount by which—

(I) the aggregate of the amounts transferred to the account of such State pursuant to subsections (a) and (b), exceeds

(II) the aggregate of the amounts used by the State pursuant to this subsection and charged against the amounts transferred to the account of such State, and

(ii) for purposes of clause (i), amounts used by a State for administration shall be chargeable against transferred amounts at the exact time the obligation is entered into, and

(E) the use of the money is accounted for in accordance with standards established by the Secretary of Labor.

(3)(A) If—

(i) amounts transferred to the account of a State pursuant to subsections (a) and (b) of this section were used in payment of unemployment benefits to individuals; and

(ii) the Governor of such State submits a request to the Secretary of Labor that such amounts be restored under this paragraph,

then the amounts described in clause (i) shall be restored to the status of funds transferred under subsections (a) and (b) of this section which have not been used by eliminating any charge against amounts so transferred for the use of such amounts in the payment of unemployment benefits.

(B) Subparagraph (A) shall apply only to the extent that the amounts described in clause (i) of such subparagraph do not exceed the amount then in the State's account.

(C) Subparagraph (A) shall not apply if the State has a balance of advances made to its account under title XII of this Act.

(D) If the Secretary of Labor determines that the requirements of this paragraph are met with respect to any request, the Secretary shall notify the Governor of the State that such requirements are met with respect to such request and the amount restored under this paragraph. Such restoration shall be as of the first day of the first month following the month in which the notification is made.

Special Transfer in Fiscal Year 2002

(d)(1) The Secretary of the Treasury shall transfer (as of the date determined under paragraph (5)) from the Federal unemployment account to the account of each State in the Unemployment Trust Fund the amount determined with respect to such State under paragraph (2).

(2)(A) The amount to be transferred under this subsection to a State account shall (as determined by the Secretary of Labor and certified by such Secretary to the Secretary of the Treasury) be equal to—

(i) the amount which would have been required to have been transferred under this section to such account at the beginning of fiscal year 2002 if—

(I) section 209(a)(1) of the Temporary Extended Unemployment Compensation Act of 2002 had been enacted before the close of fiscal year 2001, and

(II) section 5402 of Public Law 105-33 (relating to increase in Federal unemployment account ceiling) had not been enacted, minus

(ii) the amount which was in fact transferred under this section to such account at the beginning of fiscal year 2002.

(B) Notwithstanding the provisions of subparagraph (A)—

(i) the aggregate amount transferred to the States under this subsection may not exceed a total of $8,000,000,000; and

(ii) all amounts determined under subparagraph (A) shall be reduced ratably, if and to the extent necessary in order to comply with the limitation under clause (i).

(3)(A) Except as provided in paragraph (4), amounts transferred to State account pursuant to this subsection may be used only in the payment of cash benefits—

(i) to individuals with respect to their unemployment, and

(ii) which are allowable under subparagraph (B) or (C).

(B)(i) At the option of the State, cash benefits under this paragraph may include amounts which shall be payable as—

(I) regular compensation, or

(II) additional compensation, upon the exhaustion of any temporary extended unemployment compensation (if such State has entered into an agreement under the Temporary Extended Unemployment Compensation Act of

2002), for individuals eligible for regular compensation under the unemployment compensation law of such State.

(ii) Any additional compensation under clause (i) may not be taken into account for purposes of any determination relating to the amount of any extended compensation for which an individual might be eligible.

(C)(i) At the option of the State, cash benefits under this paragraph may include amounts which shall be payable to 1 or more categories of individuals not otherwise eligible for regular compensation under the unemployment compensation law of such State, including those described in clause (iii).

(ii) The benefits paid under this subparagraph to any individual may not, for any period of unemployment, exceed the maximum amount of regular compensation authorized under the unemployment compensation law of such State for that same period, plus any additional compensation (described in subparagraph (B)(i)) which could have been paid with respect to that amount.

(iii) The categories of individuals described in this clause include the following:

(I) Individuals who are seeking, or available for, only part-time (and not full-time) work.

(II) Individuals who would be eligible for regular compensation under the unemployment compensation law of such State under an alternative base period.

(D) Amounts transferred to a State account under this subsection may be used in the payment of cash benefits to individuals only for weeks of unemployment beginning after the date of enactment of this subsection.

(4) Amounts transferred to a State account under this subsection may be used for the administration of its unemployment compensation law and public employment offices (including in connection with benefits described in paragraph (3) and any recipients thereof), subject to the same conditions as set forth in subsection (c)(2) (excluding subparagraph (B) thereof, and deeming the reference to "subsections (a) and (b)" in subparagraph (D) thereof to include this subsection).

(5) Transfers under this subsection shall be made within 10 days after the date of enactment of this paragraph.

UNEMPLOYMENT TRUST FUND

Establishment, etc.

SEC. 904. **[**42 U.S.C. 1104**]** (a) There is hereby established in the Treasury of the United States a trust fund to be known as the "Unemployment Trust Fund", hereinafter in this title called the "Fund". The Secretary of the Treasury is authorized and directed to receive and hold in the Fund all moneys deposited therein by a State agency from a State unemployment fund, or by the Railroad Retirement Board to the credit of the railroad unemployment in-

surance account or the railroad unemployment insurance administration fund, or otherwise deposited in or credited to the Fund or any account therein. Such deposit may be made directly with the Secretary of the Treasury, with any depositary[8] designated by him for such purpose, or with any Federal Reserve Bank.

Investments

(b) It shall be the duty of the Secretary of the Treasury to invest such portion of the Fund as is not, in his judgment, required to meet current withdrawals. Such investment may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired (1) on original issue at the issue price, or (2) by purchase of outstanding obligations at the market price. The purposes for which obligations of the United States may be issued under chapter 31 of title 31, United States Code, are hereby extended to authorize the issuance at par of special obligations exclusively to the Fund. Such special obligations shall bear interest at a rate equal to the average rate of interest, computed as of the end of the calendar month next preceding the date of such issue, borne by all interest-bearing obligations of the United States then forming part of the public debt; except that where such average rate is not a multiple of one-eighth of 1 per centum, the rate of interest of such special obligations shall be the multiple of one-eighth of 1 per centum next lower than such average rate. Obligations other than such special obligations may be acquired for the Fund only on such terms as to provide an investment yield not less than the yield which would be required in the case of special obligations if issued to the Fund upon the date of such acquisition. Advances made to the Federal unemployment account pursuant to section 1203 shall not be invested.

Sale or Redemption of Obligations

(c) Any obligations acquired by the Fund (except special obligations issued exclusively to the Fund) may be sold at the market price, and such special obligations may be redeemed at par plus accrued interest.

Treatment of Interest and Proceeds

(d) The interest on, and the proceeds from the sale or redemption of, any obligations held in the Fund shall be credited to and form a part of the Fund.

Separate Book Accounts

(e) The Fund shall be invested as a single fund, but the Secretary of the Treasury shall maintain a separate book account for each State agency, the employment security administration account, the Federal unemployment account, the railroad unemployment insurance account, and the railroad unemployment insurance administration fund and shall credit quarterly (on March 31, June 30, September 30, and December 31, of each year) to each account, on the basis of the average daily balance of such account, a proportionate

[8] As in original. Possibly should be "depository".

part of the earnings of the Fund for the quarter ending on such date. For the purpose of this subsection, the average daily balance shall be computed—

(1) in the case of any State account, by reducing (but not below zero) the amount in the account by the balance of advances made to the State under section 1201, and

(2) in the case of the Federal unemployment account—

(A) by adding to the amount in the account the aggregate of the reductions under paragraph (1), and

(B) by subtracting from the sum so obtained the balance of advances made under section 1203 to the account.

Payments to State Agencies and Railroad Retirement Board

(f) The Secretary of the Treasury is authorized and directed to pay out of the Fund to any State agency such amount as it may duly requisition, not exceeding the amount standing to the account of such State agency at the time of such payment. The Secretary of the Treasury is authorized and directed to make such payments out of the railroad unemployment insurance account for the payment of benefits, and out of the railroad unemployment insurance administration fund for the payment of administrative expenses, as the Railroad Retirement Board may duly certify, not exceeding the amount standing to the credit of such account or such fund, as the case may be, at the time of such payment.

Federal Unemployment Account

(g) There is hereby established in the Unemployment Trust Fund a Federal unemployment account.

EXTENDED UNEMPLOYMENT COMPENSATION ACCOUNT[9]

Establishment of Account

SEC. 905. [42 U.S.C. 1105] (a) There is hereby established in the Unemployment Trust Fund an extended unemployment compensation account. For the purposes provided for in section 904(e), such account shall be maintained as a separate book account.

Transfers to Account

(b)(1) Except as provided in paragraph (3), the Secretary of the Treasury shall transfer (as of the close of each month) from the employment security administration account to the extended unemployment compensation account established by subsection (a), an amount (determined by such Secretary) equal to 20 percent of the amount by which—

(A) the transfers to the employment security administration account pursuant to section 901(b)(2) during such month, exceed

(B) the payments during such month from the employment security administration account pursuant to section 901 (b)(3) and (d).

[9] See Vol. II, P.L. 97–248, §604(a), with respect to an appropriation of funds to assist States in meeting administrative costs.

If for any such month the payments referred to in subparagraph (B) exceed the transfers referred to in subparagraph (A), proper adjustments shall be made in the amounts subsequently transferred.

(2) Whenever the Secretary of the Treasury determines pursuant to section 901(f) that there is an excess in the employment security administration account as of the close of any fiscal year beginning after June 30, 1972, there shall be transferred (as of the beginning of the succeeding fiscal year) to the extended unemployment compensation account the total amount of such excess or so much thereof as is required to increase the amount in the extended unemployment compensation account to whichever of the following is the greater:

(A) $750,000,000, or

(B) the amount (determined by the Secretary of Labor and certified by him to the Secretary of the Treasury) equal to 0.5 percent of the total wages subject (determined without any limitation on amount) to contributions under all State unemployment compensation laws for the calendar year ending during the fiscal year for which the excess is determined.

(3) The Secretary of the Treasury shall make no transfer pursuant to paragraph (1) as of the close of any month if he determines that the amount in the extended unemployment compensation account is equal to (or in excess of) the limitation provided in paragraph (2).

Transfers to State Accounts

(c) Amounts in the extended unemployment compensation account shall be available for transfer to the accounts of the States in the Unemployment Trust Fund as provided in section 204(e) of the Federal-State Extended Unemployment Compensation Act of 1970 [10].

Advances to Extended Unemployment Compensation Account and Repayment

(d) There are hereby authorized to be appropriated, without fiscal year limitation, to the extended unemployment compensation account, as repayable advances, such sums as may be necessary to carry out the purposes of the Federal-State Extended Unemployment Compensation Act of 1970. Amounts appropriated as repayable advances shall be repaid by transfers from the extended unemployment compensation account to the general fund of the Treasury, at such times as the amount in the extended unemployment compensation account is determined by the Secretary of the Treasury, in consultation with the Secretary of Labor, to be adequate for such purpose. Repayments under the preceding sentence shall be made whenever the Secretary of the Treasury (after consultation with the Secretary of Labor) determines that the amount then in the account exceeds the amount necessary to meet the anticipated payments from the account during the next 3 months. Any amount transferred as a repayment under this subsection shall be credited against, and shall operate to reduce, any balance of advances repayable under this subsection. Amounts appropriated

[10] See Vol. II, P.L. 91–373.

as repayable advances for purposes of this subsection shall bear interest at a rate equal to the average rate of interest, computed as of the end of the calendar month next preceding the date of such advance, borne by all interest bearing obligations of the United States then forming part of the public debt; except that in cases in which such average rate is not a multiple of one-eighth of 1 percent, the rate of interest shall be the multiple of one-eighth of 1 percent next lower than such average rate.

UNEMPLOYMENT COMPENSATION RESEARCH PROGRAM

SEC. 906. [42 U.S.C. 1106] (a) The Secretary of Labor shall—

(1) establish a continuing and comprehensive program of research to evaluate the unemployment compensation system. Such research shall include, but not be limited to, a program of factual studies covering the role of unemployment compensation under varying patterns of unemployment including those in seasonal industries, the relationship between the unemployment compensation and other social insurance programs, the effect of State eligibility and disqualification provisions, the personal characteristics, family situations, employment background and experience of claimants, with the results of such studies to be made public; and

(2) establish a program of research to develop information (which shall be made public) as to the effect and impact of extending coverage to excluded groups with first attention to agricultural labor.

(b) To assist in the establishment and provide for the continuation of the comprehensive research program relating to the unemployment compensation system, there are hereby authorized to be appropriated for the fiscal year ending June 30, 1971, and for each fiscal year thereafter, such sums, not to exceed $8,000,000, as may be necessary to carry out the purposes of this section. From the sums authorized to be appropriated by this subsection the Secretary may provide for the conduct of such research through grants or contracts.

PERSONNEL TRAINING

SEC. 907. [42 U.S.C. 1107] (a) In order to assist in increasing the effectiveness and efficiency of administration of the unemployment compensation program by increasing the number of adequately trained personnel, the Secretary of Labor shall—

(1) provide directly, through State agencies, or through contracts with institutions of higher education or other qualified agencies, organizations, or institutions, programs and courses designed to train individuals to prepare them, or improve their qualifications, for service in the administration of the unemployment compensation program, including claims determinations and adjudication, with such stipends and allowances as may be permitted under regulations of the Secretary;

(2) develop training materials for and provide technical assistance to the State agencies in the operation of their training programs;

(3) under such regulations as he may prescribe, award fellowships and traineeships to persons in the Federal-State employment security agencies, in order to prepare them or im-

prove their qualifications for service in the administration of the unemployment compensation program.

(b) The Secretary may, to the extent that he finds such action to be necessary, prescribe requirements to assure that any person receiving a fellowship, traineeship, stipend or allowance shall repay the costs thereof to the extent that such person fails to serve in the Federal-State employment security program for the period prescribed by the Secretary. The Secretary may relieve any individual of his obligation to so repay, in whole or in part, whenever and to the extent that such repayment would, in his judgment, be inequitable or would be contrary to the purposes of any of the programs established by this section.

(c) The Secretary, with the concurrence of the State, may detail Federal employees to State unemployment compensation administration and the Secretary may concur in the detailing of State employees to the United States Department of Labor for temporary periods for training or for purposes of unemployment compensation administration, and the provisions of section 507 of the Elementary and Secondary Education Act of 1965[11] (79 Stat. 27) or any more general program of interchange enacted by a law amending, supplementing, or replacing section 507 shall apply to any such assignment.

(d) There are hereby authorized to be appropriated for the fiscal year ending June 30, 1971, and for each fiscal year thereafter such sums, not to exceed $5,000,000, as may be necessary to carry out the purposes of this section.

ADVISORY COUNCIL ON UNEMPLOYMENT COMPENSATION

SEC. 908. [42 U.S.C. 1108] (a) ESTABLISHMENT.—Not later than February 1, 1992, and every 4th year thereafter, the Secretary of Labor shall establish an advisory council to be known as the Advisory Council on Unemployment Compensation (referred to in this section as the "Council").

(b) FUNCTION.—It shall be the function of each Council to evaluate the unemployment compensation program, including the purpose, goals, countercyclical effectiveness, coverage, benefit adequacy, trust fund solvency, funding of State administrative costs, administrative efficiency, and any other aspects of the program and to make recommendations for improvement.

(c) MEMBERS.—

(1) IN GENERAL.—Each Council shall consist of 11 members as follows:

(A) 5 members appointed by the President, to include representatives of business, labor, State government, and the public.

(B) 3 members appointed by the President pro tempore of the Senate, in consultation with the Chairman and ranking member of the Committee on Finance of the Senate.

(C) 3 members appointed by the Speaker of the House of Representative, in consultation with the Chairman and

[11] See, instead, Vol. II, 5 U.S.C. 3371–3376. [P.L. 89–10, 79 Stat. 27, §507 was classified to 20 U.S.C. 867. P.L. 91–230, §143(a)(3), redesignated §507 as §553; §553 was classified to 20 U.S.C. 869b. P.L. 91–648, 81 Stat. 1909, §403, repealed §553, effective January 5, 1971. P.L. 91–648, §402, approved January 5, 1971, amended chapter 33 of Title 5, U.S.C., to include 5 U.S.C. 3371–3376, "Subchapter VI, Assignments to and from States".]

ranking member of the Committee on Ways and Means of the House of Representatives.

(2) QUALIFICATIONS.—In appointing members under subparagraphs (B) and (C) of paragraph (1), the President pro tempore of the Senate and the Speaker of the House of Representatives shall each appoint—

(A) 1 representative of the interests of business,

(B) 1 representative of the interests of labor, and

(C) 1 representative of the interests of State governments.

(3) VACANCIES.—A vacancy in any Council shall be filled in the manner in which the original appointment was made.

(4) Chairman.—The President shall appoint the Chairman of the Council from among its members.

(d) STAFF AND OTHER ASSISTANCE.

(1) IN GENERAL.—Each council may engage any technical assistance (including actuarial services) required by the Council to carry out its functions under this section.

(2) ASSISTANCE FROM SECRETARY OF LABOR.—The Secretary of Labor shall provide each Council with any staff, office facilities, and other assistance, and any data prepared by the Department of Labor, required by the Council to carry out its functions under this section.

(e) COMPENSATION.—Each member of any Council—

(1) shall be entitled to receive compensation at the rate of pay for level V of the Executive Schedule under section 5316 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the actual performance of duties vested in the Council, and

(2) while engaged in the performance of such duties away from such member's home or regular place of business, shall be allowed travel expenses (including per diem in lieu of subsistence) as authorized by section 5703 of title 5, United States Code, for persons in the Government employed intermittently.

(f) REPORT.—

(1) IN GENERAL.—Not later than February 1 of the third year following the year in which any Council is required to be established under subsection (a), the Council shall submit to the President and the Congress a report setting forth the findings and recommendations of the Council as a result of its evaluation of the unemployment compensation program under this section.

(2) REPORT OF FIRST COUNCIL.—The Council shall include in its report required to be submitted by February 1, 1995, the Council's findings and recommendations with respect to determining eligibility for extended unemployment benefits on the basis of unemployment statistics for regions, States, or subdivisions of States.

FEDERAL EMPLOYEES COMPENSATION ACCOUNT

SEC. 909. [42 U.S.C. 1109] There is hereby established in the Unemployment Trust Fund a Federal Employees Compensation Account which shall be used for the purposes specified in section 8509 of title 5, United States Code. For the purposes provided for in sec-

tion 904(e), such account shall be maintained as a separate book account.

BORROWING BETWEEN FEDERAL ACCOUNTS

SEC. 910. [42 U.S.C. 1110] (a) IN GENERAL.—Whenever the Secretary of the Treasury (after consultation with the Secretary of Labor) determines that—

(1) the amount in the employment security administration account, Federal unemployment account, or extended unemployment compensation account, is insufficient to meet the anticipated payments from the account,

(2) such insufficiency may cause such account to borrow from the general fund of the Treasury, and

(3) the amount in any other such account exceeds the amount necessary to meet the anticipated payments from such other account,

the Secretary shall transfer to the account referred to in paragraph (1) from the account referred to paragraph (3)[12] an amount equal to the insufficiency determined under paragraph (1) (or, if less, the excess determined under paragraph (3)).

(b) TREATMENT OF ADVANCE.—Any amount transferred under subsection (a)—

(1) shall be treated as a noninterest-bearing repayable advance, and

(2) shall not be considered in computing the amount in any account for purposes of the application of sections 901(f)(2), 902(b), and 905(b).

(c) REPAYMENT.—Whenever the Secretary of the Treasury (after consultation with the Secretary of Labor) determines that the amount in the account to which an advance is made under subsection (a) exceeds the amount necessary to meet the anticipated payments from the account, the Secretary shall transfer from the account to the account from which the advance was made an amount equal to the lesser of the amount so advanced or such excess.

[12] As in original. Probably should read "in paragraph (3)".

[TITLE X—GRANTS TO STATES FOR AID TO THE BLIND] [1]

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APPROPRIATION

SEC. 1001. [42 U.S.C. 1201] For the purpose of enabling each State to furnish financial assistance, as far as practicable under the conditions in such State, to needy individuals who are blind, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for aid to the blind.

STATE PLANS FOR AID TO THE BLIND

SEC. 1002. [42 U.S.C. 1202] (a) A State plan for aid to the blind must (1) except to the extent permitted by the Secretary with respect to services, provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be manda-

[1] P.L. 92–603, §303, *repealed* Title X, effective January 1, 1974, *except* with respect to Puerto Rico, Guam, and the Virgin Islands.

Title X of the Social Security Act is administered by the Department of Health and Human Services. The Office of Family Assistance, administers benefit payments under Title X. The Administration for Public Services, Office of Human Development Services, administers social services under Title X.

Title X appears in the United States Code as §§1201–1206, subchapter X, chapter 7, Title 42.

Regulations of the Secretary of Health and Human Services relating to Title X are contained in subtitle A and chapter XIII, Title 45, Code of Federal Regulations.

The Commonwealth of the Northern Marianas may elect to initiate a Title X social services program if it chooses; see Vol. II, Appendix, P.L. 94–241, [Covenant to Establish Northern Mariana Islands], approved March 24, 1976.

See Vol. II, 31 U.S.C. 6504–6505 with respect to intergovernmental cooperation; and 31 U.S.C. 7501–7507 with respect to uniform audit requirements for State and local governments receiving Federal financial assistance.

See Vol. II, P.L. 82–183, §618, for the "Jenner Amendment", which prohibits denial of grants-in-aid under certain conditions.

See Vol. II, P.L. 88–352, §601, for prohibition against discrimination in federally assisted programs.

See Vol. II, P.L. 89–97, §121(b), with respect to restrictions on payment to a State receiving payments under Title XIX.

See Vol. II, P.L. 95–521, §102(i), with respect to reporting of benefits received under the Social Security Act.

[2] This table of contents does not appear in the law.

tory upon them; (2) provide for financial participation by the State; (3) either provide for the establishment or designation of a single State agency to administer the plan, or provide for the establishment or designation of a single State agency to supervise the administration of the plan; (4) provide (A) for granting an opportunity for a fair hearing before the State agency to any individual whose claim for aid to the blind is denied or is not acted upon with reasonable promptness, and (B) that if the State plan is administered in each of the political subdivisions of the State by a local agency and such local agency provides a hearing at which evidence may be presented prior to a hearing before the State agency, such local agency may put into effect immediately upon issuance its decision upon the matter considered at such hearing; (5) provide (A) such methods of administration (including after January 1, 1940, 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) as are found by the Secretary to be necessary for the proper and efficient operation of the plan [3], and (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; (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; and (7) provide that no aid will be furnished any individual under the plan with respect to any period with respect to which he is receiving old-age assistance under the State plan approved under section 2 of this Act or assistance under a State program funded under Part A of title IV; (8) provide that the State agency shall, in determining need, take into consideration any other income and resources of the individual claiming aid to the blind, as well as any expenses reasonably attributable to the earning of any such income, except that, in making such determination, the State agency (A) shall disregard the first $85 per month of earned income, plus one-half of earned income in excess of $85 per month, (B) shall, for a period not in excess of twelve months, and may, for a period not in excess of thirty-six months, disregard such additional amounts of other income and resources, in the case of an individual who has a plan for achieving self-support approved by the State agency, as may be necessary for the fulfillment of such plan, and (C) may, before disregarding the amounts referred to in clauses (A) and (B), disregard not more than $7.50 of any income; [4]

[3] 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).

[4] See Vol. II, 10 U.S.C. 2546 with respect to shelter for the homeless at military installations.

See Vol. II, P.L. 79–396, §12(e), with respect to exclusion from income and resources of assistance to children under that act.

See Vol. II, P.L. 81–171, §521(a)(1)(E), with respect to exclusion from income and resources of certain assistance rendered to provide occupant-owned, rental and cooperative housing.

See Vol. II, P.L. 87–543, §141(b), with respect to ineligibility to receive payments under Title X where payments have been made under Title XVI.

(9) provide safeguards which permit the use or disclosure of information concerning applicants or recipients only (A) to public officials who require such information in connection with their official duties, or (B) to other persons for purposes directly connected with

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See Vol. II, P.L. 88–352, §601, for prohibition against discrimination in federally assisted programs.

See Vol. II, P.L. 88–525, §8(b), with respect to exclusion from income and resources of the value of food stamps.

See Vol. II, P.L. 89–73, §210(b), with respect to exclusion from income of the costs of any project under that act.

See Vol. II, P.L. 89–329, §479B, with respect to exclusion from income or resources of certain student financial assistance.

See Vol. II, P.L. 89–642, §11(b), with respect to exclusion from income and resources of the value of assistance to children under that act.

See Vol. II, P.L. 90–248, §248(c), effective July 1, 1969, with respect to income disregards applicable to Guam, Puerto Rico, and the Virgin Islands.

See Vol. II, P.L. 91–646, §216, with respect to exclusion from income of payments made under that act.

See Vol. II, P.L. 93–112, §613(c), with respect to conditional exclusion of wages, allowances, transportation reimbursement, and attendant care costs.

See Vol. II, P.L. 93–113, §404(g), with respect to exclusion from income and resources of payments to volunteers under that act.

See Vol. II, P.L. 93–134, §§7 and 8, with respect to exclusion from income and resources of certain judgment funds to any Indian tribe.

See Vol. II, P.L. 93–288, §312(d), with respect to exclusion from income and resources of certain Federal major disaster and emergency assistance.

See Vol. II, P.L. 94–114, §6, with respect to exclusion from income and resources of property and receipts from submarginal land to certain Indians.

See Vol. II, P.L. 95–433, §2, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 95–498, §6, with respect to an income and resources exclusion applicable to the Pueblo of Santa Ana Indians, New Mexico.

See Vol. II, P.L. 95–499, §6, with respect to an income and resources exclusion applicable to the Pueblo of Zia Indians, New Mexico.

See Vol. II, P.L. 95–557, §410(b), with respect to exclusion from income of services (but not of wages) provided to a public housing resident or to a resident of a housing project assisted under the "Housing Act of 1959" (see Vol. II, P.L. 86–372, §202.).

See Vol. II, P.L. 97–35, §2605(f), with respect to exclusion from income and resources of home energy assistance payments or allowances.

See Vol. II, P.L. 98–64, §2(a), with respect to exclusion from income and resources of per capita payments to Indians.

See Vol. II, P.L. 98–432, §5(e), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 98–500, §8, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 98–602, §106(d), with respect to exclusion from income and resources of certain funds distributed per capita.

See Vol. II, P.L. 99–130, §8, with respect to exclusion from income and resources of certain funds.

See Vol. II, P.L. 99–146, §6(b), with respect to exclusion from income and resources of certain funds.

See Vol. II, P.L. 99–264, §16, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 99–346, §6(b), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 99–377, §4(b), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 100–139, §4(h)(6), with respect to exclusion of benefits as basis for denial of eligibility.

See Vol. II, P.L. 100–407, §105(g), with respect to the effect of financial assistance under that Act.

See Vol. II, P.L. 100–409, §5, with respect to the effect of this Act on P.L. 92–203 or P.L. 96–487.

See Vol. II, P.L. 100–411, §2(d)(3)(B), with respect to the effect of per capita payments.

See Vol. II, P.L. 100–581, §§501, 502(b)(1), and 503, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 101–41, §10(b)-(d), with respect to eligibility for Federal programs and treatment of funds, assets, and income.

See Vol. II, P.L. 101–42, §3, with respect to the restoration of Federal recognition, rights, and privileges.

See Vol. II, P.L. 101–201, with respect to Agent Orange settlement payments.

See Vol. II, P.L. 101–239, §10405, with respect to Agent Orange settlement payments excluded from countable income and resources under Federal means-tested programs.

See Vol. II, P.L. 101–277, §8(b), with respect to exclusion, from income or resources, of funds held in trust or distributed to Seminole Indians.

the administration of the State plan;[5] (10) provide that, in determining whether an individual is blind, there shall be an examination by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select; (11) effective July 1, 1951, provide that all individuals wishing to make application for aid to the blind shall have opportunity to do so, and that aid to the blind shall be furnished with reasonable promptness to all eligible individuals; (12) effective July 1, 1953, provide, if the plan includes payments to individuals in private or public institutions, for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for such institutions; (13) provide a description of the services (if any) which the State agency makes available (using whatever internal organizational arrangement it finds appropriate for this purpose) to applicants for and recipients of aid to the blind to help them attain self-support or self-care, including a description of the steps taken to assure, in the provision of such services, maximum utilization of other agencies providing similar or related services; and (14) 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.

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

(1) Any residence requirement which excludes any resident of the State who has resided therein five years during the nine years immediately preceding the application for aid and has resided therein continuously for one year immediately preceding the application; or

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

At the option of the State, the plan may provide that manuals and other policy issuances will be furnished to persons without charge for the reasonable cost of such materials, but such provision shall not be required by the Secretary as a condition for the approval of such plan under this title. In the case of any State (other than Puerto Rico and the Virgin Islands) which did not have on January 1, 1949, a State plan for aid to the blind approved under this title, the Secretary shall approve a plan of such State for aid to the blind for purposes of this title, even though it does not meet the requirements of clause (8) of subsection (a) of this section, if it meets all other requirements of this title for an approved plan for aid to the blind; but payments under section 1003 shall be made, in the case of any such plan, only with respect to expenditures thereunder which would be included as expenditures for the purposes of section 1003 under a plan approved under this section without regard to the provisions of this sentence.

PAYMENT TO STATES

SEC. 1003. [42 U.S.C. 1203] (a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State

[5] See Vol. II, P.L. 82–183, §618, for the "Jenner Amendment" prohibiting denial of grants-in-aid under certain conditions.

which has an approved plan for aid to the blind, for each quarter, beginning with the quarter commencing October 1, 1958—

[(1) Stricken.[6]]

(2) in the case of Puerto Rico, the Virgin Islands, and Guam, an amount equal to one-half of the total of the sums expended during such quarter as aid to the blind under the State plan, not counting so much of any expenditure with respect to any month as exceeds $37.50 multiplied by the total number of recipients of aid to the blind for such month; and

(3) in the case of any State, an amount equal to 50 percent of the total amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

(b) The method of computing and paying such amounts shall be as follows:

(1) The Secretary of Health, Education, and Welfare shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (a), such estimate to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, (B) records showing the number of blind individuals in the State, and (C) such other investigation as the Secretary may find necessary.

(2) The Secretary of Health, Education, and Welfare shall then certify to the Secretary of the Treasury the amount so estimated by the Secretary of Health, Education, and Welfare, (A) reduced or increased, as the case may be, by any sum by which he finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State under subsection (a) for such quarter, and (B) reduced by a sum equivalent to the pro rata share to which the United States is equitably entitled, as determined by the Secretary of Health, Education, and Welfare, of the net amount recovered during a prior quarter by the State or any political subdivision thereof with respect to aid to the blind furnished under the State plan; except that such increases or reductions shall not be made to the extent that such sums have been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Secretary of Health, Education, and Welfare for such prior quarter: *Provided*, That any part of the amount recovered from the estate of a deceased recipient which is not in excess of the amount expended by the State or any political subdivision thereof for the funeral expenses of the deceased shall not be considered as a basis for reduction under clause (B) of this paragraph.

[6] P.L. 97–35, §2184(c)(2)(A); 95 Stat. 817.

(3) The Secretary of the Treasury shall thereupon, through the Division of Disbursement[7] of the Treasury Department, and prior to audit or settlement by the General Accounting Office P.L. 108-271, §8(b)[8], pay to the State, at the time or times fixed by the Secretary of Health, Education, and Welfare, the amounts so certified.

OPERATION OF STATE PLANS

SEC. 1004. [42 U.S.C. 1204] In the case of any State plan for aid to the blind which has been approved by the Secretary of Health, Education, and Welfare, if the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, finds—

(1) that the plan has been so changed as to impose any residence or citizenship requirement prohibited by section 1002(b), or that in the administration of the plan any such prohibited requirement is imposed, with the knowledge of such State agency, in a substantial number of cases; or

(2) that in the administration of the plan there is a failure to comply substantially with any provision required by section 1002(a) to be included in the plan;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure) until the Secretary is satisfied that such prohibited requirement is no longer so imposed, and that there is no longer any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

ADMINISTRATION

SEC. 1005. [42 U.S.C. 1205] There is hereby authorized to be appropriated for the fiscal year ending June 30, 1936, the sum of $30,000, for all necessary expenses of the Board in administering the provisions of this title.

DEFINITION

SEC. 1006. [42 U.S.C. 1206] For the purposes of this title, the term "aid to the blind" means money payments to blind individuals who are needy, but does not include any such payments to or care in behalf of any individual who is an inmate of a public institution (except as a patient in a medical institution) or any individual who is a patient in an institution for tuberculosis or mental diseases. Such term also includes payments which are not included within the meaning of such term under the preceding sentence, but which would be so included except that they are made on behalf of such a needy individual to another individual who (as determined in ac-

[7] As in original. The Division of Disbursement was consolidated in the Fiscal Service of the Treasury Department by Reorganization Plan No. III, §1(a), effective June 30, 1940 (54 Stat. 1231).

[8] P.l. 108-271, §8(B), Provided That "Any Reference To The General Accounting Office In Any Law, Rule, Regulation, Certificate, Directive, Instruction, Or Other Official Paper In Force On The Date Of Enactment Of This Act (July 7, 2004) Shall Be Considered To Refer And Apply To The Government Accountability Office."

cordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such needy individual, but only with respect to a State whose State plan approved under section 1002 includes provision for—

(1) determination by the State agency that such needy individual has, by reason of his physical or mental condition, such inability to manage funds that making payments to him would be contrary to his welfare and, therefore, it is necessary to provide such aid through payments described in this sentence;

(2) making such payments only in cases in which such payments will, under the rules otherwise applicable under the State plan for determining need and the amount of aid to the blind to be paid (and in conjunction with other income and resources), meet all the need[9] of the individuals with respect to whom such payments are made;

(3) undertaking and continuing special efforts to protect the welfare of such individual and to improve, to the extent possible, his capacity for self-care and to manage funds;

(4) periodic review by such State agency of the determination under paragraph (1) to ascertain whether conditions justifying such determination still exist, with provision for termination of such payments if they do not and for seeking judicial appointment of a guardian or other legal representative, as described in section 1111, if and when it appears that such action will best serve the interests of such needy individual; and

(5) opportunity for a fair hearing before the State agency on the determination referred to in paragraph (1) for any individual with respect to whom it is made.

At the option of a State (if its plan approved under this title so provides), such term (i) need not include money payments to an individual who has been absent from such State for a period in excess of 90 consecutive days (regardless of whether he has maintained his residence in such State during such period) until he has been present in such State for 30 consecutive days in the case of such an individual who has maintained his residence in such State during such period or 90 consecutive days in the case of any other such individual, and (ii) may include rent payments made directly to a public housing agency on behalf of a recipient or a group or groups of recipients of aid under such plan.

[9] As in original. Should be "needs".

TITLE XI—GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION [1]

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[1] Title XI of the Social Security Act is administered by the Department of Health and Human Services and by the Department of Labor.

Title XI appears in the United States Code as §§1301–1320d–8, subchapter XI, chapter 7, Title 42.

Regulations of the Secretary of Health and Human Services relating to Title XI are contained in chapter III, Title 20, in chapters I, II, and IV, Title 42, and in subtitle A and chapters I, III, and XIII, Title 45, Code of Federal Regulations. Regulations of the Secretary of Labor relating to Title XI are contained in chapter V, Title 20, and subtitle A, Title 29, Code of Federal Regulations.

See Vol. II, P.L. 88–352, §601, for prohibition against discrimination in federally assisted programs.

See Vol. II, P.L. 100–204, §724(d), with respect to furnishing information to the United States Commission on Improving the Effectiveness of the United Nations; and §725(b), with respect to the detailing of Government personnel.

See Vol. II, P.L. 100–235, §§5–8, with respect to responsibilities of each Federal agency for computer systems security and privacy.

See Vol. II, P.L. 103–432, §232, with respect to measurement and reporting of welfare receipt.

[2] This table of contents does not appear in the law.

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Part A—General Provisions

DEFINITIONS

SEC. 1101. **[**42 U.S.C. 1301**]** (a) When used in this Act—

(1) The term "State", except where otherwise provided, includes the District of Columbia and the Commonwealth of Puerto Rico, and when used in titles IV, V, VII, XI, XIX, and XXI includes the Virgin Islands and Guam. Such term when used in titles III, IX, and XII also includes the Virgin Islands. Such term when used in title V and in part B of this title also includes American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands. Such term when

used in titles XIX and XXI also includes the Northern Mariana Islandsand American Samoa. In the case of Puerto Rico, the Virgin Islands, and Guam, titles I, X, and XIV, and title XVI (as in effect without regard to the amendment made by section 301 of the Social Security Amendments of 1972[3]) shall continue to apply, and the term "State" when used in such titles (but not in title XVI as in effect pursuant to such amendment after December 31, 1973) includes Puerto Rico, the Virgin Islands, and Guam. Such term when used in title XX also includes the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. Such term when used in title IV also includes American Samoa.

(2) The term "United States" when used in a geographical sense means, except where otherwise provided, the States.

(3) The term "person" means an individual, a trust or estate, a partnership, or a corporation.

(4) The term "corporation" includes associations, joint-stock companies, and insurance companies.

(5) The term "shareholder" includes a member in an association, joint-stock company, or insurance company.

(6) The term "Secretary", except when the context otherwise requires, means the Secretary of Health and Human Services.

(7) The terms "physician" and "medical care" and "hospitalization" include osteopathic practitioners or the services of osteopathic practitioners and hospitals within the scope of their practice as defined by State law.

(8)(A) The "Federal percentage" for any State (other than Puerto Rico, the Virgin Islands, and Guam) shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 50 per centum as the square of the per capita income of such State bears to the square of the per capita income of the United States; except that the Federal percentage shall in no case be less than 50 per centum or more than 65 per centum.

(B) The Federal percentage for each State (other than Puerto Rico, the Virgin Islands, and Guam) shall be promulgated by the Secretary between October 1 and November 30 of each year, on the basis of the average per capita income of each State and of the United States for the three most recent calendar years for which satisfactory data are available from the Department of Commerce. Such promulgation shall be conclusive for each of the four quarters in the period beginning October 1 next succeeding such promulgation: *Provided* , That the Secretary shall promulgate such percentages as soon as possible after the enactment of the Social Security Amendments of 1958[4], which promulgation shall be conclusive for each of the eleven quarters in the period beginning October 1, 1958, and ending with the close of June 30, 1961.

(C) The term "United States" means (but only for purposes of subparagraphs (A) and (B) of this paragraph) the fifty States and the District of Columbia.

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[3] P.L. 92–603, §301, added Title XVI, Supplemental Security Income for the Aged, Blind, and Disabled.

[4] August 28, 1958 [P.L. 85–840; 72 Stat. 1013].

(D) Promulgations made before satisfactory data are available from the Department of Commerce for a full year on the per capita income of Alaska shall prescribe a Federal percentage for Alaska of 50 per centum and, for purposes of such promulgations, Alaska shall not be included as part of the "United States". Promulgations made thereafter but before per capita income data for Alaska for a full three-year period are available from the Department of Commerce shall be based on satisfactory data available therefrom for Alaska for such one full year or, when such data are available for a two-year period, for such two years.

(9) The term "shared health facility" means any arrangement whereby—

(A) two or more health care practitioners practice their professions at a common physical location;

(B) such practitioners share (i) common waiting areas, examining rooms, treatment rooms, or other space, (ii) the services of supporting staff, or (iii) equipment;

(C) such practitioners have a person (who may himself be a practitioner)—

(i) who is in charge of, controls, manages, or supervises substantial aspects of the arrangement or operation for the delivery of health or medical services at such common physical location, other than the direct furnishing of professional health care services by the practitioners to their patients; or

(ii) who makes available to such practitioners the services of supporting staff who are not employees of such practitioners;

and who is compensated in whole or in part, for the use of such common physical location or support services pertaining thereto, on a basis related to amounts charged or collected for the services rendered or ordered at such location or on any basis clearly unrelated to the value of the services provided by the person; and

(D) at least one of such practitioners received payments on a fee-for-service basis under titles XVIII and XIX in an amount exceeding $5,000 for any one month during the preceding 12 months or in an aggregate amount exceeding $40,000 during the preceding 12 months;

except that such term does not include a provider of services (as defined in section 1861(u) of this Act), a health maintenance organization (as defined in section 1301(a) of the Public Health Service Act[5]), a hospital cooperative shared services organization meeting the requirements of section 501(e) of the Internal Revenue Code of 1954[6], or any public entity.

(10) The term "Administration" means the Social Security Administration, except where the context requires otherwise.

(b) The terms "includes" and "including" when used in a definition contained in this Act shall not be deemed to exclude other things otherwise within the meaning of the term defined.

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[5] See Vol. II, P.L. 78–410.

[6] See Vol. II, P.L. 83–591.

P.L. 99–514, §2, provides, except when inappropriate, that any reference to the Internal Revenue Code of 1954 shall include a reference to the Internal Revenue Code of 1986.

(c) Whenever under this Act or any Act of Congress, or under the law of any State, an employer is required or permitted to deduct any amount from the remuneration of an employee and to pay the amount deducted to the United States, a State, or any political subdivision thereof, then for the purposes of this Act the amount so deducted shall be considered to have been paid to the employee at the time of such deduction.

(d) Nothing in this Act shall be construed as authorizing any Federal official, agent, or representative, in carrying out any of the provisions of this Act, to take charge of any child over the objection of either of the parents of such child, or of the person standing in loco parentis to such child.

RULES AND REGULATIONS

SEC. 1102. [42 U.S.C. 1302] (a) The Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, respectively, shall make and publish such rules and regulations, not inconsistent with this Act, as may be necessary to the efficient administration of the functions with which each is charged under this Act.

(b)(1) Whenever the Secretary publishes a general notice of proposed rulemaking for any rule or regulation proposed under title XVIII, title XIX, or part B of this title that may have a significant impact on the operations of a substantial number of small rural hospitals, the Secretary shall prepare and make available for public comment an initial regulatory impact analysis. Such analysis shall describe the impact of the proposed rule or regulation on such hospitals and shall set forth, with respect to small rural hospitals, the matters required under section 603 of title 5, United States Code, to be set forth with respect to small entities. The initial regulatory impact analysis (or a summary) shall be published in the Federal Register at the time of the publication of general notice of proposed rulemaking for the rule or regulation.

(2) Whenever the Secretary promulgates a final version of a rule or regulation with respect to which an initial regulatory impact analysis is required by paragraph (1), the Secretary shall prepare a final regulatory impact analysis with respect to the final version of such rule or regulation. Such analysis shall set forth, with respect to small rural hospitals, the matters required under section 604 of title 5, United States Code, to be set forth with respect to small entities. The Secretary shall make copies of the final regulatory impact analysis available to the public and shall publish, in the Federal Register at the time of publication of the final version of the rule or regulation, a statement describing how a member of the public may obtain a copy of such analysis.

(3) If a regulatory flexibility analysis is required by chapter 6 of title 5, United States Code[7], for a rule or regulation to which this subsection applies, such analysis shall specifically address the impact of the rule or regulation on small rural hospitals.

[7] See Vol. II, Title 5, §§603 and 604.

SEPARABILITY

SEC. 1103. [42 U.S.C. 1303] If any provision of this Act, or the application thereof to any person or circumstance, is held invalid, the remainder of the Act and the application of such provision to other persons or circumstances shall not be affected thereby.

RESERVATION OF POWER

SEC. 1104. [42 U.S.C. 1304] The right to alter, amend, or repeal any provision of this Act is hereby reserved to the Congress.

SHORT TITLE

SEC. 1105. [42 U.S.C. 1305] This Act may be cited as the "Social Security Act".

DISCLOSURE OF INFORMATION IN POSSESSION OF AGENCY[8]

SEC. 1106. [42 U.S.C. 1306] (a)(1) No disclosure of any return or portion of a return (including information returns and other written statements) filed with the Commissioner of Internal Revenue under title VIII of the Social Security Act or under subchapter E of chapter 1 or subchapter A of chapter 9 of the Internal Revenue Code[9], or under regulations made under authority thereof, which has been transmitted to the head of the applicable agency by the Commissioner of Internal Revenue, or of any file, record, report, or other paper, or any information, obtained at any time by the head of the applicable agency or by any officer or employee of the applicable agency in the course of discharging the duties of the head of the applicable agency under this Act, and no disclosure of any such file, record, report, or other paper, or information, obtained at any time by any person from the head of the applicable agency or from any officer or employee of the applicable agency, shall be made except as the head of the applicable agency may by regulations prescribe and except as otherwise provided by Federal law. Any person who shall violate any provision of this section shall be deemed guilty of a felony and, upon conviction thereof, shall be punished by a fine not exceeding $10,000 for each occurrence of a violation, or by imprisonment not exceeding 5 years, or both.

(2) For purposes of this subsection and subsection (b), the term "applicable agency" means—

(A) the Social Security Administration, with respect to matter transmitted to or obtained by such Administration or matter disclosed by such Administration, or

(B) the applicable agency, with respect to matter transmitted to or obtained by such Department or matter disclosed by such Department.

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[8] See Vol. II, 5 U.S.C. 552, with respect to information available to the public from agencies; and 5 U.S.C. 8347(m)(3), with respect to disclosure of information to the Office of Personnel Management.

See Vol. II, 38 U.S.C. 5317 and 5318 with respect to Veterans' Benefits information.

See Vol. II, P.L. 83–591, §6103(l)(1), with respect to disclosure of returns and return information by the Secretary of the Treasury to the Social Security Administration; and §7213(a)(1), with respect to the penalty for unauthorized disclosure of that tax return information.

See Vol. II, P.L. 97–253, §307(f), with respect to supplying information about civil service annuitants.

See Vol. II, P.L. 106–169, §209, with respect to State data exchanges.

[9] P.L. 76–1. Should refer, instead, to P.L. 83–591, Subtitles A and C.

(b) Requests for information, disclosure of which is authorized by regulations prescribed pursuant to subsection (a) of this section, and requests for services, may, subject to such limitations as may be prescribed by the head of the applicable agency to avoid undue interference with his functions under this Act, be complied with if the agency, person, or organization making the request agrees to pay for the information or services requested in such amount, if any (not exceeding the cost of furnishing the information or services), as may be determined by the head of the applicable agency. Payments for information or services furnished pursuant to this section shall be made in advance or by way of reimbursement, as may be requested by the head of the applicable agency, and shall be deposited in the Treasury as a special deposit to be used to reimburse the appropriations (including authorizations to make expenditures from the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, the Federal Hospital Insurance Trust Fund, and the Federal Supplementary Medical Insurance Trust Fund) for the unit or units of the applicable agency which furnished the information or services. Notwithstanding the preceding provisions of this subsection, requests for information made pursuant to the provisions of part D of title IV of this Act for the purpose of using Federal records for locating parents shall be complied with and the cost incurred in providing such information shall be paid for as provided in such part D of title IV.

(c) Notwithstanding sections 552 and 552a of title 5, United States Code [10], or any other provision of law, whenever the Commissioner of Social Security or the Secretary determines that a request for information is made in order to assist a party in interest (as defined in section 3 of the Employee Retirement Income Security Act of 1974 [11] (29 U.S.C. 1002)) with respect to the administration of an employee benefit plan (as so defined), or is made for any other purpose not directly related to the administration of the program or programs under this Act to which such information relates, such Commissioner or Secretary may require the requester to pay the full cost, as determined by the such Commissioner or Secretary, of providing such information.

(d) Notwithstanding any other provision of this section, in any case in which—

(1) information regarding whether an individual is shown on the records of the Commissioner of Social Security as being alive or deceased is requested from the Commissioner for purposes of epidemiological or similar research which the Commissioner in consultation with the Secretary of Health and Human Services finds may reasonably be expected to contribute to a national health interest, and

(2) the requester agrees to reimburse the Commissioner for providing such information and to comply with limitations on safeguarding and rerelease or redisclosure of such information as may be specified by the Commissioner,

the Commissioner shall comply with such request, except to the extent that compliance with such request would constitute a violation of the terms of any contract entered into under section 205(r).

[10] See Vol. II, Title 5.
[11] See Vol. II, P.L. 93–406.

(e) Notwithstanding any other provision of this section the Secretary shall make available to each State agency operating a program under title XIX and shall, subject to the limitations contained in subsection (e)[12], make available for public inspection in readily accessible form and fashion, the following official reports (not including, however, references to any internal tolerance rules and practices that may be contained therein, internal working papers or other informal memoranda) dealing with the operation of the health programs established by titles XVIII and XIX—

(1) individual contractor performance reviews and other formal evaluations of the performance of carriers, intermediaries, and State agencies, including the reports of follow-up reviews;

(2) comparative evaluations of the performance of such contractors, including comparisons of either overall performance or of any particular aspect of contractor operation; and

(3) program validation survey reports and other formal evaluations of the performance of providers of services, including the reports of follow-up reviews, except that such reports shall not identify individual patients, individual health care practitioners, or other individuals.

(f) No report described in subsection (e) shall be made public by the Secretary or the State title XIX agency until the contractor or provider of services whose performance is being evaluated has had a reasonable opportunity (not exceeding 60 days) to review such report and to offer comments pertinent parts of which may be incorporated in the public report; nor shall the Secretary be required to include in any such report information with respect to any deficiency (or improper practice or procedures) which is known by the Secretary to have been fully corrected, within 60 days of the date such deficiency was first brought to the attention of such contractor or provider of services, as the case may be.

PENALTY FOR FRAUD[13]

SEC. 1107. [42 U.S.C. 1307] (a) Whoever, with the intent to defraud any person, shall make or cause to be made any false representation concerning the requirements of this Act, of chapter 2, 21, or 23 of the Internal Revenue Code of 1954[14], or of any provision of subtitle F of such Code which corresponds (within the meaning of section 7852(b) of such Code[15]) to a provision contained in subchapter E of chapter 9 of the Internal Revenue Code of 1939[16], or of any rules or regulations issued thereunder, knowing such representations to be false, shall be deemed guilty of a misdemeanor, and, upon conviction thereof, shall be punished by a fine not exceeding $1,000, or by imprisonment not exceeding one year, or both.

(b) Whoever, with the intent to elicit information as to the social security account number, date of birth, employment, wages, or benefits of any individual (1) falsely represents to the Commissioner of Social Security or the Secretary that he is such individual, or the wife, husband, widow, widower, divorced wife, divorced husband,

[12] As in original. Probably should be "subsection f".
[13] See Vol. II, 18 U.S.C. 1028, with respect to penalties relating to use of identification documents.
[14] P.L. 83–591.
[15] See Vol. II, P.L. 83–591.
[16] P.L. 76–1.

surviving divorced wife, surviving divorced husband, surviving divorced mother, surviving divorced father, child, or parent of such individual, or the duly authorized agent of such individual, or of the wife, husband, widow, widower, divorced wife, divorced husband, surviving divorced wife, surviving divorced husband, surviving divorced mother, surviving divorced father, child, or parent of such individual, or (2) falsely represents to any person that he is an employee or agent of the United States, shall be deemed guilty of a felony and, upon conviction thereof, shall be punished by a fine not exceeding $10,000 for each recurrence of a violation or by imprisonment not exceeding 5 years or both.

ADDITIONAL GRANTS TO PUERTO RICO, THE VIRGIN ISLANDS, GUAM, AND AMERICAN SAMOA; LIMITATION ON TOTAL PAYMENTS

SEC. 1108. [42 U.S.C. 1308] (a) LIMITATION ON TOTAL PAYMENTS TO EACH TERRITORY.—

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

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

(b) ENTITLEMENT TO MATCHING GRANT [17].—

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

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

(B) the sum of—

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

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

(2) APPROPRIATION.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated for fiscal years 1997 through 2003 [18], such sums as are necessary for grants under this paragraph.

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

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

(2) CEILING AMOUNT.—The term "ceiling amount" means, with respect to a territory and a fiscal year, the mandatory

[17] See Vol. II, P.L. 108-89, §101(a), P.L. 108-262, §2(a), and P.L. 108-308, §2(a), with respect to extension of the temporary assistance for needy families block grant program.

[18] P.L. 108-40, §3(b), struck out "2002" and substituted "2003", effective date July 1, 2003.

ceiling amount with respect to the territory, reduced for the fiscal year in accordance with subsection (e), and reduced by the amount of any penalty imposed on the territory under any provision of law specified in subsection (a) during the fiscal year.

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

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

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

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

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

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

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

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

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

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

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

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

(e) **[**Stricken.[19]**]**

(f) Subject to subsection (g) and section 1935(a)(1)(B)[20], the total amount certified by theSecretary under title XIX with respect to a fiscal year for payment to—

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

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

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

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[19] P.L. 105–33, §5512(c); 111 Stat. 619.

[20] P.L. 108-173, §103(d)(2), inserted "and section 1935(c)(1)(B)", effective December 8, 2003.

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

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

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

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

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

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

(C) For Guam, $750,000.

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

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

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

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

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

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

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

(E) American Samoa shall not exceed the sum of the amount provided in this subsection for the preceding fiscal year increased by the percentage increase referred to in subparagraph (A), rounded to the nearest $10,000.

AMOUNTS DISREGARDED NOT TO BE TAKEN INTO ACCOUNT IN DETERMINING ELIGIBILITY OF OTHER INDIVIDUALS

SEC. 1109. [42 U.S.C. 1309] Any amount which is disregarded (or set aside for future needs) in determining the eligibility of and amount of the aid or assistance for any individual under a State

plan approved under title I, X, XIV, XVI, or XIX, shall not be taken into consideration in determining the eligibility of and amount of aid or assistance for any other individual under a State plan approved under any other of such titles.

COOPERATIVE RESEARCH OR DEMONSTRATION PROJECTS[21]

SEC. 1110. [42 U.S.C. 1310] (a)(1) There are hereby authorized to be appropriated for the fiscal year ending June 30, 1957, $5,000,000 and for each fiscal year thereafter such sums as the Congress may determine for (A) making grants to States and public and other organizations and agencies for paying part of the cost of research or demonstration projects such as those relating to the prevention and reduction of dependency, or which will aid in effecting coordination of planning between private and public welfare agencies or which will help improve the administration and effectiveness of programs carried on or assisted under the Social Security Act and programs related thereto, and (B) making contracts or jointly financed cooperative arrangements with States and public and other organizations and agencies for the conduct of research or demonstration projects relating to such matters.

(2) No contract or jointly financed cooperative arrangement shall be entered into, and no grant shall be made, under paragraph (1), until the Secretary (or the Commissioner, with respect to any jointly financed cooperative agreement or grant concerning titles II or XVI) obtains the advice and recommendations of specialists who are competent to evaluate the proposed projects as to soundness of their design, the possibilities of securing productive results, the adequacy of resources to conduct the proposed research or demonstrations, and their relationship to other similar research or demonstrations already completed or in process.

(3) Grants and payments under contracts or cooperative arrangements under paragraph (1) may be made either in advance or by way of reimbursement, as may be determined by the Secretary (or the Commissioner, with respect to any jointly financed cooperative agreement or grant concerning title II or XVI); and shall be made in such installments and on such conditions as the Secretary (or the Commissioner, as applicable) finds necessary to carry out the purposes of this subsection.

(b)(1) The Commissioner is authorized to waive any of the requirements, conditions, or limitations of title XVI (or to waive them only for specified purposes, or to impose additional requirements, conditions, or limitations) to such extent and for such period as the Commissioner finds necessary to carry out one or more experimental, pilot, or demonstration projects which, in the Commissioner's judgment, are likely to assist in promoting the objectives or facilitate the administration of such title. Any costs for benefits under or administration of any such project (including planning for the project and the review and evaluation of the project and its results), in excess of those that would have been incurred without regard to the project, shall be met by the Commissioner from amounts available to the Commissioner for this purpose from appropriations made to carry out such title. The costs of any such

[21] See Vol. II, P.L. 99–272, §9215, with respect to the extension of approval of certain Medicare municipal health services demonstration projects.

project which is carried out in coordination with one or more related projects under other titles of this Act shall be allocated among the appropriations available for such projects and any Trust Funds involved, in a manner determined by the Commissioner with respect to the old-age, survivors, and disability insurance programs under title II and the supplemental security income program under title XVI, and by the Secretary with respect to other titles of this Act, taking into consideration the programs (or types of benefit) to which the project (or part of a project) is most closely related or which the project (or part of a project) is intended to benefit. If, in order to carry out a project under this subsection, the Commissioner requests a State to make supplementary payments (or the Commissioner makes them pursuant to an agreement under section 1616) to individuals who are not eligible therefor, or in amounts or under circumstances in which the State does not make such payments, the Commissioner shall reimburse such State for the non-Federal share of such payments from amounts appropriated to carry out title XVI. If, in order to carry out a project under this subsection, the Secretary requests a State to provide medical assistance under its plan approved under title XIX to individuals who are not eligible therefor, or in amounts or under circumstances in which the State does not provide such medical assistance, the Secretary shall reimburse such State for the non-Federal share of such assistance from amounts appropriated to carry out title XVI, which shall be provided by the Commissioner to the Secretary for this purpose.

(2) With respect to the participation of recipients of supplemental security income benefits in experimental, pilot, or demonstration projects under this subsection—

(A) the Commissioner is not authorized to carry out any project that would result in a substantial reduction in any individual's total income and resources as a result of his or her participation in the project;

(B) the Commissioner may not require any individual to participate in a project; and the Commissioner shall assure (i) that the voluntary participation of individuals in any project is obtained through informed written consent which satisfies the requirements for informed consent established by the Commissioner for use in any experimental, pilot, or demonstration project in which human subjects are at risk, and (ii) that any individual's voluntary agreement to participate in any project may be revoked by such individual at any time;

(C) the Commissioner shall, to the extent feasible and appropriate, include recipients who are under age 18 as well as adult recipients; and

(D) the Commissioner shall include in the projects carried out under this section such experimental, pilot, or demonstration projects as may be necessary to ascertain the feasibility of treating alcoholics and drug addicts to prevent the onset of irreversible medical conditions which may result in permanent disability, including programs in residential care treatment centers.

(c)[22] (1) In addition to the amount otherwise appropriated in any other law to carry out subsection (a) for fiscal year 2004, up to $8,500,000 is authorized and appropriated and shall be used by the Commissioner of Social Security under this subsection for purposes of conducting a statistically valid survey to determine how payments made to individuals, organizations, and State or local government agencies that are representative payees for benefits paid under title II or XVI are being managed and used on behalf of the beneficiaries for whom such benefits are paid.

(2) Not later than 18 months after the date of enactment of this subsection, the Commissioner of Social Security shall submit a report on the survey conducted in accordance with paragraph (1) to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate.

PUBLIC ASSISTANCE PAYMENTS TO LEGAL REPRESENTATIVES

SEC. 1111. [42 U.S.C. 1311] For purposes of titles I, X, XIV, and XVI, and part A of title IV, payments on behalf of an individual, made to another person who has been judicially appointed, under the law of the State in which such individual resides, as legal representative of such individual for the purpose of receiving and managing such payments (whether or not he is such individual's legal representative for other purposes), shall be regarded as money payments to such individual.

MEDICAL CARE GUIDES AND REPORTS FOR PUBLIC ASSISTANCE AND MEDICAL ASSISTANCE

SEC. 1112. [42 U.S.C. 1312] In order to assist the States to extend the scope and content, and improve the quality, of medical care and medical services for which payments are made to or on behalf of needy and low-income individuals under this Act and in order to promote better public understanding about medical care and medical assistance for needy and low-income individuals, the Secretary shall develop and revise from time to time guides or recommended standards as to the level, content, and quality of medical care and medical services for the use of the States in evaluating and improving their public assistance medical care programs and their programs of medical assistance; shall secure periodic reports from the States on items included in, and the quantity of, medical care and medical services for which expenditures under such programs are made; and shall from time to time publish data secured from these reports and other information necessary to carry out the purposes of this section.

ASSISTANCE FOR UNITED STATES CITIZENS RETURNED FROM FOREIGN COUNTRIES

SEC. 1113. [42 U.S.C. 1313] (a)(1) The Secretary is authorized to provide temporary assistance to citizens of the United States and to dependents of citizens of the United States, if they (A) are identified by the Department of State as having returned, or been brought, from a foreign country to the United States because of the destitution of the citizen of the United States or the illness of such

[22] P.L. 108-203, §107(a), added subsection (c), effective March 2, 2004.

citizen or any of his dependents or because of war, threat of war, invasion, or similar crisis, and (B) are without available resources.

(2) Except in such cases or classes of cases as are set forth in regulations of the Secretary, provision shall be made for reimbursement to the United States by the recipients of the temporary assistance to cover the cost thereof.

(3) The Secretary may provide assistance under paragraph (1) directly or through utilization of the services and facilities of appropriate public or private agencies and organizations, in accordance with agreements providing for payment, in advance or by way of reimbursement, as may be determined by the Secretary, of the cost thereof. Such cost shall be determined by such statistical, sampling, or other method as may be provided in the agreement.

(b) The Secretary is authorized to develop plans and make arrangements for provision of temporary assistance within the United States to individuals specified in subsection (a)(1). Such plans shall be developed and such arrangements shall be made after consultation with the Secretary of State, the Attorney General, and the Secretary of Defense. To the extent feasible, assistance provided under subsection (a) shall be provided in accordance with the plans developed pursuant to this subsection, as modified from time to time by the Secretary.

(c) For purposes of this section, the term "temporary assistance" means money payments, medical care, temporary billeting, transportation, and other goods and services necessary for the health or welfare of individuals (including guidance, counseling, and other welfare services) furnished to them within the United States upon their arrival in the United States and for such period after their arrival, not exceeding ninety days, as may be provided in regulations of the Secretary; except that assistance under this section may be furnished beyond such ninety-day period in the case of any citizen or dependent upon a finding by the Secretary that the circumstances involved necessitate or justify the furnishing of assistance beyond such period in that particular case.

(d) The total amount of temporary assistance provided under this section shall not exceed $1,000,000 during any fiscal year beginning after September 30, 2003[23].

(e)(1) The Secretary may accept on behalf of the United States gifts, in cash or in kind, for use in carrying out the program established under this section. Gifts in the form of cash shall be credited to the appropriation account from which this program is funded, in addition to amounts otherwise appropriated, and shall remain available until expended.

(2) Gifts accepted under paragraph (1) shall be available for obligation or other use by the United States only to the extent and in the amounts provided in appropriation Acts.

APPOINTMENT OF ADVISORY COUNCIL AND OTHER ADVISORY GROUPS[24]

SEC. 1114. [42 U.S.C. 1314] (a) The Secretary shall, during 1964, appoint an Advisory Council on Public Welfare for the purpose of reviewing the administration of the public assistance and

[23] P.L. 108-11, §1701, struck out "1991" and substituted "2003", effective April 16, 2003.

[24] See Vol. II, P.L. 92–463, §§2–15, approved October 6, 1972, with respect to provisions governing the operations of advisory committees.

See Vol. II, P.L. 103–432, §232, with respect to measurement and reporting of welfare receipt.

child welfare services programs for which funds are appropriated pursuant to this Act and making recommendations for improvement of such administration, and reviewing the status of and making recommendations with respect to the public assistance programs for which funds are so appropriated, especially in relation to the old-age, survivors, and disability insurance program, with respect to the fiscal capacities of the States and the Federal Government, and with respect to any other matters bearing on the amount and proportion of the Federal and State shares in the public assistance and child welfare services programs.

(b) The Council shall be appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service and shall consist of twelve persons who shall, to the extent possible, be representatives of employers and employees in equal numbers, representatives of State or Federal agencies concerned with the administration or financing of the public assistance and child welfare services programs, representatives of nonprofit private organizations concerned with social welfare programs, other persons with special knowledge, experience, or qualifications with respect to such programs, and members of the public.

(c) The Council is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Council such secretarial, clerical, and other assistance and such pertinent data prepared by the Department of Health and Human Services as it may require to carry out such functions.

(d) The Council shall make a report of its findings and recommendations (including recommendations for changes in the provisions of the Social Security Act) to the Secretary, such report to be submitted not later than July 1, 1966, after which date such Council shall cease to exist.

(e) The Secretary shall also from time to time thereafter appoint an Advisory Council on Public Welfare, with the same functions and constituted in the same manner as prescribed for the Advisory Council in the preceding subsections of this section. Each Council so appointed shall report its findings and recommendations, as prescribed in subsection (d), not later than July 1 of the second year after the year in which it is appointed, after which date such Council shall cease to exist.

(f) The Secretary may also appoint, without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, such advisory committees as he may deem advisable to advise and consult with him in carrying out any of his functions under this Act. The Secretary shall report to the Congress annually on the number of such committees and on the membership and activities of each such committee.

(g) Members of the Council or of any advisory committee appointed under this section who are not regular full-time employees of the United States shall, while serving on business of the Council or any such committee, be entitled to receive compensation at rates fixed by the Secretary, but not exceeding $75 per day, including travel time; and while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of

title 5, United States Code[25], for persons in Government service employed intermittently.

(h)(1) Any member of the Council or any advisory committee appointed under this Act, who is not a regular full-time employee of the United States, is hereby exempted, with respect to such appointment, from the operation of sections 203, 205, and 209 of title 18, United States Code[26], except as otherwise specified in paragraph (2) of this subsection.

(2) The exemption granted by paragraph (1) shall not extend—

(A) to the receipt or payment of salary in connection with the appointee's Government service from any source other than the employer of the appointee at the time of his appointment, or

(B) during the period of such appointment, to the prosecution or participation in the prosecution, by any person so appointed, of any claim against the Government involving any matter with which such person, during such period, is or was directly connected by reason of such appointment.

(i) [Transferred.[27]]

DEMONSTRATION PROJECTS

SEC. 1115. [42 U.S.C. 1315] (a) In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of title I, X, XIV, XVI, or XIX, or part A or D of title IV, in a State or States—

(1) the Secretary may waive compliance with any of the requirements of section 2, 402, 454, 1002, 1402, 1602, or 1902, as the case may be, to the extent and for the period he finds necessary to enable such State or States to carry out such project, and

(2)(A) costs of such project which would not otherwise be included as expenditures under section 3, 455, 1003, 1403, 1603, or 1903, as the case may be, and which are not included as part of the costs of projects under section 1110, shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under such title, or for administration of such State plan or plans, as may be appropriate, and

(B) costs of such project which would not otherwise be a permissable use of funds under part A of title IV and which are not included as part of the costs of projects under section 1110, shall to the extent and for the period prescribed by the Secretary, be regarded as a permissable use of funds under such part.

In addition, not to exceed $4,000,000 of the aggregate amount appropriated for payments to States under such titles for any fiscal year beginning after June 30, 1967, shall be available, under such terms and conditions as the Secretary may establish, for payments to States to cover so much of the cost of such projects as is not cov-

[25] See Vol. II, Title 5.
[26] See Vol. II, Title 18.
[27] P.L. 108–173, §948(a)(1), transferred 1114(i) to section 1862 and redesignated it as the new subsection (j), effective as if included in the enactment of P.L. 106-554, Appendix F.

ered by payments under such titles and is not included as part of the cost of projects for purposes of section 1110.

(b) In the case of any experimental, pilot, or demonstration project undertaken under subsection (a) to assist in promoting the objectives of part D of title IV, the project—

(1) must be designed to improve the financial well-being of children or otherwise improve the operation of the child support program;

(2) may not permit modifications in the child support program which would have the effect of disadvantaging children in need of support; and

(3) must not result in increased cost to the Federal Government under part A of such title.

(c)(1)(A) The Secretary shall enter into agreements with up to 8 States submitting applications under this subsection for the purpose of conducting demonstration projects in such States to test and evaluate the use, with respect to individuals who received aid under part A of title IV in the preceding month (on the basis of the unemployment of the parent who is the principal earner), of a number greater than 100 for the number of hours per month that such individuals may work and still be considered to be unemployed for purposes of section 407. If any State submits an application under this subsection for the purpose of conducting a demonstration project to test and evaluate the total elimination of the 100-hour rule, the Secretary shall approve at least one such application.

(B) If any State with an agreement under this subsection so requests, the demonstration project conducted pursuant to such agreement may test and evaluate the complete elimination of the 100-hour rule and of any other durational standard that might be applied in defining unemployment for purposes of determining eligibility under section 407.

(2) Notwithstanding section 402(a)(1), a demonstration project conducted under this subsection may be conducted in one or more political subdivisions of the State.

(3) An agreement under this subsection shall be entered into between the Secretary and the State agency designated under section 402(a)(3). Such agreement shall provide for the payment of aid under the applicable State plan under part A of title IV as though section 407 had been modified to reflect the definition of unemployment used in the demonstration project but shall also provide that such project shall otherwise be carried out in accordance with all of the requirements and conditions of section 407 (and, except as provided in paragraph (2), any related requirements and conditions under part A of title IV).

(4) A demonstration project under this subsection may be commenced any time after September 30, 1990, and shall be conducted for such period of time as the agreement with the Secretary may provide; except that, in no event may a demonstration project under this section be conducted after September 30, 1995.

(5)(A) Any State with an agreement under this subsection shall evaluate the comparative cost and employment effects of the use of the definition of unemployment in its demonstration project under this section by use of experimental and control

groups comprised of a random sample of individuals receiving aid under section 407 and shall furnish the Secretary with such information as the Secretary determines to be necessary to evaluate the results of the project conducted by the State.

(B) The Secretary shall report the results of the demonstration projects conducted under this subsection to the Congress not later than 6 months after all such projects are completed.

(e)(1)[28] The provisions of this subsection shall apply to the extension of any State–wide comprehensive demonstration project (in this subsection referred to as "waiver project") for which a waiver of compliance with requirements of title XIX is granted under subsection (a).

(2) During the 6–month period ending 1 year before the date the waiver under subsection (a) with respect to a waiver project would otherwise expire, the chief executive officer of the State which is operating the project may submit to the Secretary a written request for an extension, of up to 3 years, of the project.

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

(4) If such a request is granted, the deadline for submittal of a final report under the waiver project is deemed to have been extended until the date that is 1 year after the date the waiver project would otherwise have expired.

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

(6) Subject to paragraphs (4) and (7), the extension of a waiver project under this subsection shall be on the same terms and conditions (including applicable terms and conditions relating to quality and access of services, budget neutrality, data and reporting requirements, and special population protections) that applied to the project before its extension under this subsection.

(7) If an original condition of approval of a waiver project was that Federal expenditures under the project not exceed the Federal expenditures that would otherwise have been made, the Secretary shall take such steps as may be necessary to ensure that, in the extension of the project under this subsection, such condition continues to be met. In applying the previous sentence, the Secretary shall take into account the Secretary's best estimate of rates of change in expenditures at the time of the extension.

(f) An application by the chief executive officer of a State for an extension of a waiver project the State is operating under an extension under subsection (e) (in this subsection referred to as the "waiver project") shall be submitted and approved or disapproved in accordance with the following:

(1) The application for an extension of the waiver project shall be submitted to the Secretary at least 120 days prior to the expiration of the current period of the waiver project.

[28] As in original. P.L. 105-33, §4757, added subsection (e), effective August 5, 1997. No subsection (d) has been enacted.

(2) Not later than 45 days after the date such application is received by the Secretary, the Secretary shall notify the State if the Secretary intends to review the terms and conditions of the waiver project. A failure to provide such notification shall be deemed to be an approval of the application.

(3) Not later than 45 days after the date a notification is made in accordance with paragraph (2), the Secretary shall inform the State of proposed changes in the terms and conditions of the waiver project. A failure to provide such information shall be deemed to be an approval of the application.

(4) During the 30-day period that begins on the date information described in paragraph (3) is provided to a State, the Secretary shall negotiate revised terms and conditions of the waiver project with the State.

(5)(A) Not later than 120 days after the date an application for an extension of the waiver project is submitted to the Secretary (or such later date agreed to by the chief executive officer of the State), the Secretary shall—

(i) approve the application subject to such modifications in the terms and conditions—

(I) as have been agreed to by the Secretary and the State; or

(II) in the absence of such agreement, as are determined by the Secretary to be reasonable, consistent with the overall objectives of the waiver project, and not in violation of applicable law; or

(ii) disapprove the application.

(B) A failure by the Secretary to approve or disapprove an application submitted under this subsection in accordance with the requirements of subparagraph (A) shall be deemed to be an approval of the application subject to such modifications in the terms and conditions as have been agreed to (if any) by the Secretary and the State.

(6) An approval of an application for an extension of a waiver project under this subsection shall be for a period not to exceed 3 years.

(7) An extension of a waiver project under this subsection shall be subject to the final reporting and evaluation requirements of paragraphs (4) and (5) of subsection (e) (taking into account the extension under this subsection with respect to any timing requirements imposed under those paragraphs).

ADMINISTRATIVE AND JUDICIAL REVIEW OF CERTAIN ADMINISTRATIVE DETERMINATIONS

SEC. 1116. [42 U.S.C. 1316] (a)(1) Whenever a State plan is submitted to the Secretary by a State for approval under title I, X, XIV, XVI, or XIX, he shall, not later than 90 days after the date the plan is submitted to him, make a determination as to whether it conforms to the requirements for approval under such title. The 90day period provided herein may be extended by written agreement of the Secretary and the affected State.

(2) Any State dissatisfied with a determination of the Secretary under paragraph (1) with respect to any plan may, within 60 days after it has been notified of such determination, file a petition with the Secretary for reconsideration of the issue of whether such plan conforms to the requirements for approval

under such title. Within 30 days after receipt of such a petition, the Secretary shall notify the State of the time and place at which a hearing will be held for the purpose of reconsidering such issue. Such hearing shall be held not less than 20 days nor more than 60 days after the date notice of such hearing is furnished to such State, unless the Secretary and such State agree in writing to holding the hearing at another time. The Secretary shall affirm, modify, or reverse his original determination within 60 days of the conclusion of the hearing.

(3) Any State which is dissatisfied with a final determination made by the Secretary on such a reconsideration or a final determination of the Secretary under section 4, 1004, 1404, 1604, or 1904 may, within 60 days after it has been notified of such determination, file with the United States court of appeals for the circuit in which such State is located a petition for review of such determination. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary. The Secretary thereupon shall file in the court the record of the proceedings on which he based his determination as provided in section 2112 of title 28, United States Code[29] .

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

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

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

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

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

[29] See Vol. II, Title 28.

APPOINTMENT OF THE ADMINISTRATOR AND CHIEF ACTUARY OF THE CENTERS FOR MEDICARE AND MEDICAID SERVICES[30]

SEC. 1117. [42 U.S.C. 1317] (a) The Administrator of the Health Care Financing Administration shall be appointed by the President by and with the advice and consent of the Senate.

(b)(1) There is established in the Health Care Financing Administration the position of Chief Actuary. The Chief Actuary shall be appointed by, and in direct line of authority to, the Administrator of such Administration. The Chief Actuary shall be appointed from among individuals who have demonstrated, by their education and experience, superior expertise in the actuarial sciences. The Chief Actuary shall exercise such duties as are appropriate for the office of the Chief Actuary and in accordance with professional standards of actuarial independence. The Chief Actuary may be removed only for cause.

(2) The Chief Actuary shall be compensated at the highest rate of basic pay for the Senior Executive Service under section 5382(b) of title 5, United States Code.

(3)[31] In the office of the Chief Actuary there shall be an actuary whose duties relate exclusively to the programs under parts C and D of title XVIII and related provisions of such title.

ALTERNATIVE FEDERAL PAYMENT WITH RESPECT TO PUBLIC ASSISTANCE EXPENDITURES

SEC. 1118. [42 U.S.C. 1318] In the case of any State which has in effect a plan approved under title XIX for any calendar quarter, the total of the payments to which such State is entitled for such quarter, and for each succeeding quarter in the same fiscal year (which for purposes of this section means the 4 calendar quarters ending with September 30), under paragraphs (1) and (2) of sections 3(a), 1003(a), 1403(a), and 1603(a) shall, at the option of the State, be determined by application of the Federal medical assistance percentage (as defined in section 1905), instead of the percentages provided under each such section, to the expenditures under its State plans approved under titles I, X, XIV, and XVI, which would be included in determining the amounts of the Federal payments to which such State is entitled under such sections, but without regard to any maximum on the dollar amounts per recipient which may be counted under such sections. For purposes of the preceding sentence, the term "Federal medical assistance percentage" shall, in the case of Puerto Rico, the Virgin Islands, and Guam, mean 75 per centum.

FEDERAL PARTICIPATION IN PAYMENTS FOR REPAIRS TO HOME OWNED BY RECIPIENT OF AID OR ASSISTANCE

SEC. 1119. [42 U.S.C. 1319] In the case of an expenditure for repairing the home owned by an individual who is receiving aid or assistance, other than medical assistance to the aged, under a State plan approved under title I, X, XIV, or XVI, if—

(1) the State agency or local agency administering the plan approved under such title has made a finding (prior to making

[30] P.L. 108- 173, §900(e)(1)(A), amended the heading to read "Appointment of the Administrator and Chief Actuary of the Centers For Medicare and Medicaid Services".

[31] P.L. 108- 173, §900(c), added paragraph (3), effective December 8, 2003.

such expenditure) that (A) such home is so defective that continued occupancy is unwarranted, (B) unless repairs are made to such home, rental quarters will be necessary for such individual, and (C) the cost of rental quarters to take care of the needs of such individual (including his spouse living with him in such home and any other individual whose needs were taken into account in determining the need of such individual) would exceed (over such time as the Secretary may specify) the cost of repairs needed to make such home habitable together with other costs attributable to continued occupancy of such home, and

(2) no such expenditures were made for repairing such home pursuant to any prior finding under this section,

the amount paid to any such State for any quarter under section 3(a), 1003(a), 1403(a), or 1603(a) shall be increased by 50 per centum of such expenditures, except that the excess above $500 expended with respect to any one home shall not be included in determining such expenditures.

APPROVAL OF CERTAIN PROJECTS

SEC. 1120. [42 U.S.C. 1320] No payment shall be made under this Act with respect to any experimental, pilot, demonstration, or other project all or any part of which is wholly financed with Federal funds made available under this Act (without any State, local, or other non-Federal financial participation) unless such project shall have been personally approved by the Secretary or Under Secretary of Health and Human Services.

UNIFORM REPORTING SYSTEMS FOR HEALTH SERVICES FACILITIES AND ORGANIZATIONS

SEC. 1121. [42 U.S.C. 1320a] (a) For the purposes of reporting the cost of services provided by, of planning, and of measuring and comparing the efficiency of and effective use of services in, hospitals, skilled nursing facilities, intermediate care facilities, home health agencies, health maintenance organizations, and other types of health services facilities and organizations to which payment may be made under this Act, the Secretary shall establish by regulation, for each such type of health services facility or organization, a uniform system for the reporting by a facility or organization of that type of the following information:

(1) The aggregate cost of operation and the aggregate volume of services.

(2) The costs and volume of services for various functional accounts and subaccounts.

(3) Rates, by category of patient and class of purchaser.

(4) Capital assets, as defined by the Secretary, including (as appropriate) capital funds, debt service, lease agreements used in lieu of capital funds, and the value of land, facilities, and equipment.

(5) Discharge and bill data.

The uniform reporting system for a type of health services facility or organization shall provide for appropriate variation in the application of the system to different classes of facilities or organizations within that type and shall be established, to the extent practicable, consistent with the cooperative system for producing comparable

and uniform health information and statistics described in section 306(e)(1) of the Public Health Service Act[32]. In reporting under such a system, hospitals shall employ such chart of accounts, definitions, principles, and statistics as the Secretary may prescribe in order to reach a uniform reconciliation of financial and statistical data for specified uniform reports to be provided to the Secretary.

(b) The Secretary shall—

(1) monitor the operation of the systems established under subsection (a);

(2) assist with and support demonstrations and evaluations of the effectiveness and cost of the operation of such systems and encourage State adoption of such systems; and

(3) periodically revise such systems to improve their effectiveness and diminish their cost.

(c) The Secretary shall provide information obtained through use of the uniform reporting systems described in subsection (a) in a useful manner and format to appropriate agencies and organizations, including health systems agencies (designated under section 1515 of the Public Health Service Act) and State health planning and development agencies (designated under section 1521 of such Act), as may be necessary to carry out such agencies' and organizations' functions.

LIMITATION ON FEDERAL PARTICIPATION FOR CAPITAL EXPENDITURES

SEC. 1122. [42 U.S.C. 1320a–1] (a) The purpose of this section is to assure that Federal funds appropriated under titles XVIII and XIX are not used to support unnecessary capital expenditures made by or on behalf of health care facilities which are reimbursed under any of such titles and that, to the extent possible, reimbursement under such titles shall support planning activities with respect to health services and facilities in the various States.

(b) The Secretary, after consultation with the Governor (or other chief executive officer) and with appropriate local public officials, shall make an agreement with any State which is able and willing to do so under which a designated planning agency (which shall be an agency described in clause (ii) of subsection (d)(1)(B) that has a governing body or advisory board at least half of whose members represent consumer interests) will—

(1) make, and submit to the Secretary together with such supporting materials as he may find necessary, findings and recommendations with respect to capital expenditures proposed by or on behalf of any health care facility in such State within the field of its responsibilities,

(2) receive from other agencies described in clause (ii) of subsection (d)(1)(B), and submit to the Secretary together with such supporting material as he may find necessary, the findings and recommendations of such other agencies with respect to capital expenditures proposed by or on behalf of health care facilities in such State within the fields of their respective responsibilities, and

(3) establish and maintain procedures pursuant to which a person proposing any such capital expenditure may appeal a recommendation by the designated agency and will be granted an opportunity for a fair hearing by such agency or person

[32] See Vol. II, P.L. 78–410.

other than the designated agency as the Governor (or other chief executive officer) may designate to hold such hearings,

whenever and to the extent that the findings of such designated agency or any such other agency indicate that any such expenditure is not consistent with the standards, criteria, or plans developed pursuant to the Public Health Service Act[33] to meet the need for adequate health care facilities in the area covered by the plan or plans so developed.

(c) The Secretary shall pay any such State from the general fund in the Treasury, in advance or by way of reimbursement as may be provided in the agreement with it (and may make adjustments in such payments on account of overpayments or underpayments previously made), for the reasonable cost of performing the functions specified in subsection (b).

(d)(1) Except as provided in paragraph (2), if the Secretary determines that—

(A) neither the planning agency designated in the agreement described in subsection (b) nor an agency described in clause (ii) of subparagraph (B) of this paragraph had been given notice of any proposed capital expenditure (in accordance with such procedure or in such detail as may be required by such agency) at least 60 days prior to obligation for such expenditure; or

(B)(i) the planning agency so designated or an agency so described had received such timely notice of the intention to make such capital expenditure and had, within a reasonable period after receiving such notice and prior to obligation for such expenditure, notified the person proposing such expenditure that the expenditure would not be in conformity with the standards, criteria, or plans developed by such agency or any other agency described in clause (ii) for adequate health care facilities in such State or in the area for which such other agency has responsibility, and

(ii) the planning agency so designated had, prior to submitting to the Secretary the findings referred to in subsection (b)—

(I) consulted with, and taken into consideration the findings and recommendations of, the State planning agencies established pursuant to sections 314(a) and 604(a) of the Public Health Service Act[34] (to the extent that either such agency is not the agency so designated) as well as the public or nonprofit private agency or organization responsible for the comprehensive regional, metropolitan area, or other local area plan or plans referred to in section 314(b) of the Public Health Service Act and covering the area in which the health care facility proposing such capital expenditure is located (where such agency is not the agency designated in the agreement), or, if there is no such agency, such other public or nonprofit private agency or organization (if any) as performs, as determined in accordance with

[33] P.L. 78–410.
[34] See Vol. II, P.L. 78–410.

criteria included in regulations, similar functions, and

(II) granted to the person proposing such capital expenditure an opportunity for a fair hearing with respect to such findings;

then, for such period as he finds necessary in any case to effectuate the purpose of this section, he shall, in determining the Federal payments to be made under titles XVIII and XIX with respect to services furnished in the health care facility for which such capital expenditure is made, not include any amount which is attributable to depreciation, interest on borrowed funds, a return on equity capital (in the case of proprietary facilities), or other expenses related to such capital expenditure. With respect to any organization which is reimbursed on a per capita or a fixed fee or negotiated rate basis, in determining the Federal payments to be made under titles XVIII and XIX, the Secretary shall exclude an amount which in his judgment is a reasonable equivalent to the amount which would otherwise be excluded under this subsection if payment were to be made on other than a per capita or a fixed fee or negotiated rate basis.

(2) If the Secretary, after submitting the matters involved to the advisory council established or designated under subsection (i), determines that an exclusion of expenses related to any capital expenditure of any health care facility would discourage the operation or expansion of such facility which has demonstrated to his satisfaction proof of capability to provide comprehensive health care services (including institutional services) efficiently, effectively, and economically, or would otherwise be inconsistent with the effective organization and delivery of health services or the effective administration of title XVIII or XIX, he shall not exclude such expenses pursuant to paragraph (1).

(e) Where a person obtains under lease or comparable arrangement any facility or part thereof, or equipment for a facility, which would have been subject to an exclusion under subsection (d) if the person had acquired it by purchase, the Secretary shall (1) in computing such person's rental expense in determining the Federal payments to be made under titles XVIII and XIX with respect to services furnished in such facility, deduct the amount which in his judgment is a reasonable equivalent of the amount that would have been excluded if the person had acquired such facility or such equipment by purchase, and (2) in computing such person's return on equity capital deduct any amount deposited under the terms of the lease or comparable arrangement.

(f) Any person dissatisfied with a determination by the Secretary under this section may within six months following notification of such determination request the Secretary to reconsider such determination. A determination by the Secretary under this section shall not be subject to administrative or judicial review.

(g) For the purposes of this section, a "capital expenditure" is an expenditure which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance and which (1) exceeds $600,000 (or such lesser amount as the State may establish), (2) changes the bed capacity of the facility with respect to which such expenditure is made, or (3) substantially changes the services of the facility with respect to which such

expenditure is made. For purposes of clause (1) of the preceding sentence, the cost of the studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of the plant and equipment with respect to which such expenditure is made shall be included in determining whether such expenditure exceeds the dollar amount specified in clause (1).

(h) The provisions of this section shall not apply to a religious nonmedical health care institution (as defined in section 1861(ss)(1)).

(i)(1) The Secretary shall establish a national advisory council, or designate an appropriate existing national advisory council, to advise and assist him in the preparation of general regulations to carry out the purposes of this section and on policy matters arising in the administration of this section, including the coordination of activities under this section with those under other parts of this Act or under other Federal or federally assisted health programs.

(2) The Secretary shall make appropriate provision for consultation between and coordination of the work of the advisory council established or designated under paragraph (1) and the Federal Hospital Council, the National Advisory Health Council, the Health Insurance Benefits Advisory Council, and other appropriate national advisory councils with respect to matters bearing on the purposes and administration of this section and the coordination of activities under this section with related Federal health programs.

(3) If an advisory council is established by the Secretary under paragraph (1), it shall be composed of members who are not otherwise in the regular full-time employ of the United States, and who shall be appointed by the Secretary without regard to the civil service laws from among leaders in the fields of the fundamental sciences, the medical sciences, and the organization, delivery, and financing of health care, and persons who are State or local officials or are active in community affairs or public or civic affairs or who are representative of minority groups. Members of such advisory council, while attending meetings of the council or otherwise serving on business of the council, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding the maximum rate specified at the time of such service for grade GS-18 in section 5332 of title 5, United States Code, including travel-time, and while away from their homes or regular places of business they may also be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of such title 5[35] for persons in the Government service employed intermittently.

(j) A capital expenditure made by or on behalf of a health care facility shall not be subject to review pursuant to this section if 75 percent of the patients who can reasonably be expected to use the service with respect to which the capital expenditure is made will be individuals enrolled in an eligible organization as defined in section 1876(b), and if the Secretary determines that such capital expenditure is for services and facilities which are needed by such organization in order to operate efficiently and economically and

[35] See Vol. II, Title 5.

which are not otherwise readily accessible to such organization because—

(1) the facilities do not provide common services at the same site (as usually provided by the organization),

(2) the facilities are not available under a contract of reasonable duration,

(3) full and equal medical staff privileges in the facilities are not available,

(4) arrangements with such facilities are not administratively feasible, or

(5) the purchase of such services is more costly than if the organization provided the services directly.

EFFECT OF FAILURE TO CARRY OUT STATE PLAN

SEC. 1123. [42 U.S.C. 1320a–2] In an action brought to enforce a provision of the Social Security Act, such provision is not to be deemed unenforceable because of its inclusion in a section of the Act requiring a State plan or specifying the required contents of a State plan. This section is not intended to limit or expand the grounds for determining the availability of private actions to enforce State plan requirements other than by overturning any such grounds applied in Suter v. Artist M., 112 S. Ct. 1360 (1992), but not applied in prior Supreme Court decisions respecting such enforceability: *Provided*, however, That this section is not intended to alter the holding in Suter v. Artist M. that section 471(a)(15) of the Act is not enforceable in a private right of action.

REVIEWS OF CHILD AND FAMILY SERVICES PROGRAMS, AND OF FOSTER CARE AND ADOPTION ASSISTANCE PROGRAMS, FOR CONFORMITY WITH STATE PLAN REQUIREMENTS

SEC. 1123A. [42 U.S.C. 1320a–1a] (a) IN GENERAL.—The Secretary, in consultation with the State agencies administering the State programs under parts B and E of title IV, shall promulgate regulations for the review of such programs to determine whether such programs are in substantial conformity with—

(1) State plan requirements under such parts B and E,

(2) implementing regulations promulgated by the Secretary, and

(3) the relevant approved State plans.

(b) ELEMENTS OF REVIEW SYSTEM.—The regulations referred to in subsection (a) shall—

(1) specify the timetable for conformity reviews of State programs, including—

(A) an initial review of each State program;

(B) a timely review of a State program following a review in which such program was found not to be in substantial conformity; and

(C) less frequent reviews of State programs which have been found to be in substantial conformity, but such regulations shall permit the Secretary to reinstate more frequent reviews based on information which indicates that a State program may not be in conformity;

(2) specify the requirements subject to review, and the criteria to be used to measure conformity with such requirements

and to determine whether there is a substantial failure to so conform;

(3) specify the method to be used to determine the amount of any Federal matching funds to be withheld (subject to paragraph (4)) due to the State program's failure to so conform, which ensures that—

(A) such funds will not be withheld with respect to a program, unless it is determined that the program fails substantially to so conform;

(B) such funds will not be withheld for a failure to so conform resulting from the State's reliance upon and correct use of formal written statements of Federal law or policy provided to the State by the Secretary; and

(C) the amount of such funds withheld is related to the extent of the failure to so conform; and

(4) require the Secretary, with respect to any State program found to have failed substantially to so conform—

(A) to afford the State an opportunity to adopt and implement a corrective action plan, approved by the Secretary, designed to end the failure to so conform;

(B) to make technical assistance available to the State to the extent feasible to enable the State to develop and implement such a corrective action plan;

(C) to suspend the withholding of any Federal matching funds under this section while such a corrective action plan is in effect; and

(D) to rescind any such withholding if the failure to so conform is ended by successful completion of such a corrective action plan.

(c) PROVISIONS FOR ADMINISTRATIVE AND JUDICIAL REVIEW.—The regulations referred to in subsection (a) shall—

(1) require the Secretary, not later than 10 days after a final determination that a program of the State is not in conformity, to notify the State of—

(A) the basis for the determination; and

(B) the amount of the Federal matching funds (if any) to be withheld from the State;

(2) afford the State an opportunity to appeal the determination to the Departmental Appeals Board within 60 days after receipt of the notice described in paragraph (1), (or, if later after failure to continue or to complete a corrective action plan); and

(3) afford the State an opportunity to obtain judicial review of an adverse decision of the Board, within 60 days after the State receives notice of the decision of the Board, by appeal to the district court of the United States for the judicial district in which the principal or headquarters office of the agency responsible for administering the program is located.

DISCLOSURE OF OWNERSHIP AND RELATED INFORMATION [36]

SEC. 1124. [42 U.S.C. 1320a–3] (a)(1) The Secretary shall by regulation or by contract provision provide that each disclosing entity (as defined in paragraph (2)) shall—

[36] See Vol. II, P.L. 78–410, §1318, with respect to financial disclosure by health maintenance organizations.

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

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

supply the Secretary or the appropriate State agency with full and complete information as to the identity of each person with an ownership or control interest (as defined in paragraph (3)) in the entity or in any subcontractor (as defined by the Secretary in regulations) in which the entity directly or indirectly has a 5 per centum or more ownership interest and supply the Secretary with the[37] both the employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986) and social security account number (assigned under section 205(c)(2)(B)) of the disclosing entity, each person with an ownership or control interest (as defined in subsection (a)(3)), and any subcontractor in which the entity directly or indirectly has a 5 percent or more ownership interest.

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

(A) a provider of services (as defined in section 1861(u), other than a fund), an independent clinical laboratory, a renal disease facility, a managed care entity, as defined in section 1932(a)(1)(B), or a health maintenance organization (as defined in section 1301(a) of the Public Health Service Act[38]);

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

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

(3) As used in this section, the term "person with an ownership or control interest" means, with respect to an entity, a person who—

(A)(i) has directly or indirectly (as determined by the Secretary in regulations) an ownership interest of 5 per centum or more in the entity; or

(ii) is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof, which whole or part interest is equal to or exceeds 5 per centum of the total property and assets of the entity; or

[37] As in original. The word "the" probably should not appear.
[38] See Vol. II, P.L. 78–410.

(B) is an officer or director of the entity, if the entity is organized as a corporation; or

(C) is a partner in the entity, if the entity is organized as a partnership.

(b) To the extent determined to be feasible under regulations of the Secretary, a disclosing entity shall also include in the information supplied under subsection (a)(1), with respect to each person with an ownership or control interest in the entity, the name of any other disclosing entity with respect to which the person is a person with an ownership or control interest.

DISCLOSURE REQUIREMENTS FOR OTHER PROVIDERS UNDER PART B OF MEDICARE

SEC. 1124A. [42 U.S.C. 1320a–3a] (a) DISCLOSURE REQUIRED TO RECEIVE PAYMENT.—No payment may be made under part B of title XVIII for items or services furnished by any disclosing part B provider unless such provider has provided the Secretary with full and complete information—

(1) on the identity of each person with an ownership or control interest in the provider or in any subcontractor (as defined by the Secretary in regulations) in which the provider directly or indirectly has a 5 percent or more ownership interest;

(2) with respect to any person identified under paragraph (1) or any managing employee of the provider—

(A) on the identity of any other entities providing items or services for which payment may be made under title XVIII with respect to which such person or managing employee is a person with an ownership or control interest at the time such information is supplied or at any time during the 3-year period ending on the date such information is supplied, and

(B) as to whether any penalties, assessments, or exclusions have been assessed against such person or managing employee under section 1128, 1128A, or 1128B; and

(3) including the employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986) and social security account number (assigned under section 205(c)(2)(B)) of the disclosing part B provider and any person, managing employee, or other entity identified or described under paragraph (1) or (2).

(b) UPDATES TO INFORMATION SUPPLIED.—A disclosing part B provider shall notify the Secretary of any changes or updates to the information supplied under subsection (a) not later than 180 days after such changes or updates take effect.

(c) VERIFICATION.—

(1) TRANSMITTAL BY HHS.—The Secretary shall transmit—

(A) to the Commissioner of Social Security information concerning each social security account number (assigned under section 205(c)(2)(B)), and

(B) to the Secretary of the Treasury information concerning each employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986),

supplied to the Secretary pursuant to subsection (a)(3) or section 1124(c) to the extent necessary for verification of such information in accordance with paragraph (2).

(2) VERIFICATION.—The Commissioner of Social Security and the Secretary of the Treasury shall verify the accuracy of, or correct, the information supplied by the Secretary to such official pursuant to paragraph (1), and shall report such verifications or corrections to the Secretary.

(3) FEES FOR VERIFICATION.—The Secretary shall reimburse the Commissioner and Secretary of the Treasury, at a rate negotiated between the Secretary and such official, for the costs incurred by such official in performing the verification and correction services described in this subsection.

(d) DEFINITIONS.—FOR PURPOSES OF THIS SECTION—

(1) the term "disclosing part B provider" means any entity receiving payment on an assignment–related basis (or, for purposes of subsection (a)(3), any entity receiving payment) for furnishing items or services for which payment may be made under part B of title XVIII, except that such term does not include an entity described in section 1124(a)(2);

(2) the term "managing employee" means, with respect to a provider, a person described in section 1126(b); and

(3) the term "person with an ownership or control interest" means, with respect to a provider—

(A) a person described in section 1124(a)(3), or

(B) a person who has one of the 5 largest direct or indirect ownership or control interests in the provider.

ISSUANCE OF SUBPENAS BY COMPTROLLER GENERAL

SEC. 1125. [42 U.S.C. 1320a–4] (a) For the purpose of any audit, investigation, examination, analysis, review, evaluation, or other function authorized by law with respect to any program authorized under this Act, the Comptroller General of the United States shall have power to sign and issue subpenas to any person requiring the production of any pertinent books, records, documents, or other information. Subpenas so issued by the Comptroller General shall be served by anyone authorized by him (1) by delivering a copy thereof to the person named therein, or (2) by registered mail or by certified mail addressed to such person at his last dwelling place or principal place of business. A verified return by the person so serving the subpena setting forth the manner of service, or, in the case of service by registered mail or by certified mail, the return post office receipt therefor signed by the person so served, shall be proof of service.

(b) In case of contumacy by, or refusal to obey a subpena issued pursuant to subsection (a) of this section and duly served upon, any person, any district court of the United States for the judicial district in which such person charged with contumacy or refusal to obey is found or resides or transacts business, upon application by the Comptroller General, shall have jurisdiction to issue an order requiring such person to produce the books, records, documents, or other information sought by the subpena; and any failure to obey such order of the court may be punished by the court as a contempt thereof. In proceedings brought under this subsection, the Comptroller General shall be represented by attorneys employed in the General Accounting Office or by counsel whom he may employ without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and the provisions

of chapter 51 and subchapters III and VI of chapter 53 of such title, relating to classification and General Schedule pay rates.

(c) No personal medical record in the possession of the General Accounting Office[39] shall be subject to subpena or discovery proceedings in a civil action.

DISCLOSURE BY INSTITUTIONS, ORGANIZATIONS, AND AGENCIES OF OWNERS AND CERTAIN OTHER INDIVIDUALS WHO HAVE BEEN CONVICTED OF CERTAIN OFFENSES

SEC. 1126. [42 U.S.C. 1320a–5] (a) As a condition of participation in or certification or recertification under the programs established by titles XVIII, and XIX, any hospital, nursing facility, or other entity (other than an individual practitioner or group of practitioners) shall be required to disclose to the Secretary or to the appropriate State agency the name of any person that is a person described in subparagraphs (A) and (B) of section 1128(b)(8). The Secretary or the appropriate State agency shall promptly notify the Inspector General in the Department of Health and Human Services of the receipt from any entity of any application or request for such participation, certification, or recertification which discloses the name of any such person, and shall notify the Inspector General of the action taken with respect to such application or request.

(b) For the purposes of this section, the term "managing employee" means, with respect to an entity, an individual, including a general manager, business manager, administrator, and director, who exercises operational or managerial control over the entity, or who directly or indirectly conducts the day-to-day operations of the entity.

ADJUSTMENTS IN SSI BENEFITS ON ACCOUNT OF RETROACTIVE BENEFITS UNDER TITLE II

SEC. 1127. [42 U.S.C. 1320a–6] (a) Notwithstanding any other provision of this Act, in any case where an individual—

(1) is entitled to benefits under title II that were not paid in the months in which they were regularly due; and

(2) is an individual or eligible spouse eligible for supplemental security income benefits for one or more months in which the benefits referred to in clause (1) were regularly due,

then any benefits under title II that were regularly due in such month or months, or supplemental security income benefits for such month or months, which are due but have not been paid to such individual or eligible spouse shall be reduced by an amount equal to so much of the supplemental security income benefits, whether or not paid retroactively, as would not have been paid or would not be paid with respect to such individual or spouse if he had received such benefits under title II in the month or months in which they were regularly due. A benefit under title II shall not be reduced pursuant to the preceding sentence to the extent that any amount of such benefit would not otherwise be available for payment in full of the maximum fee which may be recovered from

[39] P.L. 108-271, §8(b), provided that "Any reference to the General Accounting Office in any law, rule, regulation, certificate, directive, instruction, or other official paper in force on the date of enactment of this Act (July 7, 2004) shall be considered to refer and apply to the Government Accountability Office."

such benefit by an attorney pursuant to subsection (a)(4) or (b) of section 206.

(b) For purposes of this section, the term "supplemental security income benefits" means benefits paid or payable by the Commissioner of Social Security under title XVI, including State supplementary payments under an agreement pursuant to section 1616(a) or an administration agreement under section 212(b) of Public Law 93–66[40].

(c) From the amount of the reduction made under subsection (a), the Commissioner of Social Security shall reimburse the State on behalf of which supplementary payments were made for the amount (if any) by which such State's expenditures on account of such supplementary payments for the month or months involved exceeded the expenditures which the State would have made (for such month or months) if the individual had received the benefits under title II at the times they were regularly due. An amount equal to the portion of such reduction remaining after reimbursement of the State under the preceding sentence shall be covered into the general fund of the Treasury.

EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS

SEC. 1128. [42 U.S.C. 1320a–7] (a) MANDATORY EXCLUSION.—The Secretary shall exclude the following individuals and entities from participation in any Federal health care program (as defined in section 1128B(f)):

(1) Conviction of program-related crimes.—Any individual or entity that has been convicted of a criminal offense related to the delivery of an item or service under title XVIII or under any State health care program.

(2) Conviction relating to patient abuse.—Any individual or entity that has been convicted, under Federal or State law, of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service.

(3) FELONY CONVICTION RELATING TO HEALTH CARE FRAUD.—Any individual or entity that has been convicted for an offense which occurred after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996[41], under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.

(4) FELONY CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity that has been convicted for an offense which occurred after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

[40] See Vol. II, P.L. 93–66.
[41] August 21, 1996 is the date of enactment for P.L. 104–191.

(b) PERMISSIVE EXCLUSION.—The Secretary may exclude the following individuals and entities from participation in any Federal health care program (as defined in section 1128B(f)):

(1) CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted for an offense which occurred after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996, under Federal or State law—

(A) of a criminal offense consisting of a misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct—

(i) in connection with the delivery of a health care item or service, or

(ii) with respect to any act or omission in a health care program (other than those specifically described in subsection (a)(1)) operated by or financed in whole or in part by any Federal, State, or local government agency; or

(B) of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct with respect to any act or omission in a program (other than a health care program) operated by or financed in whole or in part by any Federal, State, or local government agency.

(2) Conviction relating to obstruction of an investigation.—Any individual or entity that has been convicted, under Federal or State law, in connection with the interference with or obstruction of any investigation into any criminal offense described in paragraph (1) or in subsection (a).

(3) Misdemeanor conviction relating to controlled substance.—Any individual or entity that has been convicted, under Federal or State law, of a criminal offense consisting of a misdemeanor relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

(4) LICENSE REVOCATION OR SUSPENSION.—ANY INDIVIDUAL OR ENTITY—

(A) whose license to provide health care has been revoked or suspended by any State licensing authority, or who otherwise lost such a license or the right to apply for or renew such a license, for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity, or

(B) who surrendered such a license while a formal disciplinary proceeding was pending before such an authority and the proceeding concerned the individual's or entity's professional competence, professional performance, or financial integrity.

(5) EXCLUSION OR SUSPENSION UNDER FEDERAL OR STATE HEALTH CARE PROGRAM.—Any individual or entity which has been suspended or excluded from participation, or otherwise sanctioned, under—

(A) any Federal program, including programs of the Department of Defense or the Department of Veterans Affairs, involving the provision of health care, or

(B) a State health care program,

for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity.

(6) CLAIMS FOR EXCESSIVE CHARGES OR UNNECESSARY SERVICES AND FAILURE OF CERTAIN ORGANIZATIONS TO FURNISH MEDICALLY NECESSARY SERVICES.—Any individual or entity that the Secretary determines—

(A) has submitted or caused to be submitted bills or requests for payment (where such bills or requests are based on charges or cost) under title XVIII or a State health care program containing charges (or, in applicable cases, requests for payment of costs) for items or services furnished substantially in excess of such individual's or entity's usual charges (or, in applicable cases, substantially in excess of such individual's or entity's costs) for such items or services, unless the Secretary finds there is good cause for such bills or requests containing such charges or costs;

(B) has furnished or caused to be furnished items or services to patients (whether or not eligible for benefits under title XVIII or under a State health care program) substantially in excess of the needs of such patients or of a quality which fails to meet professionally recognized standards of health care;

(C) is—

(i) a health maintenance organization (as defined in section 1903(m)) providing items and services under a State plan approved under title XIX, or

(ii) an entity furnishing services under a waiver approved under section 1915(b)(1),

and has failed substantially to provide medically necessary items and services that are required (under law or the contract with the State under title XIX) to be provided to individuals covered under that plan or waiver, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals; or

(D) is an entity providing items and services as an eligible organization under a risk–sharing contract under section 1876 and has failed substantially to provide medically necessary items and services that are required (under law or such contract) to be provided to individuals covered under the risk–sharing contract, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals.

(7) FRAUD, KICKBACKS, AND OTHER PROHIBITED ACTIVITIES.—Any individual or entity that the Secretary determines has committed an act which is described in section 1128A, 1128B, or 1129.

(8) ENTITIES CONTROLLED BY A SANCTIONED INDIVIDUAL.—Any entity with respect to which the Secretary determines that a person—

(A)(i) who has a direct or indirect ownership or control interest of 5 percent or more in the entity or with an ownership or control interest (as defined in section 1124(a)(3)) in that entity,

(ii) who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of that entity; or

(iii) who was described in clause (i) but is no longer so described because of a transfer of ownership or con-

trol interest, in anticipation of (or following) a conviction, assessment, or exclusion described in subparagraph (B) against the person, to an immediate family member (as defined in subsection (j)(1)) or a member of the household of the person (as defined in subsection (j)(2)) who continues to maintain an interest described in such clause—

is a person—

(B)(i) who has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection;

(ii) against whom a civil monetary penalty has been assessed under section 1128A or 1129; or

(iii) who has been excluded from participation under a program under title XVIII or under a State health care program.

(9) FAILURE TO DISCLOSE REQUIRED INFORMATION.—Any entity that did not fully and accurately make any disclosure required by section 1124, section 1124A, or section 1126.

(10) FAILURE TO SUPPLY REQUESTED INFORMATION ON SUBCONTRACTORS AND SUPPLIERS.—Any disclosing entity (as defined in section 1124(a)(2)) that fails to supply (within such period as may be specified by the Secretary in regulations) upon request specifically addressed to the entity by the Secretary or by the State agency administering or supervising the administration of a State health care program—

(A) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom the entity has had, during the previous 12 months, business transactions in an aggregate amount in excess of $25,000, or

(B) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five–year period ending on the date of such request, between the entity and any wholly owned supplier or between the entity and any subcontractor.

(11) FAILURE TO SUPPLY PAYMENT INFORMATION.—Any individual or entity furnishing items or services for which payment may be made under title XVIII or a State health care program that fails to provide such information as the Secretary or the appropriate State agency finds necessary to determine whether such payments are or were due and the amounts thereof, or has refused to permit such examination of its records by or on behalf of the Secretary or that agency as may be necessary to verify such information.

(12) FAILURE TO GRANT IMMEDIATE ACCESS.—Any individual or entity that fails to grant immediate access, upon reasonable request (as defined by the Secretary in regulations) to any of the following:

(A) To the Secretary, or to the agency used by the Secretary, for the purpose specified in the first sentence of section 1864(a) (relating to compliance with conditions of participation or payment).

(B) To the Secretary or the State agency, to perform the reviews and surveys required under State plans under

paragraphs (26), (31), and (33) of section 1902(a) and under section 1903(g).

(C) To the Inspector General of the Department of Health and Human Services, for the purpose of reviewing records, documents, and other data necessary to the performance of the statutory functions of the Inspector General.

(D) To a State medicaid fraud control unit (as defined in section 1903(q)), for the purpose of conducting activities described in that section.

(13) FAILURE TO TAKE CORRECTIVE ACTION.—Any hospital that fails to comply substantially with a corrective action required under section 1886(f)(2)(B).

(14) DEFAULT ON HEALTH EDUCATION LOAN OR SCHOLARSHIP OBLIGATIONS.—Any individual who the Secretary determines is in default on repayments of scholarship obligations or loans in connection with health professions education made or secured, in whole or in part, by the Secretary and with respect to whom the Secretary has taken all reasonable steps available to the Secretary to secure repayment of such obligations or loans, except that (A) the Secretary shall not exclude pursuant to this paragraph a physician who is the sole community physician or sole source of essential specialized services in a community if a State requests that the physician not be excluded, and (B) the Secretary shall take into account, in determining whether to exclude any other physician pursuant to this paragraph, access of beneficiaries to physician services for which payment may be made under title XVIII or XIX.

(15) INDIVIDUALS CONTROLLING A SANCTIONED ENTITY.—

(A) Any individual—

(i) who has a direct or indirect ownership or control interest in a sanctioned entity and who knows or should know (as defined in section 1128A(i)(6)) of the action constituting the basis for the conviction or exclusion described in subparagraph (B); or

(ii) who is an officer or managing employee (as defined in section 1126(b)) of such an entity.

(B) For purposes of subparagraph (A), the term "sanctioned entity" means an entity—

(i) that has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection; or

(ii) that has been excluded from participation under a program under title XVIII or under a State health care program.

(c) NOTICE, EFFECTIVE DATE, AND PERIOD OF EXCLUSION.—(1) An exclusion under this section or under section 1128A shall be effective at such time and upon such reasonable notice to the public and to the individual or entity excluded as may be specified in regulations consistent with paragraph (2).

(2)(A) Except as provided in subparagraph (B), such an exclusion shall be effective with respect to services furnished to an individual on or after the effective date of the exclusion.

(B) Unless the Secretary determines that the health and safety of individuals receiving services warrants the exclusion taking effect earlier, an exclusion shall not apply to

payments made under title XVIII or under a State health care program for—

(i) inpatient institutional services furnished to an individual who was admitted to such institution before the date of the exclusion, or

(ii) home health services and hospice care furnished to an individual under a plan of care established before the date of the exclusion,

until the passage of 30 days after the effective date of the exclusion.

(3)(A) The Secretary shall specify, in the notice of exclusion under paragraph (1) and the written notice under section 1128A, the minimum period (or, in the case of an exclusion of an individual under subsection (b)(12) or in the case described in subparagraph (G), the period) of the exclusion.

(B) Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than five years, except that, upon the request of the administrator of a Federal health care program (as defined in section 1128B(f)) who determines that the exclusion would impose a hardship on individuals entitled to benefits under part A of title XVIII or enrolled under part B of such title, or both, the Secretary may, after consulting with the Inspector General of the Department of Health and Human Services, waive the exclusion under subsection (a)(1), (a)(3), or (a)(4) with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.[42] The Secretary's decision whether to waive the exclusion shall not be reviewable.

(C) In the case of an exclusion of an individual under subsection (b)(12), the period of the exclusion shall be equal to the sum of—

(i) the length of the period in which the individual failed to grant the immediate access described in that subsection, and

(ii) an additional period, not to exceed 90 days, set by the Secretary.

(D) Subject to subparagraph (G), in the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b), the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with published regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

(E) In the case of an exclusion of an individual or entity under subsection (b)(4) or (b)(5), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity

[42] P.L. 108-173, §949, struck out the first sentence of subparagraph (B), and substituted this sentence, effective December 8, 2003.

For the sentence as if formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L. 108-173.

is excluded or suspended from a Federal or State health care program.

(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.

(G) In the case of an exclusion of an individual under subsection (a) based on a conviction occurring on or after the date of the enactment of this subparagraph, if the individual has (before, on, or after such date) been convicted—

(i) on one previous occasion of one or more offenses for which an exclusion may be effected under such subsection, the period of the exclusion shall be not less than 10 years, or

(ii) on 2 or more previous occasions of one or more offenses for which an exclusion may be effected under such subsection, the period of the exclusion shall be permanent.

(d) NOTICE TO STATE AGENCIES AND EXCLUSION UNDER STATE HEALTH CARE PROGRAMS.—(1) Subject to paragraph (3), the Secretary shall exercise the authority under this section and section 1128A in a manner that results in an individual's or entity's exclusion from all the programs under title XVIII and all the State health care programs in which the individual or entity may otherwise participate.

(2) The Secretary shall promptly notify each appropriate State agency administering or supervising the administration of each State health care program (and, in the case of an exclusion effected pursuant to subsection (a) and to which section 304(a)(5) of the Controlled Substances Act[43] may apply, the Attorney General)—

(A) of the fact and circumstances of each exclusion effected against an individual or entity under this section or section 1128A, and

(B) of the period (described in paragraph (3)) for which the State agency is directed to exclude the individual or entity from participation in the State health care program.

(3)(A) Except as provided in subparagraph (B), the period of the exclusion under a State health care program under paragraph (2) shall be the same as any period of exclusion under title XVIII.

(B)(i) The Secretary may waive an individual's or entity's exclusion under a State health care program under paragraph (2) if the Secretary receives and approves a request for the waiver with respect to the individual or entity from the State agency administering or supervising the administration of the program.

(ii) A State health care program may provide for a period of exclusion which is longer than the period of exclusion under title XVIII.

(e) NOTICE TO STATE LICENSING AGENCIES.—The Secretary shall—

(1) promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of an individual or entity excluded (or directed to be excluded)

[43] See Vol. II, P.L. 91–513.

from participation under this section or section 1128A, of the fact and circumstances of the exclusion,

(2) request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and

(3) request that the State or local agency or authority keep the Secretary and the Inspector General of the Department of Health and Human Services fully and currently informed with respect to any actions taken in response to the request.

(f) NOTICE, HEARING, AND JUDICIAL REVIEW.—(1) Subject to paragraph (2), any individual or entity that is excluded (or directed to be excluded) from participation under this section is entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g), except that, in so applying such sections and section 205(l), any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

(2) Unless the Secretary determines that the health or safety of individuals receiving services warrants the exclusion taking effect earlier, any individual or entity that is the subject of an adverse determination under subsection (b)(7) shall be entitled to a hearing by an administrative law judge (as provided under section 205(b)) on the determination under subsection (b)(7) before any exclusion based upon the determination takes effect.

(3) The provisions of section 205(h) shall apply with respect to this section and sections 1128A, 1129, and 1156 to the same extent as it is applicable with respect to title II, except that, in so applying such section and section 205(l), any reference therein to the Commissioner of Social Security shall be considered a reference to the Secretary.

(g) APPLICATION FOR TERMINATION OF EXCLUSION.—(1) An individual or entity excluded (or directed to be excluded) from participation under this section or section 1128A may apply to the Secretary, in the manner specified by the Secretary in regulations and at the end of the minimum period of exclusion provided under subsection (c)(3) and at such other times as the Secretary may provide, for termination of the exclusion effected under this section or section 1128A.

(2) The Secretary may terminate the exclusion if the Secretary determines, on the basis of the conduct of the applicant which occurred after the date of the notice of exclusion or which was unknown to the Secretary at the time of the exclusion, that—

(A) there is no basis under subsection (a) or (b) or section 1128A(a) for a continuation of the exclusion, and

(B) there are reasonable assurances that the types of actions which formed the basis for the original exclusion have not recurred and will not recur.

(3) The Secretary shall promptly notify each appropriate State agency administering or supervising the administration of each State health care program (and, in the case of an exclusion effected pursuant to subsection (a) and to which section

304(a)(5) of the Controlled Substances Act[44] may apply, the Attorney General) of the fact and circumstances of each termination of exclusion made under this subsection.

(h) DEFINITION OF STATE HEALTH CARE PROGRAM.—For purposes of this section and sections 1128A and 1128B, the term "State health care program" means—

(1) a State plan approved under title XIX,

(2) any program receiving funds under title V or from an allotment to a State under such title,

(3) any program receiving funds under title XX or from an allotment to a State under such title, or

(4) a State child health plan approved under title XXI.

(i) CONVICTED DEFINED.—For purposes of subsections (a) and (b), an individual or entity is considered to have been "convicted" of a criminal offense—

(1) when a judgment of conviction has been entered against the individual or entity by a Federal, State, or local court, regardless of whether there is an appeal pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged;

(2) when there has been a finding of guilt against the individual or entity by a Federal, State, or local court;

(3) when a plea of guilty or nolo contendere by the individual or entity has been accepted by a Federal, State, or local court; or

(4) when the individual or entity has entered into participation in a first offender, deferred adjudication, or other arrangement or program where judgment of conviction has been withheld.

(j) DEFINITION OF IMMEDIATE FAMILY MEMBER AND MEMBER OF HOUSEHOLD.—For purposes of subsection (b)(8)(A)(iii):

(1) The term "immediate family member" means, with respect to a person—

(A) the husband or wife of the person;

(B) the natural or adoptive parent, child, or sibling of the person;

(C) the stepparent, stepchild, stepbrother, or stepsister of the person;

(D) the father–, mother–, daughter–, son–, brother–, or sister–in–law of the person;

(E) the grandparent or grandchild of the person; and

(F) the spouse of a grandparent or grandchild of the person.

(2) The term "member of the household" means, with respect to any person, any individual sharing a common abode as part of a single family unit with the person, including domestic employees and others who live together as a family unit, but not including a roomer or boarder.

CIVIL MONETARY PENALTIES

SEC. 1128A. [42 U.S.C. 1320a–7a] (a) Any person (including an organization, agency, or other entity, but excluding a beneficiary, as defined in subsection (i)(5)) that—

[44] See Vol. II, P.L. 91–513.

(1) knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (i)(1)), a claim (as defined in subsection (i)(2)) that the Secretary determines—

(A) is for a medical or other item or service that the person knows or should know was not provided as claimed, including any person who engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided,

(B) is for a medical or other item or service and the person knows or should know the claim is false or fraudulent,

(C) is presented for a physician's service (or an item or service incident to a physician's service) by a person who knows or should know that the individual who furnished (or supervised the furnishing of) the service—

(i) was not licensed as a physician,

(ii) was licensed as a physician, but such license had been obtained through a misrepresentation of material fact (including cheating on an examination required for licensing), or

(iii) represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board when the individual was not so certified,

(D) is for a medical or other item or service furnished during a period in which the person was excluded from the program under which the claim was made pursuant to a determination by the Secretary under this section or under section 1128, 1156, 1160(b) (as in effect on September 2, 1982), 1862(d) (as in effect on the date of the enactment of the Medicare and Medicaid Patient and Program Protection Act of 1987[45]), or 1866(b) or as a result of the application of the provisions of section 1842(j)(2), or

(E) is for a pattern of medical or other items or services that a person knows or should know are not medically necessary;

(2) knowingly presents or causes to be presented to any person a request for payment which is in violation of the terms of (A) an assignment under section 1842(b)(3)(B)(ii), or (B) an agreement with a State agency (or other requirement of a State plan under title XIX) not to charge a person for an item or service in excess of the amount permitted to be charged, or (C) an agreement to be a participating physician or supplier under section 1842(h)(1), or (D) an agreement pursuant to section 1866(a)(1)(G);

(3) knowingly gives or causes to be given to any person, with respect to coverage under title XVIII of inpatient hospital services subject to the provisions of section 1886, information that he knows or should know is false or misleading, and that could

[45] August 18, 1987 [P.L. 100–93].

reasonably be expected to influence the decision when to discharge such person or another individual from the hospital;

(4) in the case of a person who is not an organization, agency, or other entity, is excluded from participating in a program under title XVIII or a State health care program in accordance with this subsection or under section 1128 and who, at the time of a violation of this subsection—

(A) retains a direct or indirect ownership or control interest in an entity that is participating in a program under title XVIII or a State health care program, and who knows or should know of the action constituting the basis for the exclusion; or

(B) is an officer or managing employee (as defined in section 1126(b)) of such an entity;

(5) offers to or transfers remuneration to any individual eligible for benefits under title XVIII of this Act, or under a State health care program (as defined in section 1128(h)) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under title XVIII, or a State health care program (as so defined);

(6) arranges or contracts (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from participation in a Federal health care program (as defined in section 1128B(f)), for the provision of items or services for which payment may be made under such a program; or

(7) commits an act described in paragraph (1) or (2) of section 1128B(b)

shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $10,000 for each item or service (or, in cases under paragraph (3), $15,000 for each individual with respect to whom false or misleading information was given; in cases under paragraph (4), $10,000 for each day the prohibited relationship occurs; or in cases under paragraph (7), $50,000 for each such act). In addition, such a person shall be subject to an assessment of not more than 3 times the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim (or, in cases under paragraph (7), damages of not more than 3 times the total amount of remuneration offered, paid, solicited, or received, without regard to whether a portion of such remuneration was offered, paid, solicited, or received for a lawful purpose). In addition the Secretary may make a determination in the same proceeding to exclude the person from participation in the Federal health care programs (as defined in section 1128B(f)(1))and to direct the appropriate State agency to exclude the person from participation in any State health care program.

(b)(1) If a hospital or a critical access hospital knowingly makes a payment, directly or indirectly, to a physician as an inducement to reduce or limit services provided with respect to individuals who—

(A) are entitled to benefits under part A or part B of title XVIII or to medical assistance under a State plan approved under title XIX, and

(B) are under the direct care of the physician,

the hospital or a critical access hospital shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $2,000 for each such individual with respect to whom the payment is made.

(2) Any physician who knowingly accepts receipt of a payment described in paragraph (1) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $2,000 for each individual described in such paragraph with respect to whom the payment is made.

(3)(A) Any physician who executes a document described in subparagraph (B) with respect to an individual knowing that all of the requirements referred to in such subparagraph are not met with respect to the individual shall be subject to a civil monetary penalty of not more than the greater of—

(i) $5,000, or

(ii) three times the amount of the payments under title XVIII for home health services which are made pursuant to such certification.

(B) A document described in this subparagraph is any document that certifies, for purposes of title XVIII, that an individual meets the requirements of section 1814(a)(2)(C) or 1835(a)(2)(A) in the case of home health services furnished to the individual.

(c)(1) The Secretary may initiate a proceeding to determine whether to impose a civil money penalty, assessment, or exclusion under subsection (a) or (b) only as authorized by the Attorney General pursuant to procedures agreed upon by them. The Secretary may not initiate an action under this section with respect to any claim, request for payment, or other occurrence described in this section later than six years after the date the claim was presented, the request for payment was made, or the occurrence took place. The Secretary may initiate an action under this section by serving notice of the action in any manner authorized by Rule 4 of the Federal Rules of Civil Procedure[46].

(2) The Secretary shall not make a determination adverse to any person under subsection (a) or (b) until the person has been given written notice and an opportunity for the determination to be made on the record after a hearing at which the person is entitled to be represented by counsel, to present witnesses, and to cross-examine witnesses against the person.

(3) In a proceeding under subsection (a) or (b) which—

(A) is against a person who has been convicted (whether upon a verdict after trial or upon a plea of guilty or nolo contendere) of a Federal crime charging fraud or false statements, and

(B) involves the same transaction as in the criminal action,

the person is estopped from denying the essential elements of the criminal offense.

(4) The official conducting a hearing under this section may sanction a person, including any party or attorney, for failing to comply with an order or procedure, failing to defend an ac-

[46] See Vol. II, Rules of Civil Procedure.

tion, or other misconduct as would interfere with the speedy, orderly, or fair conduct of the hearing. Such sanction shall reasonably relate to the severity and nature of the failure or misconduct. Such sanction may include—

(A) in the case of refusal to provide or permit discovery, drawing negative factual inferences or treating such refusal as an admission by deeming the matter, or certain facts, to be established,

(B) prohibiting a party from introducing certain evidence or otherwise supporting a particular claim or defense,

(C) striking pleadings, in whole or in part,

(D) staying the proceedings,

(E) dismissal of the action,

(F) entering a default judgment,

(G) ordering the party or attorney to pay attorneys' fees and other costs caused by the failure or misconduct, and

(H) refusing to consider any motion or other action which is not filed in a timely manner.

(d) In determining the amount or scope of any penalty, assessment, or exclusion imposed pursuant to subsection (a) or (b), the Secretary shall take into account—

(1) the nature of claims and the circumstances under which they were presented,

(2) the degree of culpability, history of prior offenses, and financial condition of the person presenting the claims, and

(3) such other matters as justice may require.

(e) Any person adversely affected by a determination of the Secretary under this section may obtain a review of such determination in the United States Court of Appeals for the circuit in which the person resides, or in which the claim was presented, by filing in such court (within sixty days following the date the person is notified of the Secretary's determination) a written petition requesting that the determination be modified or set aside. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary, and thereupon the Secretary shall file in the Court the record in the proceeding as provided in section 2112 of title 28, United States Code[47]. Upon such filing, the court shall have jurisdiction of the proceeding and of the question determined therein, and shall have the power to make and enter upon the pleadings, testimony, and proceedings set forth in such record a decree affirming, modifying, remanding for further consideration, or setting aside, in whole or in part, the determination of the Secretary and enforcing the same to the extent that such order is affirmed or modified. No objection that has not been urged before the Secretary shall be considered by the court, unless the failure or neglect to urge such objection shall be excused because of extraordinary circumstances. The findings of the Secretary with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, shall be conclusive. If any party shall apply to the court for leave to adduce additional evidence and shall show to the satisfaction of the court that such additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the hearing before the Secretary, the court may order such additional evidence to be taken before the Secretary and

[47] See Vol. II, Title 28.

to be made a part of the record. The Secretary may modify his findings as to the facts, or make new findings, by reason of additional evidence so taken and filed, and he shall file with the court such modified or new findings, which findings with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, shall be conclusive, and his recommendations, if any, for the modification or setting aside of his original order. Upon the filing of the record with it, the jurisdiction of the court shall be exclusive and its judgment and decree shall be final, except that the same shall be subject to review by the Supreme Court of the United States, as provided in section 1254 of title 28, United States Code[48].

(f) Civil money penalties and assessments imposed under this section may be compromised by the Secretary and may be recovered in a civil action in the name of the United States brought in United States district court for the district where the claim was presented, or where the claimant resides, as determined by the Secretary. Amounts recovered under this section shall be paid to the Secretary and disposed of as follows:

(1)(A) In the case of amounts recovered arising out of a claim under title XIX, there shall be paid to the State agency an amount bearing the same proportion to the total amount recovered as the State's share of the amount paid by the State agency for such claim bears to the total amount paid for such claim.

(B) In the case of amounts recovered arising out of a claim under an allotment to a State under title V, there shall be paid to the State agency an amount equal to three-sevenths of the amount recovered.

(2) Such portion of the amounts recovered as is determined to have been paid out of the trust funds under sections 1817 and 1841 shall be repaid to such trust funds.

(3) With respect to amounts recovered arising out of a claim under a Federal health care program (as defined in section 1128B(f)), the portion of such amounts as is determined to have been paid by the program shall be repaid to the program, and the portion of such amounts attributable to the amounts recovered under this section by reason of the amendments made by the Health Insurance Portability and Accountability Act of 1996 (as estimated by the Secretary) shall be deposited into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C).

(4)The remainder of the amounts recovered shall be deposited as miscellaneous receipts of the Treasury of the United States.

The amount of such penalty or assessment, when finally determined, or the amount agreed upon in compromise, may be deducted from any sum then or later owing by the United States or a State agency to the person against whom the penalty or assessment has been assessed.

(g) A determination by the Secretary to impose a penalty, assessment, or exclusion under subsection (a) or (b) shall be final upon the expiration of the sixty-day period referred to in subsection (e). Matters that were raised or that could have been raised in a hearing before the Secretary or in an appeal pursuant to subsection (e)

[48] See Vol. II, Title 28.

may not be raised as a defense to a civil action by the United States to collect a penalty, assessment, or exclusion assessed under this section.

(h) Whenever the Secretary's determination to impose a penalty, assessment, or exclusion under subsection (a) or (b) becomes final, he shall notify the appropriate State or local medical or professional organization, the appropriate State agency or agencies administering or supervising the administration of State health care programs (as defined in section 1128(h)), and the appropriate utilization and quality control peer review organization, and the appropriate State or local licensing agency or organization (including the agency specified in section 1864(a) and 1902(a)(33)) that such a penalty, assessment, or exclusion has become final and the reasons therefor.

(i) For the purposes of this section:

(1) The term "State agency" means the agency established or designated to administer or supervise the administration of the State plan under title XIX of this Act or designated to administer the State's program under title V or title XX of this Act.

(2) The term "claim" means an application for payments for items and services under a Federal health care program (as defined in section 1128B(f)).

(3) The term "item or service" includes (A) any particular item, device, medical supply, or service claimed to have been provided to a patient and listed in an itemized claim for payment, and (B) in the case of a claim based on costs, any entry in the cost report, books of account or other documents supporting such claim.

(4) The term "agency of the United States" includes any contractor acting as a fiscal intermediary, carrier, or fiscal agent or any other claims processing agent for a Federal health care program (as so defined).

(5) The term "beneficiary" means an individual who is eligible to receive items or services for which payment may be made under a Federal health care program (as so defined) but does not include a provider, supplier, or practitioner.

(6) The term "remuneration" includes the waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for free or for other than fair market value. The term "remuneration" does not include—

(A) the waiver of coinsurance and deductible amounts by a person, if—

(i) the waiver is not offered as part of any advertisement or solicitation;

(ii) the person does not routinely waive coinsurance or deductible amounts; and

(iii) the person—

(I) waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need; or

(II) fails to collect coinsurance or deductible amounts after making reasonable collection efforts;

(B) subject to subsection (n), any permissible practice described in any subparagraph of section 1128B(b)(3) or in regulations issued by the Secretary;

(C) differentials in coinsurance and deductible amounts as part of a benefit plan design as long as the differentials have been disclosed in writing to all beneficiaries, third party payers, and providers, to whom claims are presented and as long as the differentials meet the standards as defined in regulations promulgated by the Secretary not later than 180 days after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996[49];

(D) incentives given to individuals to promote the delivery of preventive case as determined by the Secretary in regulations so promulgated; or

(D)[50] a reduction in the copayment amount for covered OPD services under section 1833(t)(5)(B).

(7) The term "should know" means that a person, with respect to information—

(A) acts in deliberate ignorance of the truth or falsity of the information; or

(B) acts in reckless disregard of the truth or falsity of the information,

and no proof of specific intent to defraud is required.

(j)(1) The provisions of subsections (d) and (e) of section 205 shall apply with respect to this section to the same extent as they are applicable with respect to title II. The Secretary may delegate the authority granted by section 205(d) (as made applicable to this section) to the Inspector General of the Department of Health and Human Services for purposes of any investigation under this section.

(2) The Secretary may delegate authority granted under this section and under section 1128 to the Inspector General of the Department of Health and Human Services.

(k) Whenever the Secretary has reason to believe that any person has engaged, is engaging, or is about to engage in any activity which makes the person subject to a civil monetary penalty under this section, the Secretary may bring an action in an appropriate district court of the United States (or, if applicable, a United States court of any territory) to enjoin such activity, or to enjoin the person from concealing, removing, encumbering, or disposing of assets which may be required in order to pay a civil monetary penalty if any such penalty were to be imposed or to seek other appropriate relief.

(l) A principal is liable for penalties, assessments, and an exclusion under this section for the actions of the principal's agent acting within the scope of the agency.

(m)(1) For purposes of this section, with respect to a Federal health care program not contained in this Act, references to the Secretary in this section shall be deemed to be references to the Secretary or Administrator of the department or agency with jurisdiction over such program and references to the Inspector General of the Department of Health and Human Services in this section shall be deemed to be references to the Inspector General of the applicable department or agency.

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[49] August 21, 1996 is the date of enactment of P.L. 104-191.

[50] As in original. P.L. 105–33, §4523(c)(3), added this subparagraph (D), effective August 5, 1997.

(2)(A) The Secretary and Administrator of the departments and agencies referred to in paragraph (1) may include in any action pursuant to this section, claims within the jurisdiction of other Federal departments or agencies as long as the following conditions are satisfied:

(i) The case involves primarily claims submitted to the Federal health care programs of the department or agency initiating the action.

(ii) The Secretary or Administrator of the department or agency initiating the action gives notice and an opportunity to participate in the investigation to the Inspector General of the department or agency with primary jurisdiction over the Federal health care programs to which the claims were submitted.

(B) If conditions specified in subparagraph (A) are fulfilled, the Inspector General of the department or agency initiating the action is authorized to exercise all powers granted under the Inspector General Act of 1978 (5 U.S.C. App.) with respect to the claims submitted to the other departments or agencies to the same manner and extent as provided in that Act with respect to claims submitted to such departments or agencies.

(n)(1) Subparagraph (B) of subsection (i)(6) shall not apply to a practice described in paragraph (2) unless—

(A) the Secretary, through the Inspector General of the Department of Health and Human Services, promulgates a rule authorizing such a practice as an exception to remuneration; and

(B) the remuneration is offered or transferred by a person under such rule during the 2–year period beginning on the date the rule is first promulgated.

(2) A practice described in this paragraph is a practice under which a health care provider or facility pays, in whole or in part, premiums for medicare supplemental policies for individuals entitled to benefits under part A of title XVIII pursuant to section 226A.

CRIMINAL PENALTIES FOR ACTS INVOLVING FEDERAL HEALTH CARE PROGRAMS[51]

SEC. 1128B. [42 U.S.C. 1320a–7b] (a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program (as defined in subsection (f)),

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or

[51] See Vol. II, 18 U.S.C. 1028, with respect to penalties relating to use of identification documents.

quantity than is due or when no such benefit or payment is authorized,

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

(5) presents or causes to be presented a claim for a physician's service for which payment may be made under a Federal health care program and knows that the individual who furnished the service was not licensed as a physician, or

(6) for a fee knowingly and willfully counsels or assists an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under a State plan under title XIX, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1917(c),

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under the program, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, conversion, or provision of counsel or assistance by any other person be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a Federal health care program is convicted of an offense under the preceding provisions of this subsection, the administrator of such program may at its option (notwithstanding any other provision of such program) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under Federal health care program,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or

indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to—

(A) a discount or other reduction in price obtained by a provider of services or other entity under title XVIII or a State health care program if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under title XVIII or a State health care program;

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services;

(C) any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services reimbursed under title XVIII or a State health care program if—

(i) the person has a written contract, with each such individual or entity, which specifies the amount to be paid the person, which amount may be a fixed amount or a fixed percentage of the value of the purchases made by each such individual or entity under the contract, and

(ii) in the case of an entity that is a provider of services (as defined in section 1861(u)), the person discloses (in such form and manner as the Secretary requires) to the entity and, upon request, to the Secretary the amount received from each such vendor with respect to purchases made by or on behalf of the entity;

(D) a waiver of any coinsurance under part B of title XVIII by a Federally qualified health care center with respect to an individual who qualifies for subsidized services under a provision of the Public Health Service Act [52];

(E) any payment practice specified by the Secretary in regulations promulgated pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection

[52] P.L. 78–410.

Act of 1987[53] or in regulations under section 1860D-3(a)(6)[54];[55]

(F) any remuneration between an organization and an individual or entity providing items or services, or a combination thereof, pursuant to a written agreement between the organization and the individual or entity if the organization is an eligible organization under section 1876 or if the written agreement, through a risk–sharing arrangement, places the individual or entity at substantial financial risk for the cost or utilization of the items or services, or a combination thereof, which the individual or entity is obligated to provide;[56]

(G)[57] the waiver or reduction by pharmacies (including pharmacies of the Indian Health Service, Indian tribes, tribal organizations, and urban Indian organizations) of any cost- sharing imposed under part D of title XVIII, if the conditions described in clauses (i) through (iii) of section 1128A(i)(6)(A) are met with respect to the waiver or reduction (except that, in the case of such a waiver or reduction on behalf of a subsidy eligible individual (as defined in section 1860D-14(a)(3)), section 1128A(i)(6)(A) shall be applied without regard to clauses (ii) and (iii) of that section); and[58]

(H)[59] any remuneration between a health center entity described under clause (i) or (ii) of section 1905(l)(2)(B) and any individual or entity providing goods, items, services, donations, loans, or a combination thereof, to such health center entity pursuant to a contract, lease, grant, loan, or other agreement, if such agreement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center entity.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution, facility, or entity in order that such institution, facility, or entity may qualify (either upon initial certification or upon recertification) as a hospital, critical access hospital, skilled nursing facility, nursing facility, intermediate care facility for the mentally retarded, or other entity (including an eligible organization under section 1876(b)) for which certification is required under title XVIII or a State health care program (as defined in section 1128(h)), or with respect to information required to be

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[53] P.L. 100–93.

[54] P.L. 108-173, §101(e)(8)(A), inserted "or in regulations under section 1860D-3(e)(6)", effective December 8, 2003. Executed as if §1128B(b)(3)(E) was intended rather than §1128B(b)(3)(C).

[55] P.L. 108-173, §101(e)(2)(A), struck out "and".

[56] P.L. 108-173, §101(e)(2)(B), struck out the period and substituted "; and"; §431(a)(1), struck out "and".

[57] P.L. 108-173, §101(e)(2)(C), added subparagraph (G), effective December 8, 2003.

[58] P.L. 108-173, §431(a)(2), struck out the period and substituted "; and ".

[59] P.L. 108-173, §431(a)(3), added subparagraph (H), effective December 8, 2003.

See Vol. II, P.L. 108-173, §431(b), with respect to rulemaking for exception for health center entity arrangements.

P.L. 108-173, 237(d), amends (b)(3); in several places, adding a new subparagraph (H), to be applicable to services provided on or after January 1, 2006, and contract years beginning on and after January 1, 2006.

[60] P.L. 108-173, §949, struck out the first sentence of subparagraph (B), and substituted this sentence, effective December 8, 2003.

provided under section 1124A, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully—

(1) charges, for any service provided to a patient under a State plan approved under title XIX, money or other consideration at a rate in excess of the rates established by the State, (or, in the case of services provided to an individual enrolled with a medicaid managed care organization under title XIX under a contract under section 1903(m) or under a contractual, referral, or other arrangement under such contract, at a rate in excess of the rate permitted under such contract), or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under title XIX, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)—

(A) as a precondition of admitting a patient to a hospital, nursing facility, or intermediate care facility for the mentally retarded, or

(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(e) Whoever accepts assignments described in section 1842(b)(3)(B)(ii) or agrees to be a participating physician or supplier under section 1842(h)(1) and knowingly, willfully, and repeatedly violates the term of such assignments or agreement, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $2,000 or imprisoned for not more than six months, or both.

(f) For purposes of this section, the term "Federal health care program" means—

(1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the health insurance program under chapter 89 of title 5, United States Code); or

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

FRAUD AND ABUSE CONTROL PROGRAM

SEC. 1128C. [42 U.S.C. 1320a–7c] (a) ESTABLISHMENT OF PROGRAM.—

(1) IN GENERAL.—Not later than January 1, 1997, the Secretary, acting through the Office of the Inspector General of the Department of Health and Human Services, and the Attorney General shall establish a program—

(A) to coordinate Federal, State, and local law enforcement programs to control fraud and abuse with respect to health plans,

(B) to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States,

(C) to facilitate the enforcement of the provisions of sections 1128, 1128A, and 1128B and other statutes applicable to health care fraud and abuse,

(D) to provide for the modification and establishment of safe harbors and to issue advisory opinions and special fraud alerts pursuant to section 1128D, and

(E) to provide for the reporting and disclosure of certain final adverse actions against health care providers, suppliers, or practitioners pursuant to the data collection system established under section 1128E.

(2) COORDINATION WITH HEALTH PLANS.—In carrying out the program established under paragraph (1), the Secretary and the Attorney General shall consult with, and arrange for the sharing of data with representatives of health plans.

(3) GUIDELINES.—

(A) IN GENERAL.—The Secretary and the Attorney General shall issue guidelines to carry out the program under paragraph (1). The provisions of sections 553, 556, and 557 of title 5, United States Code, shall not apply in the issuance of such guidelines.

(B) INFORMATION GUIDELINES.—

(i) IN GENERAL.—Such guidelines shall include guidelines relating to the furnishing of information by health plans, providers, and others to enable the Secretary and the Attorney General to carry out the program (including coordination with health plans under paragraph (2)).

(ii) CONFIDENTIALITY.—Such guidelines shall include procedures to assure that such information is provided and utilized in a manner that appropriately protects the confidentiality of the information and the privacy of individuals receiving health care services and items.

(iii) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) (relating to limitation on liability) shall apply to a person providing information to the Secretary or the Attorney General in conjunction with their performance of duties under this section.

(4) ENSURING ACCESS TO DOCUMENTATION.—The Inspector General of the Department of Health and Human Services is authorized to exercise such authority described in paragraphs (3) through (9) of section 6 of the Inspector General Act of 1978 (5 U.S.C. App.) as necessary with respect to the activities under the fraud and abuse control program established under this subsection.

(5) AUTHORITY OF INSPECTOR GENERAL.—Nothing in this Act shall be construed to diminish the authority of any Inspector General, including such authority as provided in the Inspector General Act of 1978 (5 U.S.C. App.).

(b) ADDITIONAL USE OF FUNDS BY INSPECTOR GENERAL.—

(1) REIMBURSEMENTS FOR INVESTIGATIONS.—The Inspector General of the Department of Health and Human Services is authorized to receive and retain for current use reimbursement

for the costs of conducting investigations and audits and for monitoring compliance plans when such costs are ordered by a court, voluntarily agreed to be the payor, or otherwise.

(2) CREDITING.—Funds received by the Inspector General under paragraph (1) as reimbursement for costs of conducting investigations shall be deposited to the credit of the appropriation from which initially paid, or to appropriations for similar purposes currently available at the time of deposit, and shall remain available for obligation for 1 year from the date of the deposit of such funds.

(c) HEALTH PLAN DEFINED.—For purposes of this section, the term "health plan" means a plan or program that provides health benefits, whether directly, through insurance, or otherwise, and includes—

(1) a policy of health insurance;

(2) a contract of a service benefit organization; and

(3) a membership agreement with a health maintenance organization or other prepaid health plan.

GUIDANCE REGARDING APPLICATION OF HEALTH CARE FRAUD AND ABUSE SANCTIONS

SEC. 1128D. [42 U.S.C. 1320a–7d] (a) SOLICITATION OF PUBLICATION OF MODIFICATIONS TO EXISTING SAFE HARBORS AND NEW SAFE HARBORS.—

(1) IN GENERAL.—

(A) SOLICITATION OF PROPOSALS FOR SAFE HARBORS.—Not later than January 1, 1997, and not less than annually thereafter, the Secretary shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60–day period, for—

(i) modifications to existing safe harbors issued pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987 (42 U.S.C. 1320a–7b note);

(ii) additional safe harbors specifying payment practices that shall not be treated as a criminal offense under section 1128B(b) and shall not serve as the basis for an exclusion under section 1128(b)(7);

(iii) advisory opinions to be issued pursuant to subsection (b);and

(iv) special fraud alerts to be issued pursuant to subsection (c).

(B) PUBLICATION OF PROPOSED MODIFICATIONS AND PROPOSED ADDITIONAL SAFE HARBORS.—After considering the proposals described in clauses (i) and (ii) of subparagraph (A), the Secretary, in consultation with the Attorney General, shall publish in the Federal Register proposed modifications to existing safe harbors and proposed additional safe harbors, if appropriate, with a 60–day comment period. After considering any public comments received during this period, the Secretary shall issue final rules modifying the existing safe harbors and establishing new safe harbors, as appropriate.

(C) REPORT.—The Inspector General of the Department of Health and Human Services (in this section referred to as the "Inspector General") shall, in an annual report to

Congress or as part of the year–end semiannual report required by section 5 of the Inspector General Act of 1978 (5 U.S.C. App.), describe the proposals received under clauses (i) and (ii) of subparagraph (A) and explain which proposals were included in the publication described in subparagraph (B), which proposals were not included in that publication, and the reasons for the rejection of the proposals that were not included.

(2) CRITERIA FOR MODIFYING AND ESTABLISHING SAFE HARBORS.—In modifying and establishing safe harbors under paragraph (1)(B), the Secretary may consider the extent to which providing a safe harbor for the specified payment practice may result in any of the following:

(A) An increase or decrease in access to health care services.

(B) An increase or decrease in the quality of health care services.

(C) An increase or decrease in patient freedom of choice among health care providers.

(D) An increase or decrease in competition among health care providers.

(E) An increase or decrease in the ability of health care facilities to provide services in medically underserved areas or to medically underserved populations.

(F) An increase or decrease in the cost to Federal health care programs (as defined in section 1128B(f)).

(G) An increase or decrease in the potential overutilization of health care services.

(H) The existence or nonexistence of any potential financial benefit to a health care professional or provider which may vary based on their decisions of—

(i) whether to order a health care item or service; or

(ii) whether to arrange for a referral of health care items or services to a particular practitioner or provider.

(I) Any other factors the Secretary deems appropriate in the interest of preventing fraud and abuse in Federal health care programs (as so defined).

(b) ADVISORY OPINIONS.—

(1) ISSUANCE OF ADVISORY OPINIONS.—The Secretary, in consultation with the Attorney General, shall issue written advisory opinions as provided in this subsection.

(2) MATTERS SUBJECT TO ADVISORY OPINIONS.—The Secretary shall issue advisory opinions as to the following matters:

(A) What constitutes prohibited remuneration within the meaning of section 1128B(b) or section 1128A(i)(6).

(B) Whether an arrangement or proposed arrangement satisfies the criteria set forth in section 1129B(b)(3) for activities which do not result in prohibited remuneration.

(C) Whether an arrangement or proposed arrangement satisfies the criteria which the Secretary has established, or shall establish by regulation for activities which do not result in prohibited remuneration.

(D) What constitutes an inducement to reduce or limit services to individuals entitled to benefits under title XVIII or title XIX within the meaning of section 1128A(b).

(E) Whether any activity or proposed activity constitutes grounds for the imposition of a sanction under section 1128, 1128A, or 1128B.

(3) MATTERS NOT SUBJECT TO ADVISORY OPINIONS.—Such advisory opinions shall not address the following matters:

(A) Whether the fair market value shall be, or was paid or received for any goods, services or property.

(B) Whether an individual is a bona fide employee within the requirements of section 3121(d)(2) of the Internal Revenue Code of 1986[60].

(4) EFFECT OF ADVISORY OPINIONS.—

(A) BINDING AS TO SECRETARY AND PARTIES INVOLVED.—Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

(B) FAILURE TO SEEK OPINION.—The failure of a party to seek an advisory opinion may not be introduced into evidence to prove that the party intended to violate the provisions of sections 1128, 1128A, or 1128B.

(5) REGULATIONS.—

(A) IN GENERAL.—Not later than 180 days after the date of the enactment of this section, the Secretary shall issue regulations to carry out this section. Such regulations shall provide for—

(i) the procedure to be followed by a party applying for an advisory opinion;

(ii) the procedure to be followed by the Secretary in responding to a request for an advisory opinion;

(iii) the interval in which the Secretary shall respond;

(iv) the reasonable fee to be charged to the party requesting an advisory opinion; and

(v) the manner in which advisory opinions will be made available to the public.

(B) SPECIFIC CONTENTS.—Under the regulations promulgated pursuant to subparagraph (A)—

(i) the Secretary shall be required to issue to a party requesting an advisory opinion by not later than 60 days after the request is received; and

(ii) the fee charged to the party requesting an advisory opinion shall be equal to the costs incurred by the Secretary in responding to the request.

(6) APPLICATION OF SUBSECTION.—This subsection shall apply to requests for advisory opinions made on or after the date which is 6 months after the date of enactment[61] of this section.

(c) SPECIAL FRAUD ALERTS.—

(1) IN GENERAL.—

(A) REQUEST FOR SPECIAL FRAUD ALERTS.—Any person may present, at any time, a request to the Inspector General for a notice which informs the public of practices which the Inspector General considers to be suspect or of particular concern under the Medicare program under title

[61] See P.L. 83-591, §3121 (this volume).
[62] August 21, 1996 [P.L. 104–191, §205].

XVIII or a State health care program, as defined in section 1128(h) (in this subsection referred to as a "special fraud alert").

(B) ISSUANCE AND PUBLICATION OF SPECIAL FRAUD ALERTS.—Upon receipt of a request described in subparagraph (A), the Inspector General shall investigate the subject matter of the request to determine whether a special fraud alert should be issued. If appropriate, the Inspector General shall issue a special fraud alert in response to the request. All special fraud alerts issued pursuant to this subparagraph shall be published in the Federal Register.

(2) CRITERIA FOR SPECIAL FRAUD ALERTS.—In determining whether to issue a special fraud alert upon a request described in paragraph (1), the Inspector General may consider—

(A) whether and to what extent the practices that would be identified in the special fraud alert may result in any of the consequences described in subsection (a)(2); and

(B) the volume and frequency of the conduct that would be identified in the special fraud alert.

HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM

SEC. 1128E. [42 U.S.C. 1320a–7e] (a) GENERAL PURPOSE.—Not later than January 1, 1997, the Secretary shall establish a national health care fraud and abuse data collection program for the reporting of final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b), with access as set forth in subsection (c), and shall maintain a database of the information collected under this section.

(b) REPORTING OF INFORMATION.—

(1) IN GENERAL.—Each Government agency and health plan shall report any final adverse action (not including settlements in which no findings of liability have been made) taken against a health care provider, supplier, or practitioner.

(2) INFORMATION TO BE REPORTED.—The information to be reported under paragraph (1) includes:

(A) The name and TIN (as defined in section 7701(a)(41) of the Internal Revenue Code of 1986) of any health care provider, supplier, or practitioner who is the subject of a final adverse action.

(B) The name (if known) of any health care entity with which a health care provider, supplier, or practitioner, who is the subject of a final adverse action, is affiliated or associated.

(C) The nature of the final adverse action and whether such action is on appeal.

(D) A description of the acts or omissions and injuries upon which the final adverse action was based, and such other information as the Secretary determines by regulation is required for appropriate interpretation of information reported under this section.

(3) CONFIDENTIALITY.—In determining what information is required, the Secretary shall include procedures to assure that the privacy of individuals receiving health care services is appropriately protected.

(4) TIMING AND FORM OF REPORTING.—The information required to be reported under this subsection shall be reported regularly (but not less often than monthly) and in such form and manner as the Secretary prescribes. Such information shall first be required to be reported on a date specified by the Secretary.

(5) TO WHOM REPORTED.—The information required to be reported under this subsection shall be reported to the Secretary.

(6) SANCTIONS FOR FAILURE TO REPORT.—

(A) HEALTH PLANS.—Any health plan that fails to report information on an adverse action required to be reported under this subsection shall be subject to a civil money penalty of not more than $25,000 for each such adverse action not reported. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

(B) GOVERNMENTAL AGENCIES.—The Secretary shall provide for a publication of a public report that identifies those Government agencies that have failed to report information on adverse actions as required to be reported under this subsection.

(c) DISCLOSURE AND CORRECTION OF INFORMATION.—

(1) DISCLOSURE.—With respect to the information about final adverse actions (not including settlements in which no findings of liability have been made) reported to the Secretary under this section with respect to a health care provider, supplier, or practitioner, the Secretary shall, by regulation, provide for—

(A) disclosure of the information, upon request, to the health care provider, supplier, or licensed practitioner, and

(B) procedures in the case of disputed accuracy of the information.

(2) CORRECTIONS.—Each Government agency and health plan shall report corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner, in such form and manner that the Secretary prescribes by regulation.

(d) ACCESS TO REPORTED INFORMATION.—

(1) AVAILABILITY.—The information in the database maintained under this section shall be available to Federal and State government agencies and health plans pursuant to procedures that the Secretary shall provide by regulation.

(2) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for the disclosure of information in such database (other than with respect to requests by Federal agencies). The amount of such a fee shall be sufficient to recover the full costs of operating the database. Such fees shall be available to the Secretary or, in the Secretary's discretion to the agency designated under this section to cover such costs.

(e) PROTECTION FROM LIABILITY FOR REPORTING.—No person or entity, including the agency designated by the Secretary in subsection (b)(5) shall be held liable in any civil action with respect to any report made as required by this section, without knowledge of the falsity of the information contained in the report.

(f) COORDINATION WITH NATIONAL PRACTITIONER DATA BANK.—The Secretary shall implement this section in such a manner as to

avoid duplication with the reporting requirements established for the National Practitioner Data Bank under the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.).

(g) DEFINITIONS AND SPECIAL RULES.—For purposes of this section:

(1) FINAL ADVERSE ACTION.—

(A) IN GENERAL.—The term "final adverse action" includes:

(i) Civil judgments against a health care provider, supplier, or practitioner in Federal or State court related to the delivery of a health care item or service.

(ii) Federal or State criminal convictions related to the delivery of a health care item or service.

(iii) Actions by Federal or State agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including—

(I) formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation,

(II) any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non–renewability, or otherwise, or

(III) any other negative action or finding by such Federal or State agency that is publicly available information.

(iv) Exclusion from participation in Federal or State health care programs (as defined in sections 1128B(f) and 1128(h), respectively).

(v) Any other adjudicated actions or decisions that the Secretary shall establish by regulation.

(B) EXCEPTION.—The term does not include any action with respect to a malpractice claim.

(2) PRACTITIONER.—The terms "licensed health care practitioner", "licensed practitioner", and "practitioner" mean, with respect to a State, an individual who is licensed or otherwise authorized by the State to provide health care services (or any individual who, without authority holds himself or herself out to be so licensed or authorized).

(3) GOVERNMENT AGENCY.—The term "Government agency" shall include:

(A) The Department of Justice.

(B) The Department of Health and Human Services.

(C) Any other Federal agency that either administers or provides payment for the delivery of health care services, including, but not limited to the Department of Defense and the Department of Veterans Affairs.

(D) State law enforcement agencies.

(E) State medicaid fraud control units.

(F) Federal or State agencies responsible for licensing and certification of health care providers and licensed health care practitioners.

(4) HEALTH PLAN.—The term "health plan" has the meaning given such term by section 1128C(c).

(5) DETERMINATION OF CONVICTION.—For purposes of paragraph (1), the existence of a conviction shall be determined under paragraphs (1) through (4) of section 1128(i).

COORDINATION OF MEDICARE AND MEDICAID SURETY BOND PROVISIONS

SEC. 1128F. [42 U.S.C. 1320a–7f] In the case of a home health agency that is subject to a surety bond requirement under title XVIII and title XIX, the surety bond provided to satisfy the requirement under one such title shall satisfy the requirement under the other such title so long as the bond applies to guarantee return of overpayments under both such titles.

CIVIL MONETARY PENALTIES AND ASSESSMENTS FOR TITLES II, VIII AND XVI

SEC. 1129. [42 U.S.C. 1320a–8] (a)(1) Any person (including an organization, agency, or other entity) who—[62]

(A) makes, or causes to be made, a statement or representation of a material fact, for use in determining any initial or continuing right to or the amount of monthly insurance benefits under title II or benefits or payments under title VIII or XVI, that the person knows or should know is false or misleading,

(B) makes such a statement or representation for such use with knowing disregard for the truth, or

(C) omits from a statement or representation for such use, or otherwise withholds disclosure of, a fact which the person knows or should know is material to the determination of any initial or continuing right to or the amount of monthly insurance benefits under title II or benefits or payments under title VIII or XVI, if the person knows, or should know, that the statement or representation with such omission is false or misleading or that the withholding of such disclosure is misleading,

shall be subject to[63], in addition to any other penalties that may be prescribed by law, a civil money penalty of not more than $5,000 for each such statement or representation or each receipt of such benefits or payments while withholding disclosure of such fact[64].

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[63] P.L. 108-203, §201(a)(1)(A), strikes out "who" and substitutes "who—", applicable with respect to violations committed after the date on which the Commissioner of Social Security implements the centralized computer file described in §202 (See Vol. II, P.L.108-203, §202(d)), effective as soon as possible, but not later than March 2, 2005.

[64] P.L. 108-203, §201(a)(1)(B), strikes out "makes" and all that follows through "shall be subject to," and substitutes subparagraphs (A), (B), and (C) and "shall be subject to", applicable with respect to violations committed after the date on which the Commissioner of Social Security implements the centralized computer file described in §202 (effective as soon as possible, but not later than March 2, 2005). Until then, the first sentence of § 1129(a)(1) reads "Any person (including an organization, agency, or other entity) who makes, or causes to be made, a statement or representation of a material fact for use in determining any initial or continuing right to or the amount of—

(A) monthly insurance benefits under title II,

(B) benefits or payments under title VIII, or

(C) benefits or payments under title XVI,

that the persons knows or should know is false or misleading or knows or should know omits a material fact or makes such a statement with Knowing disregard for the truth shall be subject to".

[65] P.L. 108-203, §201(a)(1)(C), inserts "or each receipt of such benefits or payments while withholding disclosure of such fact", applicable with respect to violations committed after the date

Continued

Such person also shall be subject to an assessment, in lieu of damages sustained by the United States because of such statement or representation or because of such withholding of disclosure of a material fact[65], of not more than twice the amount of benefits or payments paid as a result of such a statement or representation or such a withholding of disclosure[66] . In addition, the Commissioner of Social Security may make a determination in the same proceeding to recommend that the Secretary exclude, as provided in section 1128, such a person who is a medical provider or physician from participation in the programs under title XVIII.

(2) For purposes of this section, a material fact is one which the Commissioner of Social Security may consider in evaluating whether an applicant is entitled to benefits under title II or title VIII, or eligible for benefits or payments under title XVI.

(3)[67]Any person (including an organization, agency, or other entity) who, having received, while acting in the capacity of a representative payee pursuant to section 205(j), 807, or 1631(a)(2), a payment under title II, VIII, or XVI for the use and benefit of another individual, converts such payment, or any part thereof, to a use that such person knows or should know is other than for the use and benefit of such other individual shall be subject to, in addition to any other penalties that may be prescribed by law, a civil money penalty of not more than $5,000 for each such conversion. Such person shall also be subject to an assessment, in lieu of damages sustained by the United States resulting from the conversion, of not more than twice the amount of any payments so converted.

(b)(1) The Commissioner of Social Security may initiate a proceeding to determine whether to impose a civil money penalty or assessment, or whether to recommend exclusion under subsection (a) only as authorized by the Attorney General pursuant to procedures agreed upon by the Commissioner of Social Security and the Attorney General. The Commissioner of Social Security may not initiate an action under this section with respect to any violation described in subsection (a) later than 6 years after the date the violation was committed. The Commissioner of Social Security may initiate an action under this section by serving notice of the action in any manner authorized by Rule 4 of the Federal Rules of Civil Procedure[68].

(2) The Commissioner of Social Security shall not make a determination adverse to any person under this section until the person has been given written notice and an opportunity for the determination to be made on the record after a hearing at which the person is entitled to be represented by counsel, to

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on which the Commissioner of Social Security implements the centralized computer file described in §202 (effective as soon as possible, but not later than March 2, 2005).

[66] P.L. 108-203, §201(a)(1)(D), inserted "or because of such withholding of disclosure of a material fact", applicable with respect to violations committed after the date on which the Commissioner of Social Security implements the centralized computer file described in §202 (effective as soon as possible, but not later than March 2, 2005).

[67] P.L. 108-203, §201(a)(1)(E), inserted "or such a withholding of disclosure", applicable with respect to violations committed after the date on which the Commissioner of Social Security implements the centralized computer file described in §202 (effective as soon as possible, but not later than March 2, 2005).

[68] P.L. 108-203, §111(a), added paragraph (3), applicable with respect to violations committed after March 2, 2004.

[69] See Vol. II, Federal Rules of Civil Procedure.

present witnesses, and to cross-examine witnesses against the person.

(3) In a proceeding under this section which—

(A) is against a person who has been convicted (whether upon a verdict after trial or upon a plea of guilty or nolo contendere) of a Federal or State crime[69]; and

(B) involves the same transaction as in the criminal action;

the person is estopped from denying the essential elements of the criminal offense.

(4) The official conducting a hearing under this section may sanction a person, including any party or attorney, for failing to comply with an order or procedure, for failing to defend an action, or for such other misconduct as would interfere with the speedy, orderly, or fair conduct of the hearing. Such sanction shasll reasonably relate to the severity and nature of the failure or misconduct. Such sanction may include—

(A) in the case of refusal to provide or permit discovery, drawing negative factual inference or treating such refusal as an admission by deeming the matter, or certain facts, to be established;

(B) prohibiting a party from introducing certain evidence or otherwise supporting a particular claim or defense;

(C) striking pleadings, in whole or in part;

(D) staying the proceedings;

(E) dismissal of the action;

(F) entering a default judgment;

(G) ordering the party or attorney to pay attorney's fees and other costs caused by the failure or misconduct; and

(H) refusing to consider any motion or other action which is not filed in a timely manner.

(c) In determining pursuant to subsection (a) the amount or scope of any penalty or assessment, or whether to recommend and exclusion, the Commissioner of Social Security shall take into account—

(1) the nature of the statements, representations, or actions[70] referred to in subsection (a) and the circumstances under which they occurred;

(2) the degree of culpability, history of prior offenses, and financial condition of the person committing the offense; and

(3) such other matters as justice may require.

(d)(1) Any person adversely affected by a determination of the Commissioner of Social Security under this section may obtain a review of such determination in the United States Court of Appeals for the circuit in which the person resides, or in which the statement or representation referred to in subsection (a) was made, by filing in such court (within 60 days following the date the person is notified of the Commissioner's determination) a written petition requesting that the determination be modified or set aside. A copy

[70] P.L. 108-203, §201(c)(1), strikes out "charging fraud or false statements", applicable with respect to violations committed after the date on which the Commissioner of Social Security implements the centralized computer file described in §202 (effective as soon as possible, but not later than March 2, 2005).

[71] P.L. 108-203, §201(c) (2), strikes out "and representations" and substitutes ", representations, or actions", applicable with respect to violations committed after the date on which the Commissioner of Social Security implements the centralized computer file described in §202 (effective as soon as possible, but not later than March 2, 2005).

of the petition shall be forthwith transmitted by the clerk of the court to the Commissioner of Social Security, and thereupon the Commissioner of Social Security shall file in the court the record in the proceeding as provided in section 2112 of title 28, United States Code[71]. Upon such filing, the court shall have jurisdiction of the proceeding and of the question determined therein, and shall have the power to make and enter upon the pleadings, testimony, and proceedings set forth in such record a decree affirming, modifying, remanding for further consideration, or setting aside, in whole or in part, the determination of the Commissioner of Social Security and enforcing the same to the extent that such order is affirmed or modified. No objection that has not been urged before the Commissioner of Social Security shall be considered by the court, unless the failure to neglect to urge such objection shall be excused because of extraordinary circumstances.

(2) The findings of the Commissioner of Social Security with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, shall be conclusive in the review described in paragraph (1). If any party shall apply to the court for leave to adduce additional evidence and shall show to the satisfaction of the court that such additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the hearing before the Commissioner of Social Security, the court may order such additional evidence to be taken before the Commissioner of Social Security and to be made a part of the record. The Commissioner of Social Security may modify such findings as to the facts, or make new findings, by reason of additional evidence so taken and filed, and the Commissioner of Social Security shall file with the court such modified or new findings, which findings with respect to questions of fact, if supported by substantial evidence on the record considered as a whole shall be conclusive, and the Commissioner's recommendations, if any, for the modification or setting aside of the Commissioner's original order.

(3) Upon the filing of the record and the Commissioner's original or modified order with the court, the jurisdiction of the court shall be exclusive and its judgment and decree shall be final, except that the same shall be subject to review by the Supreme Court of the United States, as provided in section 1254 of title 28, United States Code[72].

(e)(1) Civil money penalties and assessments imposed under this section may be compromised by the Commissioner of Social Security and may be recovered—

(A) in a civil action in the name of the United States brought in United States district court for the district where the, violation occurred[73] or where the person resides, as determined by the Commissioner of Social Security.

(B) by means of reduction in tax refunds to which the person is entitled, based on notice to the Secretary of the

[72] See Vol. II, Title 28.

[73] See Vol. II, Title 28.

[74] P.L. 108-203, §201(c)(3), strikes out "statement or representation referred to in subsection (a) was made" and substitutes "violation occurred", applicable with respect to violations committed after the date on which the Commissioner of Social Security implements the centralized computer file described in §202 (effective as soon as possible, but not later than March 2, 2005).

Treasury as permitted under section 3720A of title 31, United States Code[74];

(C)(i) by decrease of any payment of monthly insurance benefits under title II, notwithstanding section 207,

(ii) by decrease of any payment under title VIII to which the person is entitled, or

(iii) by decrease of any payment under title XVI for which the person is eligible, notwithstanding section 207, as made applicable to title XVI by reason of section 1631(d)(1);

(D) by authorities provided under the Debt Collection Act of 1982, as amended, to the extent applicable to debts arising under the Social Security Act;

(E) by deduction of the amount of such penalty or assessment, when finally determined, or the amount agreed upon in comprise, from any sum then or later owing by the United States to the person against whom the penalty or assessment has been assessed; or

(F) by any combination of the foregoing.

(2) Amounts recovered under this section shall be recovered under by the Commissioner of Social Security and shall be disposed of as follows:

(A) In the case of amounts recovered arising out of a determination relating to title II, the amounts shall be transferred to the Managing Trustee of the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund, as determined appropriate by the Secretary, and such amounts shall be deposited by the Managing Trustee into such Trust Fund.

(B) In the case of any other amounts recovered under this section,[75] the amounts shall be deposited by the Commissioner of Social Security into the general fund of the Treasury as miscellaneous receipts.

(f) A determination pursuant to subsection (a) by the Commissioner of Social Security to impose a penalty or assessment, or to recommend an exclusion shall be final upon the expiration of the 60-day period referred to in subsection (d). Matters that were raised or that could have been raised in a hearing before the Commissioner of Social Security or in an appeal pursuant to subsection (d) may not be raised as a defense to a civil action by the United States to collect a penalty or assessment imposed under this section.

(g) Whenever the Commissioner's determination to impose a penalty or assessment under this section with respect to a medical provider or physician becomes final, the Commissioner shall notify the Secretary of the final determination and the reasons therefor, and the Secretary shall then notify the entities described in section 1128A(h) of such final determination.

(h) Whenever the Commissioner of Social Security has reason to believe that any person has engaged, is engaging, or is about to engage in any activity which makes the person subject to a civil mon-

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[75] See Vol. II, Title 31.

[76] P.L. 108-203, §201(b), strikes out "In the case of amounts recovered arising out of a determination relating to title VIII or XVI," and substitutes "In the case of any other amounts recovered under this section," applicable with respect to violations committed after the date on which the Commissioner of Social Security implements the centralized computer file described in §202 (effective as soon as possible, but not later than March 2, 2005).

etary penalty under this section, the Commissioner of Social Security may bring action in an appropriate district court of the United States (or, if applicable, a United States court of any territory) to enjoin such activity, or to enjoin the person from concealing, removing, encumbering, or disposing of assets which may be required in order to pay a civil monetary penalty and assessment if any such penalty were to be imposed or to seek other appropriate relief.

(i)(1) The provisions of subsections (d) and (e) of section 205 shall apply with respect to this section to the same extent as they are applicable with respect to title II. The Commissioner of Social Security may delegate the authority granted by section 205(d) (as made applicable to this section) to the Inspector General for purposes of any investigation under this section.

(2) The Commissioner of Social Security may delegate authority granted under this section to the Inspector General.

(j) For purposes of this section, the term "State agency", shall have the same meaning as in section 1128A(i)(1).

(k) A principal is liable for penalties and assessments under subsection (a), and for an exclusion under section 1128 based on a recommendation under subsection (a), for the actions of the principal's agent acting within the scope of the agency.

(l) As soon as the Inspector General, Social Security Administration, has reason to believe that fraud was involved in the application of an individual for monthly insurance benefits under title II or for benefits under title VIII or XVI, the Inspector General shall make available to the Commissioner of Social Security information identifying the individual, unless a United States attorney, or equivalent State prosecutor, with jurisdiction over potential or actual related criminal cases, certifies, in writing, that there is a substantial risk that making the information so available in a particular investigation or redetermining the eligibility of the individual for such benefits would jeopardize the criminal prosecution of any person who is a subject of the investigation from which the information is derived.

ADMINISTRATIVE PROCEDURE FOR IMPOSING PENALTIES FOR FALSE OR MISLEADING STATEMENTS

SEC. 1129A. [42 U.S.C. 1320a–8a] (a) IN GENERAL.—Any person who—[76]

(1) makes, or causes to be made, a statement or representation of a material fact, for use in determining any initial or continuing right to or the amount of monthly insurance benefits under title II or benefits or payments under title VIII or XVI, that the person knows or should know is false or misleading,

(2) makes such a statement or representation for such use with knowing disregard for the truth, or

(3) omits from a statement or representation for such use, or otherwise withholds disclosure of, a fact which the person knows or should know is material to the determination of any initial or continuing right to or the amount of monthly insurance benefits under title II or benefits or payments under title

[77] P.L. 108-203, §201(a)(2)(A), strikes out "who" and substitutes "who—", applicable with respect to violations committed after the date on which the Commissioner of Social Security implements the centralized computer file described in §202 (effective as soon as possible, but not later than 1 year after March 2, 2004).

VIII or XVI, if the person knows, or should know, that the statement or representation with such omission is false or misleading or that the withholding of such disclosure is misleading,

shall be subject to,[77] in addition to any other penalties that may be prescribed by law, a penalty described in subsection (b) to be imposed by the Commissioner of Social Security.

(b) PENALTY.—The penalty described in this subsection is—

(1) nonpayment of benefits under title II that would otherwise be payable to the person; and

(2) ineligibility for cash benefits under title XVI,

for each month that begins during the applicable period described in subsection (c).

(c) DURATION OF PENALTY.—The duration of the applicable period, with respect to a determination by the Commissioner under subsection (a) that a person has engaged in conduct described in subsection (a), shall be—

(1) six consecutive months, in the case of the first such determination with respect to the person;

(2) twelve consecutive months, in the case of the second such determination with respect to the person; and

(3) twenty–four consecutive months, in the case of the third or subsequent such determination with respect to the person.

(d) EFFECT ON OTHER ASSISTANCE.—A person subject to a period of nonpayment of benefits under title II or ineligibility for title XVI benefits by reason of this section nevertheless shall be considered to be eligible for and receiving such benefits, to the extent that the person would be receiving or eligible for such benefits but for the imposition of the penalty, for purposes of—

(1) determination of the eligibility of the person for benefits under titles XVIII and XIX; and

(2) determination of the eligibility or amount of benefits payable under title II or XVI to another person.

(e) DEFINITION.—In this section, the term "benefits under title VIII or XVI" includes State supplementary payments made by the Commissioner pursuant to an agreement under section 810A or 1616(a) of this Act or section 212(b) of Public Law 93–66, as the case may be.

(f) CONSULTATIONS.—The Commissioner of Social Security shall consult with the Inspector General of the Social Security Administration regarding initiating actions under this section.

ATTEMPTS TO INTERFERE WITH ADMINISTRATION OF SOCIAL SECURITY ACT[78]

SEC. 1129B. [42 U.S.C. 1320a-8b] Whoever corruptly or by force or threats of force (including any threatening letter or communication) attempts to intimidate or impede any officer, employee, or contractor of the Social Security Administration (including any State employee of a disability determination service or any other

[78] P.L. 108-203, §201(a)(2)(B), strikes out "makes and all that follows through "shall be subject to,", applicable with respect to violations committed after the date on which the Commissioner of Social Security implements the centralized computer file described in §202 (effective as soon as possible, but not later than 1 year after March 2, 2004).

Until that time, §1129A(a) reads:

(a) IN GENERAL—Any person who makes, or causes to be made, a statement or representation of a material fact for use in determining any initial or continuing right to or the amount of—

[79] P.L. 108-203, §206, added §1129B, effective March 2, 2004.

individual designated by the Commissioner of Social Security) acting in an official capacity to carry out a duty under this Act, or in any other way corruptly or by force or threats of force (including any threatening letter or communication) obstructs or impedes, or attempts to obstruct or impede, the due administration of this Act, shall be fined not more than $5,000, imprisoned not more than 3 years, or both, except that if the offense is committed only by threats of force, the person shall be fined not more than $3,000, imprisoned not more than 1 year, or both. In this subsection, the term 'threats of force' means threats of harm to the officer or employee of the United States or to a contractor of the Social Security Administration, or to a member of the family of such an officer or employee or contractor.

DEMONSTRATION PROJECTS

SEC. 1130. [42 U.S.C. 1320a–9] (a) AUTHORITY TO APPROVE DEMONSTRATION PROJECTS [79].—

(1) IN GENERAL.—The Secretary may authorize States to conduct demonstration projects pursuant to this section which the Secretary finds are likely to promote the objectives of part B or E of title IV.

(2) LIMITATION.—The Secretary may authorize not more than 10 demonstration projects under paragraph (1) in each of fiscal years 1998 through 2003 [80].

(3) CERTAIN TYPES OF PROPOSALS REQUIRED TO BE CONSIDERED.—

(A) If an appropriate application therefor is submitted, the Secretary shall consider authorizing a demonstration project which is designed to identify and address barriers that result in delays to adoptive placements for children in foster care.

(B) If an appropriate application therefor is submitted, the Secretary shall consider authorizing a demonstration project which is designed to identify and address parental substance abuse problems that endanger children and result in the placement of children in foster care, including through the placement of children with their parents in residential treatment facilities (including residential treatment facilities for post–partum depression) that are specifically designed to serve parents and children together in order to promote family reunification and that can ensure the health and safety of the children in such placements.

(C) If an appropriate application therefor is submitted, the Secretary shall consider authorizing a demonstration project which is designed to address kinship care.

(4) LIMITATION ON ELIGIBILITY.—The Secretary may not authorize a State to conduct a demonstration project under this section if the State fails to provide health insurance coverage to any child with special needs (as determined under section 473(c)) for whom there is in effect an adoption assistance agreement between a State and an adoptive parent or parents.

[80] See Vol. II, P.L. 108-89, §102, P.L. 108-262, §3, and P.L. 108-308, §3, with respect to extension of the National Random Sample Study of Child Welfare and child welfare waiver authority.
[81] P.L. 108-40, §5, struck out "2002" and substituted "2003", effective July 1, 2003.

(5) REQUIREMENT TO CONSIDER EFFECT OF PROJECT ON TERMS AND CONDITIONS OF CERTAIN COURT ORDERS.—In considering an application to conduct a demonstration project under this section that has been submitted by a State in which there is in effect a court order determining that the State's child welfare program has failed to comply with the provisions of part B or E of title IV, or with the Constitution of the United States, the Secretary shall take into consideration the effect of approving the proposed project on the terms and conditions of the court order related to the failure to comply.

(b) WAIVER AUTHORITY.—The Secretary may waive compliance with any requirement of part B or E of title IV which (if applied) would prevent a State from carrying out a demonstration project under this section or prevent the State from effectively achieving the purpose of such a project, except that the Secretary may not waive—

(1) any provision of section 427 (as in effect before April 1, 1996), section 422(b)(9) (as in effect after such date), or section 479; or

(2) any provision of such part E, to the extent that the waiver would impair the entitlement of any qualified child or family to benefits under a State plan approved under such part E.

(c) TREATMENT AS PROGRAM EXPENDITURES.—For purposes of parts B and E of title IV, the Secretary shall consider the expenditures of any State to conduct a demonstration project under this section to be expenditures under subpart 1 or 2 of such part B, or under such part E, as the State may elect.

(d) DURATION OF DEMONSTRATION.—A demonstration project under this section may be conducted for not more than 5 years, unless in the judgment of the Secretary, the demonstration project should be allowed to continue.

(e) APPLICATION.—Any State seeking to conduct a demonstration project under this section shall submit to the Secretary an application, in such form as the Secretary may require, which includes

(1) a description of the proposed project, the geographic area in which the proposed project would be conducted, the children or families who would be served by the proposed project, and the services which would be provided by the proposed project (which shall provide, where appropriate, for random assignment of children and families to groups served under the project and to control groups);

(2) a statement of the period during which the proposed project would be conducted;

(3) a discussion of the benefits that are expected from the proposed project (compared to a continuation of activities under the approved plan or plans of the State);

(4) an estimate of the costs or savings of the proposed project;

(5) a statement of program requirements for which waivers would be needed to permit the proposed project to be conducted;

(6) a description of the proposed evaluation design; and

(7) such additional information as the Secretary may require.

(f) EVALUATIONS; REPORT.—Each State authorized to conduct a demonstration project under this section shall—

(1) obtain an evaluation by an independent contractor of the effectiveness of the project, using an evaluation design approved by the Secretary which provides for—

(A) comparison of methods of service delivery under the project, and such methods under a State plan or plans, with respect to efficiency, economy, and any other appropriate measures of program management;

(B) comparison of outcomes for children and families (and groups of children and families) under the project, and such outcomes under a State plan or plans, for purposes of assessing the effectiveness of the project in achieving program goals; and

(C) any other information that the Secretary may require; and

(2) provide interim and final evaluation reports to the Secretary, at such times and in such manner as the Secretary may require.

(g) COST NEUTRALITY.—The Secretary may not authorize a State to conduct a demonstration project under this section unless the Secretary determines that the total amount of Federal funds that will be expended under (or by reason of) the project over its approved term (or such portion thereof or other period as the Secretary may find appropriate) will not exceed the amount of such funds that would be expended by the State under the State plans approved under parts B and E of title IV if the project were not conducted.

EFFECT OF FAILURE TO CARRY OUT STATE PLAN

SEC. 1130A. [42 U.S.C. 1320a–10] In an action brought to enforce a provision of the Social Security Act, such provision is not to be deemed unenforceable because of its inclusion in a section of the Act requiring a State plan or specifying the required contents of a State plan. This section is not intended to limit or expand the grounds for determining the availability of private actions to enforce State plan requirements other than by overturning any such grounds applied in Suter v. Artist M., 112 S. Ct. 1360 (1992), but not applied in prior Supreme Court decisions respecting such enforceability: *Provided*, however, That this section is not intended to alter the holding in Suter v. Artist M. that section 471(a)(15) of the Act is not enforceable in a private right of action.

NOTIFICATION OF SOCIAL SECURITY CLAIMANT WITH RESPECT TO DEFERRED VESTED BENEFITS

SEC. 1131. [42 U.S.C. 1320b–1] (a) Whenever—

(1) the Commissioner of Social Security makes a finding of fact and a decision as to—

(A) the entitlement of any individual to monthly benefits under section 202, 223, or 228, or

(B) the entitlement of any individual to a lump-sum death payment payable under section 202(i) on account of the death of any person to whom such individual is related by blood, marriage, or adoption, or

(2) the Commissioner of Social Security makes a finding of fact and a decision as to the entitlement under section 226 of

any individual to hospital insurance benefits under part A of title XVIII, or

(3) the Commissioner of Social Security is requested to do so—

(A) by any individual with respect to whom the Commissioner of Social Security holds information obtained under section 6057 of the Internal Revenue Code of 1954[81], or

(B) in the case of the death of the individual referred to in subparagraph (A), by the individual who would be entitled to payment under section 204(d) of this Act,

the Commissioner of Social Security shall transmit to the individual referred to in paragraph (1) or (2) or the individual making the request under paragraph (3) any information, as reported by the employer, regarding any deferred vested benefit transmitted to the Commissioner of Social Security pursuant to such section 6057 with respect to the individual referred to in paragraph (1), (2), or (3)(A) or the person on whose wages and self-employment income entitlement (or claim of entitlement) is based.

(b)(1) For purposes of section 201(g)(1), expenses incurred in the administration of subsection (a) shall be deemed to be expenses incurred for the administration of title II.

(2) There are hereby authorized to be appropriated to the Federal Old-Age and Survivors Insurance Trust Fund for each fiscal year (commencing with the fiscal year ending June 30, 1974) such sums as the Commissioner of Social Security deems necessary on account of additional administrative expenses resulting from the enactment of the provisions of subsection (a).

PERIOD WITHIN WHICH CERTAIN CLAIMS MUST BE FILED

SEC. 1132. [42 U.S.C. 1320b–2] (a) Notwithstanding any other provision of this Act (but subject to subsection (b)), any claim by a State for payment with respect to an expenditure made during any calendar quarter by the State—

(1) in carrying out a State plan approved under title I, IV, X, XIV, XVI, XIX, or XX of this Act, or

(2) under any other provision of this Act which provides (on an entitlement basis) for Federal financial participation in expenditures made under State plans or programs,

shall be filed (in such form and manner as the Secretary shall by regulations prescribe) within the two-year period which begins on the first day of the calendar quarter immediately following such calendar quarter; and payment shall not be made under this Act on account of any such expenditure if claim therefor is not made within such two-year period; except that this subsection shall not be applied so as to deny payment with respect to any expenditure involving court-ordered retroactive payments or audit exceptions, or adjustments to prior year costs.

(b) The Secretary shall waive the requirement imposed under subsection (a) with respect to the filing of any claim if he determines (in accordance with regulations) that there was good cause for the failure by the State to file such claim within the period prescribed under subsection (a). Any such waiver shall be only for such additional period of time as may be necessary to provide the

[82] See Vol. II, P.L. 83–591.

State with a reasonable opportunity to file such claim. A failure to file a claim within such time period which is attributable to neglect or administrative inadequacies shall be deemed not to be for good cause.

APPLICANTS OR RECIPIENTS UNDER PUBLIC ASSISTANCE PROGRAMS NOT TO BE REQUIRED TO MAKE ELECTION RESPECTING CERTAIN VETERANS' BENEFITS

SEC. 1133. [42 U.S.C. 1320b–3] (a) Notwithstanding any other provision of law (but subject to subsection (b)), no individual who is an applicant for or recipient of aid or assistance under a State plan approved under title I, X, XIV, or XVI, or of benefits under the Supplemental Security Income program established by title XVI shall—

(1) be required, as a condition of eligibility for (or of continuing to receive) such aid, assistance, or benefits, to make an election under section 306 of the Veterans' and Survivors' Pension Improvement Act of 1978[82] with respect to pension paid by the Secretary of Veterans Affairs, or

(2) by reason of failure or refusal to make such an election, be denied (or suffer a reduction in the amount of) such aid, assistance, or benefits.

(b) The provisions of subsection (a) shall be applicable only with respect to an individual, who is an applicant for or recipient of aid, assistance, or benefits described in subsection (a), during a period with respect to which there is in effect—

(1) in case such individual is an applicant for or recipient of aid or assistance under a State plan referred to in subsection (a), in the State having such plan, or

(2) in case such individual is an applicant for or recipient of benefits under the Supplemental Security Income program established by title XVI, in the State in which the individual applies for or receives such benefits,

a State plan for medical assistance, approved under title XIX, under which medical assistance is available to such individual only for periods for which such individual is a recipient of aid, assistance, or benefits described in subsection (a).

NONPROFIT HOSPITAL PHILANTHROPY

SEC. 1134. [42 U.S.C. 1320b–4] For purposes of determining, under titles XVIII and XIX of this Act, the reasonable costs of services provided by nonprofit hospitals or critical access hospitals, the following items shall not be deducted from the operating costs of such hospitals or critical access hospitals:

(1) A grant, gift, or endowment, or income therefrom, which is to or for such a hospital and which has not been designated by the donor for paying any specific operating costs.

(2) A grant or similar payment which is to such a hospital, which was made by a governmental entity, and which is not available under the terms of the grant or payment for use as operating funds.

(3) Those types of donor designated grants and gifts (including grants and similar payments which are made by a govern-

[83] See Vol. II, P.L. 95–588.

mental entity), and income therefrom, which the Secretary determines, in the best interests of needed health care, should be encouraged.

(4) The proceeds from the sale or mortgage of any real estate or other capital asset of such a hospital, which real estate or asset the hospital acquired through gift or grant, if such proceeds are not available for use as operating funds under the terms of the gift or grant.

Paragraph (4) shall not apply to the recovery of the appropriate share of depreciation when gains or losses are realized from the disposal of depreciable assets.

AUTHORITY TO WAIVE REQUIREMENTS DURING NATIONAL EMERGENCIES

SEC. 1135. [42 U.S.C. 1320b–5] (a) PURPOSE.—The purpose of this section is to enable the Secretary to ensure to the maximum extent feasible, in any emergency area and during an emergency period (as defined in subsection (g)(1))—

(1) that sufficient health care items and services are available to meet the needs of individuals in such area enrolled in the programs under titles XVIII, XIX, and XXI; and

(2) that health care providers (as defined in subsection (g)(2)) that furnish such items and services in good faith, but that are unable to comply with one or more requirements described in subsection (b), may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse.

(b) SECRETARIAL AUTHORITY.—To the extent necessary to accomplish the purpose specified in subsection (a), the Secretary is authorized, subject to the provisions of this section, to temporarily waive or modify the application of, with respect to health care items and services furnished by a health care provider (or classes of health care providers) in any emergency area (or portion of such an area) during any portion of an emergency period, the requirements of titles XVIII, XIX, or XXI, or any regulation thereunder (and the requirements of this title other than this section, and regulations thereunder, insofar as they relate to such titles), pertaining to—

(1)(A) conditions of participation or other certification requirements for an individual health care provider or types of providers,

(B) program participation and similar requirements for an individual health care provider or types of providers, and

(C) pre-approval requirements;

(2) requirements that physicians and other health care professionals be licensed in the State in which they provide such services, if they have equivalent licensing in another State and are not affirmatively excluded from practice in that State or in any State a part of which is included in the emergency area;

(3) sanctions under section 1867 (relating to examination and treatment for emergency medical conditions and women in labor) for a transfer of an individual who has not been stabilized in violation of subsection (c) of such section if the transfer arises out of the circumstances of the emergency;

(4) sanctions under section 1877(g) (relating to limitations on physician referral);

(5) deadlines and timetables for performance of required activities, except that such deadlines and timetables may only be modified, not waived; and

(6) limitations on payments under section 1851(i) for health care items and services furnished to individuals enrolled in a Medicare+Choice plan by health care professionals or facilities not included under such plan.

Insofar as the Secretary exercises authority under paragraph (6) with respect to individuals enrolled in a Medicare+Choice plan, to the extent possible given the circumstances, the Secretary shall reconcile payments made on behalf of such enrollees to ensure that the enrollees do not pay more than would be required had they received services from providers within the network of the plan and may reconcile payments to the organization offering the plan to ensure that such organization pays for services for which payment is included in the capitation payment it receives under part C of title XVIII.

(c) AUTHORITY FOR RETROACTIVE WAIVER.—A waiver or modification of requirements pursuant to this section may, at the Secretary's discretion, be made retroactive to the beginning of the emergency period or any subsequent date in such period specified by the Secretary.

(d) CERTIFICATION TO CONGRESS.—The Secretary shall provide a certification and advance written notice to the Congress at least two days before exercising the authority under this section with respect to an emergency area. Such a certification and notice shall include—

(1) a description of—

(A) the specific provisions that will be waived or modified;

(B) the health care providers to whom the waiver or modification will apply;

(C) the geographic area in which the waiver or modification will apply; and

(D) the period of time for which the waiver or modification will be in effect; and

(2) a certification that the waiver or modification is necessary to carry out the purpose specified in subsection (a).

(e) DURATION OF WAIVER.—

(1) IN GENERAL.—A waiver or modification of requirements pursuant to this section terminates upon—

(A) the termination of the applicable declaration of emergency or disaster described in subsection (g)(1)(A);

(B) the termination of the applicable declaration of public health emergency described in subsection (g)(1)(B); or

(C) subject to paragraph (2), the termination of a period of 60 days from the date the waiver or modification is first published (or, if applicable, the date of extension of the waiver or modification under paragraph (2)).

(2) EXTENSION OF 60-DAY PERIODS.—The Secretary may, by notice, provide for an extension of a 60-day period described in paragraph (1)(C) (or an additional period provided under this paragraph) for additional period or periods (not to exceed, except as subsequently provided under this paragraph, 60 days

each), but any such extension shall not affect or prevent the termination of a waiver or modification under subparagraph (A) or (B) of paragraph (1).

(f) REPORT TO CONGRESS.—Within one year after the end of the emergency period in an emergency area in which the Secretary exercised the authority provided under this section, the Secretary shall report to the Congress regarding the approaches used to accomplish the purposes described in subsection (a), including an evaluation of such approaches and recommendations for improved approaches should the need for such emergency authority arise in the future.

(g) DEFINITIONS.—For purposes of this section:

(1) EMERGENCY AREA; EMERGENCY PERIOD.—An "emergency area" is a geographical area in which, and an "emergency period" is the period during which, there exists—

(A) an emergency or disaster declared by the President pursuant to the National Emergencies Act[83] or the Robert T. Stafford Disaster Relief and Emergency Assistance Act[84]; and

(B) a public health emergency declared by the Secretary pursuant to section 319 of the Public Health Service Act.

(2) HEALTH CARE PROVIDER.—The term "health care provider" means any entity that furnishes health care items or services, and includes a hospital or other provider of services, a physician or other health care practitioner or professional, a health care facility, or a supplier of health care items or services.

EXCLUSION OF REPRESENTATIVES AND HEALTH CARE PROVIDERS CONVICTED OF VIOLATIONS FROM PARTICIPATION IN SOCIAL SECURITY PROGRAMS

SEC. 1136. [42 U.S.C. 1320b–6] (a) IN GENERAL.—The Commissioner of Social Security shall exclude from participation in the social security programs any representative or health care provider—

(1) who is convicted of a violation of section 208 or 1632 of this Act;

(2) who is convicted of any violation under title 18, United States Code, relating to an initial application for or continuing entitlement to, or amount of, benefits under title II of this Act, or an initial application for or continuing eligibility for, or amount of, benefits under title XVI of this Act; or

(3) who the Commissioner determines has committed an offense described in section 1129(a)(1) of this Act.

(b) NOTICE, EFFECTIVE DATE, AND PERIOD OF EXCLUSION.—(1) An exclusion under this section shall be effective at such time, for such period, and upon such reasonable notice to the public and to the individual excluded as may be specified in regulations consistent with paragraph (2).

(2) Such an exclusion shall be effective with respect to services furnished to any individual on or after the effective date of the exclusion. Nothing in this section may be construed to preclude, in determining disability under title II or title XVI, consideration of any medical evidence derived from services

[84] P.L. 94-412.
[85] P.L. 93-288.

provided by a health care provider before the effective date of the exclusion of the health care provider under this section.

(3)(A) The Commissioner shall specify, in the notice of exclusion under paragraph (1), the period of the exclusion.

(B) Subject to subparagraph (C), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be 5 years, except that the Commissioner may waive the exclusion in the case of an individual who is the sole source of essential services in a community. The Commissioner's decision whether to waive the exclusion shall not be reviewable.

(C) In the case of an exclusion of an individual under subsection (a) based on a conviction or a determination described in subsection (a)(3) occurring on or after the date of the enactment of this section, if the individual has (before, on, or after such date of the enactment) been convicted, or if such a determination has been made with respect to the individual—

(i) on one previous occasion of one or more offenses for which an exclusion may be effected under such subsection, the period of the exclusion shall be not less than 10 years; or

(ii) on two or more previous occasions of one or more offenses for which an exclusion may be effected under such subsection, the period of the exclusion shall be permanent.

(c) NOTICE TO STATE AGENCIES.—The Commissioner shall promptly notify each appropriate State agency employed for the purpose of making disability determinations under section 221 or 1633(a)—

(1) of the fact and circumstances of each exclusion effected against an individual under this section; and

(2) of the period (described in subsection (b)(3)) for which the State agency is directed to exclude the individual from participation in the activities of the State agency in the course of its employment.

(d) NOTICE TO STATE LICENSING AGENCIES.—The Commissioner shall—

(1) promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of an individual excluded from participation under this section of the fact and circumstances of the exclusion;

(2) request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy; and

(3) request that the State or local agency or authority keep the Commissioner and the Inspector General of the Social Security Administration fully and currently informed with respect to any actions taken in response to the request.

(e) NOTICE, HEARING, AND JUDICIAL REVIEW.—(1) Any individual who is excluded (or directed to be excluded) from participation under this section is entitled to reasonable notice and opportunity for a hearing thereon by the Commissioner to the same extent as is provided in section 205(b), and to judicial review of the Commissioner's final decision after such hearing as is provided in section 205(g).

(2) The provisions of section 205(h) shall apply with respect to this section to the same extent as it is applicable with respect to title II.

(f) APPLICATION FOR TERMINATION OF EXCLUSION.—(1) An individual excluded from participation under this section may apply to the Commissioner, in the manner specified by the Commissioner in regulations and at the end of the minimum period of exclusion provided under subsection (b)(3) and at such other times as the Commissioner may provide, for termination of the exclusion effected under this section.

(2) The Commissioner may terminate the exclusion if the Commissioner determines, on the basis of the conduct of the applicant which occurred after the date of the notice of exclusion or which was unknown to the Commissioner at the time of the exclusion, that—

(A) there is no basis under subsection (a) for a continuation of the exclusion; and

(B) there are reasonable assurances that the types of actions which formed the basis for the original exclusion have not recurred and will not recur.

(3) The Commissioner shall promptly notify each State agency employed for the purpose of making disability determinations under section 221 or 1633(a) of the fact and circumstances of each termination of exclusion made under this subsection.

(g) AVAILABILITY OF RECORDS OF EXCLUDED REPRESENTATIVES AND HEALTH CARE PROVIDERS.—Nothing in this section shall be construed to have the effect of limiting access by any applicant or beneficiary under title II or XVI, any State agency acting under section 221 or 1633(a), or the Commissioner to records maintained by any representative or health care provider in connection with services provided to the applicant or beneficiary prior to the exclusion of such representative or health care provider under this section.

(h) REPORTING REQUIREMENT.—Any representative or health care provider participating in, or seeking to participate in, a social security program shall inform the Commissioner, in such form and manner as the Commissioner shall prescribe by regulation, whether such representative or health care provider has been convicted of a violation described in subsection (a).

(i) DELEGATION OF AUTHORITY.—The Commissioner may delegate authority granted by this section to the Inspector General.

(j) DEFINITIONS.—For purposes of this section:

(1) EXCLUDE.—The term "exclude" from participation means—

(A) in connection with a representative, to prohibit from engaging in representation of an applicant for, or recipient of, benefits, as a representative payee under section 205(j) or section 1631(a)(2)(A)(ii), or otherwise as a representative, in any hearing or other proceeding relating to entitlement to benefits; and

(B) in connection with a health care provider, to prohibit from providing items or services to an applicant for, or recipient of, benefits for the purpose of assisting such applicant or recipient in demonstrating disability.

(2) SOCIAL SECURITY PROGRAM.—The term "social security programs" means the program providing for monthly insurance benefits under title II, and the program providing for monthly supplemental security income benefits to individuals under title XVI (including State supplementary payments made by the Commissioner pursuant to an agreement under section 1616(a) of this Act or section 212(b) of Public Law 93-66).

(3) CONVICTED.—An individual is considered to have been "convicted" of a violation—

(A) when a judgment of conviction has been entered against the individual by a Federal, State, or local court, except if the judgment of conviction has been set aside or expunged;

(B) when there has been a finding of guilt against the individual by a Federal, State, or local court;

(C) when a plea of guilty or nolo contendere by the individual has been accepted by a Federal, State, or local court; or

(D) when the individual has entered into participation in a first offender, deferred adjudication, or other arrangement or program where judgment of conviction has been withheld.

INCOME AND ELIGIBILITY VERIFICATION SYSTEM [85]

SEC. 1137. [42 U.S.C. 1320b–7] (a) In order to meet the requirements of this section, a State must have in effect an income and eligibility verification system which meets the requirements of subsection (d) and under which—

(1) the State shall require, as a condition of eligibility for benefits under any program listed in subsection (b), that each applicant for or recipient of benefits under that program furnish to the State his social security account number (or numbers, if he has more than one such number), and the State shall utilize such account numbers in the administration of that program so as to enable the association of the records pertaining to the applicant or recipient with his account number;

(2) wage information from agencies administering State unemployment compensation laws available pursuant to section 3304(a)(16) of the Internal Revenue Code of 1954 [86], wage information reported pursuant to paragraph (3) of this subsection, and wage, income, and other information from the Social Security Administration and the Internal Revenue Service available pursuant to section 6103(l)(7) of such Code [87], shall be requested and utilized to the extent that such information may be useful in verifying eligibility for, and the amount of, benefits available under any program listed in subsection (b), as determined by the Secretary of Health and Human Services (or, in the case of the unemployment compensation program, by the Secretary of Labor, or, in the case of the food stamp program, by the Secretary of Agriculture);

[86] See Vol. II, P.L. 103–432, §232, with respect to measurement and reporting of welfare receipt.
[87] See P.L. 83–591 (this volume).
[88] See Vol. II, P.L. 83–591.

(3) employers (as defined in section 453A(a)(2)(B)) (including State and local governmental entities and labor organizations) in such State are required, effective September 30, 1988, to make quarterly wage reports to a State agency (which may be the agency administering the State's unemployment compensation law) except that the Secretary of Labor (in consultation with the Secretary of Health and Human Services and the Secretary of Agriculture) may waive the provisions of this paragraph if he determines that the State has in effect an alternative system which is as effective and timely for purposes of providing employment related income and eligibility data for the purposes described in paragraph (2), and except that no report shall be filed with respect to an employee of a State or local agency performing intelligence or counterintelligence functions, if the head of such agency has determined that filing such a report could endanger the safety of the employee or compromise an ongoing investigation or intelligence mission, and except that in the case of wage reports with respect to domestic service employment, a State may permit employers (as so defined) that make returns with respect to such employment on a calendar year basis pursuant to section 3510 of the Internal Revenue Code of 1986 to make such reports on an annual basis;

(4) the State agencies administering the programs listed in subsection (b) adhere to standardized formats and procedures established by the Secretary of Health and Human Services (in consultation with the Secretary of Agriculture) under which—

(A) the agencies will exchange with each other information in their possession which may be of use in establishing or verifying eligibility or benefit amounts under any other such program;

(B) such information shall be made available to assist in the child support program under part D of title IV of this Act, and to assist the Secretary of Health and Human Services in establishing or verifying eligibility or benefit amounts under titles II and XVI of this Act, but subject to the safeguards and restrictions established by the Secretary of the Treasury with respect to information released pursuant to section 6103(l) of the Internal Revenue Code of 1954[88] and

(C) the use of such information shall be targeted to those uses which are most likely to be productive in identifying and preventing ineligibility and incorrect payments, and no State shall be required to use such information to verify the eligibility of all recipients;

(5) adequate safeguards are in effect so as to assure that—

(A) the information exchanged by the State agencies is made available only to the extent necessary to assist in the valid administrative needs of the program receiving such information, and the information released pursuant to section 6103(l) of the Internal Revenue Code of 1954 is only exchanged with agencies authorized to receive such information under such section 6103(l); and

[89] See Vol. II, P.L. 83–591.

(B) the information is adequately protected against unauthorized disclosure for other purposes, as provided in regulations established by the Secretary of Health and Human Services, or, in the case of the unemployment compensation program, the Secretary of Labor, or, in the case of the food stamp program, the Secretary of Agriculture, or in the case of information released pursuant to section 6103(l) of the Internal Revenue Code of 1954, the Secretary of the Treasury;

(6) all applicants for and recipients of benefits under any such program shall be notified at the time of application, and periodically thereafter, that information available through the system will be requested and utilized; and

(7) accounting systems are utilized which assure that programs providing data receive appropriate reimbursement from the programs utilizing the data for the costs incurred in providing the data.

(b) The programs which must participate in the income and eligibility verification system are—

(1) any State program funded under part A of title IV of this Act;

(2) the medicaid program under title XIX of this Act;

(3) the unemployment compensation program under section 3304 of the Internal Revenue Code of 1954 [89];

(4) the food stamp program under the Food Stamp Act of 1977 [90]; and

(5) any State program under a plan approved under title I, X, XIV, or XVI of this Act.

(c)(1) In order to protect applicants for and recipients of benefits under the programs identified in subsection (b), or under the supplemental security income program under title XVI, from the improper use of information obtained from the Secretary of the Treasury under section 6103(l)(7)(B) of the Internal Revenue Code of 1954 [91], no Federal, State, or local agency receiving such information may terminate, deny, suspend, or reduce any benefits of an individual until such agency has taken appropriate steps to independently verify information relating to—

(A) the amount of the asset or income involved,

(B) whether such individual actually has (or had) access to such asset or income for his own use, and

(C) the period or periods when the individual actually had such asset or income.

(2) Such individual shall be informed by the agency of the findings made by the agency on the basis of such verified information, and shall be given an opportunity to contest such findings, in the same manner as applies to other information and findings relating to eligibility factors under the program.

(d) The requirements of this subsection, with respect to an income and eligibility verification system of a State, are as follows:

(1)(A) The State shall require, as a condition of an individual's eligibility for benefits under a program listed in subsection (b), a declaration in writing, under penalty of perjury—

(i) by the individual,

[90] See P.L. 83–591 (this volume).
[91] P.L. 88–525.
[92] See Vol. II, P.L. 83–591.

(ii) in the case in which eligibility for program benefits is determined on a family or household basis, by any adult member of such individual's family or household (as applicable), or

(iii) in the case of an individual born into a family or household receiving benefits under such program, by any adult member or such family or household no later than the next redetermination of eligibility of such family or household following the birth of such individual,

stating whether the individual is a citizen or national of the United States, and, if that individual is not a citizen or national of the United States, that the individual is in a satisfactory immigration status.

(B) In this subsection, in the case of the program described in subsection (b)(4)—

(i) any reference to the State shall be considered a reference to the State agency, and

(ii) any reference to an individual's eligibility for benefits under the program shall be considered a reference to the individual's eligibility to participate in the program as a member of a household, and

(iii) the term "satisfactory immigration status" means an immigration status which does not make the individual ineligible for benefits under the applicable program.

(2) If such an individual is not a citizen or national of the United States, there must be presented either—

(A) alien registration documentation or other proof of immigration registration from the Immigration and Naturalization Service that contains the individual's alien admission number or alien file number (or numbers if the individual has more than one number), or

(B) such other documents as the State determines constitutes reasonable evidence indicating a satisfactory immigration status.

(3) If the documentation described in paragraph (2)(A) is presented, the State shall utilize the individual's alien file or alien admission number to verify with the Immigration and Naturalization Service the individual's immigration status through an automated or other system (designated by the Service for use with States) that—

(A) utilizes the individual's name, file number, admission number, or other means permitting efficient verification, and

(B) protects the individual's privacy to the maximum degree possible.

(4) In the case of such an individual who is not a citizen or national of the United States, if, at the time of application for benefits, the statement described in paragraph (1) is submitted but the documentation required under paragraph (2) is not presented or if the documentation required under paragraph (2)(A) is presented but such documentation is not verified under paragraph (3)—

(A) the State—

(i) shall provide a reasonable opportunity to submit to the State evidence indicating a satisfactory immigration status, and

(ii) may not delay, deny, reduce, or terminate the individual's eligibility for benefits under the program on the basis of the individual's immigration status until such a reasonable opportunity has been provided; and

(B) if there are submitted documents which the State determines constitutes reasonable evidence indicating such status—

(i) the State shall transmit to the Immigration and Naturalization Service either photostatic or other similar copies of such documents, or information from such documents, as specified by the Immigration and Naturalization Service, for official verification,

(ii) pending such verification, the State may not delay, deny, reduce, or terminate the individual's eligibility for benefits under the program on the basis of the individual's immigration status, and

(iii) the State shall not be liable for the consequences of any action, delay, or failure of the Service to conduct such verification.

(5) If the State determines, after complying with the requirements of paragraph (4), that such an individual is not in a satisfactory immigration status under the applicable program—

(A) the State shall deny or terminate the individual's eligibility for benefits under the program, and

(B) the applicable fair hearing process shall be made available with respect to the individual.

(e) Each Federal agency responsible for administration of a program described in subsection (b) shall not take any compliance, disallowance, penalty, or other regulatory action against a State with respect to any error in the State's determination to make an individual eligible for benefits based on citizenship or immigration status—

(1) if the State has provided such eligibility based on a verification of satisfactory immigration status by the Immigration and Naturalization Service,

(2) because the State, under subsection (d)(4)(A)(ii), was required to provide a reasonable opportunity to submit documentation,

(3) because the State, under subsection (d)(4)(B)(ii), was required to wait for the response of the Immigration and Naturalization Service to the State's request for official verification of the immigration status of the individual, or

(4) because of a fair hearing process described in subsection (d)(5)(B).

(f) Subsections (a)(1) and (d) shall not apply with respect to aliens seeking medical assistance for the treatment of an emergency medical condition under section 1903(v)(2).

HOSPITAL PROTOCOLS FOR ORGAN PROCUREMENT AND STANDARDS FOR ORGAN PROCUREMENT AGENCIES

SEC. 1138. [42 U.S.C. 1320b–8] (a)(1) The Secretary shall provide that a hospital or critical access hospital meeting the require-

ments of title XVIII or XIX may participate in the program established under such title only if—

(A) the hospital or critical access hospital establishes written protocols for the identification of potential organ donors that—

(i) assure that families of potential organ donors are made aware of the option of organ or tissue donation and their option to decline,

(ii) encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of such families, and

(iii) require that such hospital's designated organ procurement agency (as defined in paragraph (3)(B)) is notified of potential organ donors;

(B) in the case of a hospital in which organ transplants are performed, the hospital is a member of, and abides by the rules and requirements of, the Organ Procurement and Transplantation Network established pursuant to section 372 of the Public Health Service Act[92] (in this section referred to as the "Network"); and

(C) the hospital or critical access hospital has an agreement (as defined in paragraph (3)(A)) only with such hospital's designated organ procurement agency.

(2)(A) The Secretary shall grant a waiver of the requirements under subparagraphs (A)(iii) and (C) of paragraph (1) to a hospital or critical access hospital desiring to enter into an agreement with an organ procurement agency other than such hospital's designated organ procurement agency if the Secretary determines that—

(i) the waiver is expected to increase organ donation; and

(ii) the waiver will assure equitable treatment of patients referred for transplants within the service area served by such hospital's designated organ procurement agency and within the service area served by the organ procurement agency with which the hospital seeks to enter into an agreement under the waiver.

(B) In making a determination under subparagraph (A), the Secretary may consider factors that would include, but not be limited to—

(i) cost effectiveness;

(ii) improvements in quality;

(iii) whether there has been any change in a hospital's designated organ procurement agency due to a change made on or after December 28, 1992, in the definitions for metropolitan statistical areas (as established by the Office of Management and Budget); and

(iv) the length and continuity of a hospital's relationship with an organ procurement agency other than the hospital's designated organ procurement agency;

except that nothing in this subparagraph shall be construed to permit the Secretary to grant a waiver that does not meet the requirements of subparagraph (A).

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[93] See Vol. II, P.L. 78–410.

(C) Any hospital or critical access hospital seeking a waiver under subparagraph (A) shall submit an application to the Secretary containing such information as the Secretary determines appropriate.

(D) The Secretary shall—

(i) publish a public notice of any waiver application received from a hospital or critical access hospital under this paragraph within 30 days of receiving such application; and

(ii) prior to making a final determination on such application under subparagraph (A), offer interested parties the opportunity to submit written comments to the Secretary during the 60-day period beginning on the date such notice is published.

(3) For purposes of this subsection—

(A) the term "agreement" means an agreement described in section 371(b)(3)(A) of the Public Health Service Act;

(B) the term "designated organ procurement agency" means, with respect to a hospital or critical access hospital, the organ procurement agency designated pursuant to subsection (b) for the service area in which such hospital is located; and

(C) the term "organ" means a human kidney, liver, heart, lung, pancreas, and any other human organ or tissue specified by the Secretary for purposes of this subsection.

(b)(1) The Secretary shall provide that payment may be made under title XVIII or XIX with respect to organ procurement costs attributable to payments made to an organ procurement agency only if the agency—

(A)(i) is a qualified organ procurement organization (as described in section 371(b) of the Public Health Service Act[93]) that is operating under a grant made under section 371(a) of such Act, or (ii) has been certified or recertified by the Secretary within the previous 2 years (4 years if the Secretary determines appropriate for an organization on the basis of its past practices) as meeting the standards to be a qualified organ procurement organization (as so described);

(B) meets the requirements that are applicable under such title for organ procurement agencies;

(C) meets performance-related standards prescribed by the Secretary;

(D) is a member of, and abides by the rules and requirements of, the Network;

(E) allocates organs, within its service area and nationally, in accordance with medical criteria and the policies of the Network; and

(F) is designated by the Secretary as an organ procurement organization payments to which may be treated as organ procurement costs for purposes of reimbursement under such title.

(2) The Secretary may not designate more than one organ procurement organization for each service area (described in

[94] See Vol. II, P.L. 78–410.

section 371(b)(1)(E) of the Public Health Service Act) under paragraph (1)(F).

NATIONAL COMMISSION ON CHILDREN

SEC. 1139. [42 U.S.C. 1320b–9] (a)(1)[94] There is hereby established a commission to be known as the National Commission on Children (in this section referred to as the "Commission").

(b)(1) The Commission shall consist of—

(A) 12 members to be appointed by the President,

(B) 12 members to be appointed by the Speaker of the House of Representatives, and

(C) 12 members to be appointed by the President pro tempore of the Senate.

(2) The President, the Speaker, and the President pro tempore shall each appoint as members of the Commission—

(A) 4 individuals who—

(i) are representatives of organizations providing services to children,

(ii) are involved in activities on behalf of children, or

(iii) have engaged in academic research with respect to the problems and needs of children,

(B) 4 individuals who are elected or appointed public officials (at the Federal, State, or local level) involved in issues and programs relating to children, and

(C) 4 individuals who are parents or representatives of parents or parents' organizations.

(3) The appointments made pursuant to subparagraphs (B) and (C) of paragraph (1) shall be made in consultation with the chairmen of committees of the House of Representatives and the Senate, respectively, having jurisdiction over relevant Federal programs.

(c)(1) It shall be the duty and function of the Commission to serve as a forum on behalf of the children of the Nation and to conduct the studies and issue the report required by subsection (d).

(2) The Commission (and any committees that it may form) shall conduct public hearings in different geographic areas of the country, both urban and rural, in order to receive the views of a broad spectrum of the public on the status of the Nation's children and on ways to safeguard and enhance the physical, mental, and emotional well-being of all of the children of the Nation, including those with physical or mental disabilities, and others whose circumstances deny them a full share of the opportunities that parents of the Nation may rightfully expect for their children.

(3) The Commission shall receive testimony from individuals, and from representatives of public and private organizations and institutions with an interest in the welfare of children, including educators, health care professionals, religious leaders, providers of social services, representatives of organizations with children as members, elected and appointed public officials, and from parents and children speaking in their own behalf.

[95] As in original. No paragraph (2) has been enacted.

(d) The Commission shall submit to the President, and to the Committees on Finance and Labor and Human Resources of the Senate and the Committees on Ways and Means, Education and Labor, and Energy and Commerce of the House of Representatives, an interim report no later than March 31, 1990, and a final report no later than March 31, 1991, setting forth recommendations with respect to the following subjects:

(1) Questions relating to the health of children that the Commission shall address include—

(A) how to reduce infant mortality,

(B) how to reduce the number of low-birth-weight babies,

(C) how to reduce the number of children with chronic illnesses and disabilities,

(D) how to improve the nutrition of children,

(E) how to promote the physical fitness of children,

(F) how to ensure that pregnant women receive adequate prenatal care,

(G) how to ensure that all children have access to both preventive and acute care health services, and

(H) how to improve the quality and availability of health care for children.

(2) Questions relating to social and support services for children and their parents that the Commission shall address include—

(A) how to prevent and treat child neglect and abuse,

(B) how to provide help to parents who seek assistance in meeting the problems of their children,

(C) how to provide counseling services for children,

(D) how to strengthen the family unit,

(E) how children can be assured of adequate care while their parents are working or participating in education or training programs,

(F) how to improve foster care and adoption services,

(G) how to reduce drug and alcohol abuse by children and youths, and

(H) how to reduce the incidence of teenage pregnancy.

(3) Questions relating to education that the Commission shall address include—

(A) how to encourage academic excellence for all children at all levels of education,

(B) how to use preschool experiences to enhance educational achievement,

(C) how to improve the qualifications of teachers,

(D) how schools can better prepare the Nation's youth to compete in the labor market,

(E) how parents and schools can work together to help children achieve success at each step of the academic ladder,

(F) how to encourage teenagers to complete high school and remain in school to fulfill their academic potential,

(G) how to address the problems of drug and alcohol abuse by young people,

(H) how schools might lend support to efforts aimed at reducing the incidence of teenage pregnancy, and

(I) how schools might better meet the special needs of children who have physical or mental handicaps.

(4) Questions relating to income security that the Commission shall address include—

(A) how to reduce poverty among children,

(B) how to ensure that parents support their children to the fullest extent possible through improved child support collection services, including services on behalf of children whose parents are unmarried, and

(C) how to ensure that cash assistance to needy children is adequate.

(5) Questions relating to tax policy that the Commission shall address include—

(A) how to assure the equitable tax treatment of families with children,

(B) the effect of existing tax provisions, including the dependent care tax credit, the earned income tax credit, and the targeted jobs tax credit, on children living in poverty,

(C) whether the dependent care tax credit should be refundable and the effect of such a policy,

(D) whether the earned income tax credit should be adjusted for family size and the effect of such a policy, and

(E) whether there are other tax-related policies which would reduce poverty among children.

(6) In addition to addressing the questions specified in paragraphs (1) through (5), the Commission shall—

(A) seek to identify ways in which public and private organizations and institutions can work together at the community level to identify deficiencies in existing services for families and children and to develop recommendations to ensure that the needs of families and children are met, using all available resources, in a coordinated and comprehensive manner, and

(B) assess the existing capacities of agencies to collect and analyze data on the status of children and on relevant programs, identify gaps in the data collection system, and recommend ways to improve the collection of data and the coordination among agencies in the collection and utilization of data.

The reports required by this subsection shall be based upon the testimony received in the hearings conducted pursuant to subsection (c), and upon other data and findings developed by the Commission.

(e)(1)(A) Members of the Commission shall first be appointed not later than 60 days after the date of the enactment of this section[95], for terms ending on March 31, 1991.

(B) A vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as the vacant position was first filled.

(2) The Commission shall elect one of its members to serve as Chairman of the Commission. The Chairman shall be a nonvoting member of the Commission.

(3) A majority of the members of the Commission shall constitute a quorum for the transaction of business.

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[96] December 22, 1987 [P.L. 100–203; 101 Stat. 1330–316].

(4)(A) The Commission shall meet at the call of the Chairman, or at the call of a majority of the members of the Commission.

(B) The Commission shall meet not less than 4 times during the period beginning with the date of the enactment of this section and ending with September 30, 1990.

(5) Decisions of the Commission shall be according to the vote of a simple majority of those present and voting at a properly called meeting.

(6) Members of the Commission shall serve without compensation, but shall be reimbursed for travel, subsistence, and other necessary expenses incurred in the performance of their duties as members of the Commission.

(f)(1) The Commission shall appoint an Executive Director of the Commission. In addition to the Executive Director, the Commission may appoint and fix the compensation of such personnel as it deems advisable. Such appointments and compensation may be made without regard to title 5, United States Code, that govern appointments in the competitive services, and the provisions of chapter 51 and subchapter III of chapter 53 of such title that relate to classifications and the General Schedule pay rates.

(2) The Commission may procure such temporary and intermittent services of consultants under section 3109(b) of title 5, United States Code[96], as the Commission determines to be necessary to carry out the duties of the Commission.

(g) In carrying out its duties, the Commission, or any duly organized committee thereof, is authorized to hold such hearings, sit and act at such times and places, and take such testimony, with respect to matters for which it has a responsibility under this section, as the Commission or committee may deem advisable.

(h)(1) The Commission may secure directly from any department or agency of the United States such data and information as may be necessary to carry out its responsibilities.

(2) Upon request of the Commission, any such department or agency shall furnish any such data or information.

(i) The General Services Administration shall provide to the Commission, on a reimbursable basis, such administrative support services as the Commission may request.

(j) There are authorized to be appropriated through fiscal year 1991, such sums as may be necessary to carry out this section for each of fiscal years 1989 and 1990.

(k)(1) The Commission is authorized to accept donations of money, property, or personal services. Funds received from donations shall be deposited in the Treasury in a separate fund created for this purpose. Funds appropriated for the Commission and donated funds may be expended for such purposes as official reception and representation expenses, public surveys, public service announcements, preparation of special papers, analyses, and documentaries, and for such other purposes as determined by the Commission to be in furtherance of its mission to review national issues affecting children.

(2) For purposes of Federal income, estate, and gift taxation, money and other property accepted under paragraph (1) of this

[97] See Vol. II, Title 5.

subsection shall be considered as a gift or bequest to or for the use of the United States.

(3) Expenditure of appropriated and donated funds shall be subject to such rules and regulations as may be adopted by the Commission and shall not be subject to Federal procurement requirements.

(l) The Commission is authorized to conduct such public surveys as it deems necessary in support of its review of national issues affecting children and, in conducting such surveys, the Commission shall not be deemed to be an "agency" for the purpose of section 3502 of title 44, United States Code[97].

PROHIBITION OF MISUSE OF SYMBOLS, EMBLEMS, OR NAMES IN REFERENCE TO SOCIAL SECURITY OR MEDICARE

SEC. 1140. [42 U.S.C. 1320b–10] (a)(1) No person may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet, or other communication, or a play, motion picture, broadcast, telecast, or other production, alone or with other words, letters, symbols, or emblems—

(A) the words "Social Security", "Social Security Account", "Social Security System", "Social Security Administration", "Medicare", "Centers for Medicare and Medicaid Services"[98], "Department of Health and Human Services", "Health and Human Services", "Supplemental Security Income Program", or "Medicaid", the letters "SSA", "CMS"[99], "DHHS", "HHS", or "SSI", or any other combination or variation of such words or letters, or

(B) a symbol or emblem of the Social Security Administration, Centers for Medicare and Medicaid Services[100], or Department of Health and Human Services (including the design of, or a reasonable facsimile of the design of, the social security card issued pursuant to section 205(c)(2)(F), or the Medicare card the check used for payment of benefits under title II, or envelopes or other stationery used by the Social Security Administration, Centers for Medicare and Medicaid Services[101], or Department of Health and Human Services) or any other combination or variation of such symbols or emblems,

in a manner which such person knows or should know would convey, or in a manner which reasonably could be interpreted or construed as conveying, the false impression that such item is approved, endorsed, or authorized by the Social Security Administration, the Centers for Medicare and Medicaid Services[102], or the Department of Health and Human Services or that such person has some connection with, or authorization from, the Social Security Administration, the Health Care Financing Administration, or the Department of Health and Human Services. The preceding provi-

[98] See Vol. II, Title 44.

[99] P.L. 108-173, §900(e)(1)(B)(i), struck out "Health Care Financing Administration", and substituted "Centers for Medicare and Medicaid Services".

[100] P.L. 108-173, §900(e)(1)(B)(ii)(II)), struck out "HCFA", and substituted "CMS".

[101] P.L. 108-173, §900(e)(1)(B)(ii)(I), struck out "Health Care Financing Administration", and substituted "Centers for Medicare and Medicaid Services".

[102] P.L. 108-173, §900(e)(1)(B)(iii), struck out "Health Care Financing Administration", and substituted "Centers for Medicare and Medicaid Services".

[103] P.L. 108-173, §900(e)(1)(B)(iii), struck out "Health Care Financing Administration", and substituted "Centers for Medicare and Medicaid Services".

sions of this subsection shall not apply with respect to the use by any agency or instrumentality of a State or political subdivision of a State of any words or letters which identify an agency or instrumentality of such State or of a political subdivision of such State or the use by any such agency or instrumentality of any symbol or emblem of an agency or instrumentality of such State or a political subdivision of such State.

(2)(A) No person may, for a fee, reproduce, reprint, or distribute any item consisting of a form, application, or other publication of the Social Security Administration unless such person has obtained specific, written authorization for such activity in accordance with regulations which the Commissioner of Social Security shall prescribe.

(B) No person may, for a fee, reproduce, reprint, or distribute any item consisting of a form, application, or other publication of the Department of Health and Human Services unless such person has obtained specific, written authorization for such activity in accordance with regulations which the Secretary shall prescribe.

(3) Any determination of whether the use of one or more words, letters, symbols, or emblems (or any combination or variation thereof) in connection with an item described in paragraph (1) or the reproduction, reprinting, or distribution of an item described in paragraph (2) is a violation of this subsection shall be made without regard to any inclusion in such item (or any so reproduced, reprinted, or distributed copy thereof) of a disclaimer of affiliation with the United States Government or any particular agency or instrumentality thereof.

(b) The Commissioner or the Secretary (as applicable) may, pursuant to regulations, impose a civil money penalty not to exceed—

(1) except as provided in paragraph (2), $5,000, or

(2) in the case of a violation consisting of a broadcast or telecast, $25,000,

against any person for each violation by such person of subsection (a). In the case of any items referred to in subsection (a)(1) consisting of pieces of mail, each such piece of mail which contains one or more words, letters, symbols, or emblems in violation of subsection (a) shall represent a separate violation. In the case of any item referred to in subsection (a)(2), the reproduction, reprinting, or distribution of such item shall be treated as a separate violation with respect to each copy thereof so reproduced, reprinted, or distributed.

(c)(1) The provisions of section 1128A (other than subsections (a), (b), (f), (h), and (i) and the first sentence of subsection (c)) shall apply to civil money penalties under subsection (b) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(2) Penalties imposed against a person under subsection (b) may be compromised by the Commissioner or the Secretary (as applicable) and may be recovered in a civil action in the name of the United States brought in the district court of the United States for the district in which the violation occurred or where the person resides, has its principal office, or may be found, as determined by the Commissioner or the Secretary (as applicable). Amounts recovered under this section shall be paid to the Secretary and shall be deposited as miscellaneous receipts of

the Treasury of the United States, except that (A) to the extent that such amounts are recovered under this section as penalties imposed for misuse of words, letters, symbols, or emblems relating to the Social Security Administration, such amounts shall be deposited into the Federal Old-Age and Survivors Insurance Trust Fund, and (B) to the extent that such amounts are recovered under this section as penalties imposed for misuse of words, letters, symbols, or emblems relating to the Department of Health and Human Services, such amounts shall be deposited into the Federal Hospital Insurance Trust Fund or the Federal Supplementary Medical Insurance Trust Fund, as appropriate. The amount of such penalty when finally determined, or the amount agreed upon in compromise, may be deducted from any sum then or later owing by the United States to the person against whom the penalty has been imposed.

(d) The preceding provisions of this section may be enforced through the Office of the Inspector General of the Social Security Administration or the Office of the Inspector General of the Department of Health and Human Services (as appropriate).

BLOOD DONOR LOCATOR SERVICE

SEC. 1141. [42 U.S.C. 1320b–11] (a) IN GENERAL.—The Commissioner of Social Security shall establish and conduct a Blood Donor Locator Service, which shall be used to obtain and transmit to any authorized person (as defined in subsection (h)(1)) the most recent mailing address of any blood donor who, as indicated by the donated blood or products derived therefrom or by the history of the subsequent use of such blood or blood products, has or may have the virus for acquired immune deficiency syndrome, in order to inform such donor of the possible need for medical care and treatment.

(b) PROVISION OF ADDRESS INFORMATION.—Whenever the Commissioner of Social Security receives a request, filed by an authorized person (as defined in subsection (h)(1)), for the mailing address of a donor described in subsection (a) and the Commissioner of Social Security is reasonably satisfied that the requirements of this section have been met with respect to such request, the Commissioner of Social Security shall promptly undertake to provide the requested address information from—

(1) the files and records maintained by the Social Security Administration, and

(2) such files and records obtained pursuant to section 6103(m)(6) of the Internal Revenue Code of 1986[103] as the Commissioner of Social Security considers necessary to comply with such request.

(c) MANNER AND FORM OF REQUESTS.—A request for address information under this section shall be filed in such manner and form as the Commissioner of Social Security shall by regulation prescribe, shall include the blood donor's social security account number, and shall be accompanied or supported by such documents as the Commissioner of Social Security may determine to be necessary.

[104] See Vol. II, P.L. 83–591.

(d) PROCEDURES AND SAFEGUARDS.—Any authorized person shall, as a condition for receiving address information from the Blood Donor Locator Service—

(1) establish and maintain, to the satisfaction of the Commissioner of Social Security, a system for standardizing records with respect to any request, the reason for such request, and the date of such request made by or of it and any disclosure of address information made by or to it,

(2) establish and maintain, to the satisfaction of the Commissioner of Social Security, a secure area or place in which such address information and all related blood donor records shall be stored,

(3) restrict, to the satisfaction of the Commissioner of Social Security, access to the address information and related blood donor records only to persons whose duties or responsibilities require access and to whom disclosure may be made under the provisions of this section,

(4) provide such other safeguards which the Commissioner of Social Security determines (and which the Commissioner of Social Security prescribes in regulations) to be necessary or appropriate to protect the confidentiality of the address information and related blood donor records,

(5) furnish a report to the Commissioner of Social Security, at such time and containing such information as the Commissioner of Social Security may prescribe, which describes the procedures established and utilized by the authorized person for ensuring the confidentiality of address information and related blood donor records required under this subsection, and

(6) destroy such address information and related blood donor records, upon completion of their use in providing the notification for which the information was obtained, so as to make such information and records undisclosable.

If the Commissioner of Social Security determines that any authorized person has failed to, or does not, meet the requirements of this subsection, the Commissioner of Social Security may, after any proceedings for review established under subsection (f), take such actions as are necessary to ensure such requirements are met, including refusing to disclose address information to such authorized person until the Commissioner of Social Security determines that such requirements have been or will be met. In the case of any authorized person who discloses any address information received pursuant to this section or any related blood donor records to any agent, this subsection shall apply to such authorized person and each such agent (except that, in the case of an agent, any report to the Commissioner of Social Security or other action with respect to the Commissioner of Social Security shall be made or taken through such authorized person). The Commissioner of Social Security shall destroy all related blood donor records in the possession of the Social Security Administration upon completion of their use in transmitting mailing addresses as required under subsection (a), so as to make such records undisclosable.

(e) ARRANGEMENTS WITH STATE AGENCIES AND AUTHORIZED PERSONS.—The Commissioner of Social Security, in carrying out the Commissioner's duties and functions under this section, shall enter into arrangements—

(1) with State agencies to accept and to transmit to the Commissioner of Social Security requests for address information under this section and to accept and to transmit such information to authorized persons, and

(2) with State agencies and authorized persons otherwise to cooperate with the Commissioner of Social Security in carrying out the purposes of this section.

(f) PROCEDURES FORI ADMINISTRATIVE REVIEW.—The Commissioner of Social Security shall by regulation prescribe procedures which provide for administrative review of any determination that any authorized person has failed to meet the requirements of this section.

(g) UNAUTHORIZED DISCLOSURE OF INFORMATION.—Paragraphs (1), (2), and (3) of section 7213(a) of the Internal Revenue Code of 1986[104] shall apply with respect to the unauthorized willful disclosure to any person of address information or related blood donor records acquired or maintained by or under the Commissioner of Social Security, or pursuant to this section by any authorized person, or of information derived from any such address information or related blood donor records, in the same manner and to the same extent as such paragraphs apply with respect to unauthorized disclosures of return and return information described in such paragraphs. Paragraph (4) of section 7213(a) of such Code shall apply with respect to the willful offer of any item of material value in exchange for any such address information or related blood donor record in the same manner and to the same extent as such paragraph applies with respect to offers (in exchange for any return or return information) described in such paragraph.

(h) DEFINITIONS.—for purposes of this section—

(1) AUTHORIZED PERSON.—The term "authorized person" means—

(A) any agency of a State (or of a political subdivision of a State) which has duties or authority under State law relating to the public health or otherwise has the duty or authority under State law to regulate blood donations, and

(B) any entity engaged in the acceptance of blood donations which is licensed or registered by the Food and Drug Administration in connection with the acceptance of such blood donations, and which, in accordance with such regulations as may be prescribed by the Commissioner of Social Security, provides for—

(i) the confidentiality of any address information received pursuant to this section and related blood donor records,

(ii) blood donor notification procedures for individuals with respect to whom such information is requested and a finding has been made that they have or may have the virus for acquired immune deficiency syndrome, and

(iii) counseling services for such individuals who have been found to have such virus.

(2) RELATED BLOOD DONOR RECORD.—The term "related blood donor record" means any record, list, or compilation which indicates, directly or indirectly, the identity of any individual

[105] See Vol. II, P.L. 83–591.

with respect to whom a request for address information has been made pursuant to this section.

(3) STATE.—The term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Commonwealth of the Northern Marianas, and the Trust Territory of the Pacific Islands.

RESEARCH ON OUTCOMES OF HEALTH CARE SERVICES AND PROCEDURES

SEC. 1142. [42 U.S.C. 1320b–12] (a) ESTABLISHMENT OF PROGRAM.—

(1) IN GENERAL.—The Secretary, acting through the Administrator for Health Care Policy and Research [105], shall—

(A) conduct and support research with respect to the outcomes, effectiveness, and appropriateness of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically; and

(B) assure that the needs and priorities of the program under title XVIII are appropriately reflected in the development and periodic review and updating (through the process set forth in section 913 of the Public Health Service Act [106]) of treatment-specific or condition-specific practice guidelines for clinical treatments and conditions in forms appropriate for use in clinical practice, for use in educational programs, and for use in reviewing quality and appropriateness of medical care.

(2) EVALUATIONS OF ALTERNATIVE SERVICES AND PROCEDURES.—In carrying out paragraph (1), the Secretary shall conduct or support evaluations of the comparative effects, on health and functional capacity, of alternative services and procedures utilized in preventing, diagnosing, treating, and clinically managing diseases, disorders, and other health conditions.

(3) INITIAL GUIDELINES.—

(A) In carrying out paragraph (1)(B) of this subsection, and section 912(d) of the Public Health Service Act [107], the Secretary shall, by not later than January 1, 1991, assure the development of an initial set of the guidelines specified in paragraph (1)(B) that shall include not less than 3 clinical treatments or conditions that—

(i)(I) account for a significant portion of expenditures under title XVIII; and

(II) have a significant variation in the frequency or the type of treatment provided; or

(ii) otherwise meet the needs and priorities of the program under title XVIII, as set forth under subsection (b)(3).

(B)(i) The Secretary shall provide for the use of guidelines developed under subparagrah [108] (A) to improve the

[106] PL. 106-129, §2(b)(2), provided that any reference to the Administrator for Health Care Policy and Research is deemed to be a reference to the Director of the Agency for Health Care and Quality.

[107] See Vol. II, P.L. 78–410.

[108] See Vol. II, P.L. 78–410.

[109] As in original; should be "subparagraph".

quality, effectiveness, and appropriateness of care provided under title XVIII. The Secretary shall determine the impact of such use on the quality, appropriateness, effectiveness, and cost of medical care provided under such title and shall report to the Congress on such determination by not later than January 1, 1993.

(ii) For the purpose of carrying out clause (i), the Secretary shall expend, from the amounts specified in clause (iii), $1,000,000 for fiscal year 1990 and $1,500,000 for each of the fiscal years 1991 and 1992.

(iii) For each fiscal year, for purposes of expenditures required in clause (ii)—

(I) 60 percent of an amount equal to the expenditure involved is appropriated from the Federal Hospital Insurance Trust Fund (established under section 1817); and

(II) 40 percent of an amount equal to the expenditure involved is appropriated from the Federal Supplementary Medical Insurance Trust Fund (established under section 1841).

(b) PRIORITIES.—

(1) IN GENERAL.—The Secretary shall establish priorities with respect to the diseases, disorders, and other health conditions for which research and evaluations are to be conducted or supported under subsection (a). In establishing such priorities, the Secretary shall, with respect to a disease, disorder, or other health condition, consider the extent to which—

(A) improved methods of prevention, diagnosis, treatment, and clinical management can benefit a significant number of individuals;

(B) there is significant variation among physicians in the particular services and procedures utilized in making diagnoses and providing treatments or there is significant variation in the outcomes of health care services or procedures due to different patterns of diagnosis or treatment;

(C) the services and procedures utilized for diagnosis and treatment result in relatively substantial expenditures; and

(D) the data necessary for such evaluations are readily available or can readily be developed.

(2) PRELIMINARY ASSESSMENTS.—For the purpose of establishing priorities under paragraph (1), the Secretary may, with respect to services and procedures utilized in preventing, diagnosing, treating, and clinically managing diseases, disorders, and other health conditions, conduct or support assessments of the extent to which—

(A) rates of utilization vary among similar populations for particular diseases, disorders, and other health conditions;

(B) uncertainties exist on the effect of utilizing a particular service or procedure; or

(C) inappropriate services and procedures are provided.

(3) RELATIONSHIP WITH MEDICARE PROGRAM.—In establishing priorities under paragraph (1) for research and evaluation, and

under section 914(a) of the Public Health Service Act [109] for the agenda under such section, the Secretary shall assure that such priorities appropriately reflect the needs and priorities of the program under title XVIII, as set forth by the Administrator of the Centers for Medicare and Medicaid Services [110].

(c) METHODOLOGIES AND CRITERIA FOR EVALUATIONS.—For the purpose of facilitating research under subsection (a), the Secretary shall—

(1) conduct and support research with respect to the improvement of methodologies and criteria utilized in conducting research with respect to outcomes of health care services and procedures;

(2) conduct and support reviews and evaluations of existing research findings with respect to such treatment or conditions;

(3) conduct and support reviews and evaluations of the existing methodologies that use large data bases in conducting such research and shall develop new research methodologies, including data-based methods of advancing knowledge and methodologies that measure clinical and functional status of patients, with respect to such research;

(4) provide grants and contracts to research centers, and contracts to other entities, to conduct such research on such treatment or conditions, including research on the appropriate use of prescription drugs;

(5) conduct and support research and demonstrations on the use of claims data and data on clinical and functional status of patients in determining the outcomes, effectiveness, and appropriateness of such treatment; and

(6) conduct and support supplementation of existing data bases, including the collection of new information, to enhance data bases for research purposes, and the design and development of new data bases that would be used in outcomes and effectiveness research.

(d) STANDARDS FOR DATABASES.—In carrying out this section, the Secretary shall develop—

(1) uniform definitions of data to be collected and used in describing a patient's clinical and functional status;

(2) common reporting formats and linkages for such data; and

(3) standards to assure the security, confidentiality, accuracy, and appropriate maintenance of such data.

(e) DISSEMINATION OF RESEARCH FINDINGS AND GUIDELINES.—

(1) IN GENERAL.—The Secretary shall provide for the dissemination of the findings of research and the guidelines described in subsection (a), and for the education of providers and others in the application of such research findings and guidelines.

(2) COOPERATIVE EDUCATIONAL ACTIVITIES.—In disseminating findings and guidelines under paragraph (1), and in providing for education under such paragraph, the Secretary shall work with professional associations, medical specialty and subspecialty organizations, and other relevant groups to identify and implement effective means to educate physicians, other

[110] See Vol. II, P.L. 78–410.

[111] P.L. 108-173, §900(e)(1)(C), struck out "Health Care Financing Administration", and substituted "Centers for Medicare and Medicaid Services".

providers, consumers, and others in using such findings and guidelines, including training for physician managers within provider organizations.

(f) EVALUATIONS.—The Secretary shall conduct and support evaluations of the activities carried out under this section to determine the extent to which such activities have had an effect on the practices of physicians in providing medical treatment, the delivery of health care, and the outcomes of health care services and procedures.

(g) RESEARCH WITH RESPECT TO DISSEMINATION.—The Secretary may conduct or support research with respect to improving methods of disseminating information on the effectiveness and appropriateness of health care services and procedures.

(h) REPORT TO CONGRESS.—Not later than February 1 of each of the years 1991 and 1992, and of each second year thereafter, the Secretary shall report to the Congress on the progress of the activities under this section during the preceding fiscal year (or preceding 2 fiscal years, as appropriate), including the impact of such activities on medical care (particularly medical care for individuals receiving benefits under title XVIII).

(i) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated to carry out this section—

(A) $50,000,000 for fiscal year 1990;
(B) $75,000,000 for fiscal year 1991;
(C) $110,000,000 for fiscal year 1992;
(D) $148,000,000 for fiscal year 1993; and
(E) $185,000,000 for fiscal year 1994.

(2) SPECIFICATIONS.—For the purpose of carrying out this section, for each of the fiscal years 1990 through 1992 an amount equal to two-thirds of the amounts authorized to be appropriated under paragraph (1), and for each of the fiscal years 1993 and 1994 an amount equal to 70 percent of such amounts, are to be appropriated in the following proportions from the following trust funds:

(A) 60 percent from the Federal Hospital Insurance Trust Fund (established under section 1817).

(B) 40 percent from the Federal Supplementary Medical Insurance Trust Fund (established under section 1841).

(3) ALLOCATIONS.—

(A) For each fiscal year, of the amounts transferred or otherwise appropriated to carry out this section, the Secretary shall reserve appropriate amounts for each of the purposes specified in clauses (i) through (iv) of subparagraph (B).

(B) The purposes referred to in subparagraph (A) are—

(i) the development of guidelines, standards, performance measures, and review criteria;
(ii) research and evaluation;
(iii) data-base standards and development; and
(iv) education and information dissemination.

SOCIAL SECURITY ACCOUNT STATEMENTS

Provision Upon Request

SEC. 1143. [42 U.S.C. 1320b–13] (a)(1) Beginning not later than October 1, 1990, the Secretary shall provide upon the request of an eligible individual a social security account statement (hereinafter referred to as the "statement").

(2) Each statement shall contain—

(A) the amount of wages paid to and self-employment income derived by the eligible individual as shown by the records of the Secretary at the date of the request;

(B) an estimate of the aggregate of the employer, employee, and self-employment contributions of the eligible individual for old-age, survivors, and disability insurance as shown by the records of the Secretary on the date of the request;

(C) a separate estimate of the aggregate of the employer, employee, and self-employment contributions of the eligible individual for hospital insurance as shown by the records of the Secretary on the date of the request; and

(D) an estimate of the potential monthly retirement, disability, survivor, and auxiliary benefits payable on the eligible individual's account together with a description of the benefits payable under the medicare program of title XVIII.

(3) For purposes of this section, the term "eligible individual" means an individual who—

(A) has a social security account number,

(B) has attained age 25 or over, and

(C) has wages or net earnings from self-employment.

Notice to Eligible Individuals

(b) The Secretary shall, to the maximum extent practicable, take such steps as are necessary to assure that eligible individuals are informed of the availability of the statement described in subsection (a).

Mandatory Provision of Statements

(c)(1) By not later than September 30, 1995, the Secretary shall provide a statement to each eligible individual who has attained age 60 by October 1, 1994, and who is not receiving benefits under title II and for whom a current mailing address can be determined through such methods as the Secretary determines to be appropriate. In fiscal years 1995 through 1999 the Secretary shall provide a statement to each eligible individual who attains age 60 in such fiscal years and who is not receiving benefits under title II and for whom a current mailing address can be determined through such methods as the Secretary determines to be appropriate. The Secretary shall provide with each statement to an eligible individual notice that such statement is updated annually and is available upon request.

(2) Beginning not later than October 1, 1999, the Secretary shall provide a statement on an annual basis to each eligible individual who is not receiving benefits under title II and for

whom a mailing address can be determined through such methods as the Secretary determines to be appropriate. With respect to statements provided to eligible individuals who have not attained age 50, such statements need not include estimates of monthly retirement benefits. However, if such statements provided to eligible individuals who have not attained age 50 do not include estimates of retirement benefit amounts, such statements shall include a description of the benefits (including auxiliary benefits) that are available upon retirement.

Disclosure to Governmental Employees of Effect of Noncovered Employment

(d)[111] (1) In the case of any individual commencing employment on or after January 1, 2005, in any agency or instrumentality of any State (or political subdivision thereof, as defined in section 218(b)(2)) in a position in which service performed by the individual does not constitute 'employment' as defined in section 210, the head of the agency or instrumentality shall ensure that, prior to the date of the commencement of the individual's employment in the position, the individual is provided a written notice setting forth an explanation, in language calculated to be understood by the average individual, of the maximum effect on computations of primary insurance amounts (under section 215(a)(7)) and the effect on benefit amounts (under section 202(k)(5)) of monthly periodic payments or benefits payable based on earnings derived in such service. Such notice shall be in a form which shall be prescribed by the Commissioner of Social Security.

(2) The written notice provided to an individual pursuant to paragraph (1) shall include a form which, upon completion and signature by the individual, would constitute certification by the individual of receipt of the notice. The agency or instrumentality providing the notice to the individual shall require that the form be completed and signed by the individual and submitted to the agency or instrumentality and to the pension, annuity, retirement, or similar fund or system established by the governmental entity involved responsible for paying the monthly periodic payments or benefits, before commencement of service with the agency or instrumentality.

OUTREACH EFFORTS TO INCREASE AWARENESS OF THE AVAILABILITY OF MEDICARE COST–SHARING AND SUBSIDIES FOR LOW-INCOME INDIVIDUALS UNDER TITLE XVIII[112]

SEC. 1144. [42 U.S.C. 1320b–14] (a) OUTREACH.—

(1) IN GENERAL.—The Commissioner of Social Security (in this section referred to as the "Commissioner") shall conduct outreach efforts to—

(A) identify individuals entitled to benefits under the medicare program under title XVIII who may be eligible for medical assistance for payment of the cost of medicare cost–sharing under the medicaid program pursuant to sections 1902(a)(10)(E) and 1933 for the transitional assist-

[112] P.L. 108-203, §419(c), added subsection (d), effective March 2, 2004.

[113] P.L. 108-173, §103(g)(1), inserted "and subsidies for low-income individuals under titles xviii" after "cost-sharing", effective December 8, 2003.

ance under section 1869D-31(f), or for premium and cost-sharing subsidies under section 1860D-14 [113]; and

(B) notify such individuals of the availability of such medical assistance program, and subsidies [114] under such sections.

(2) CONTENT OF NOTICE.—Any notice furnished under paragraph (1) shall state that eligibility for medicare cost–sharing assistance, the transitional assistance under section 1860D-31(f), or premium and cost-sharing subsidies under section 1860D-14 [115] under such sections is conditioned upon—

(A) the individual providing to the State information about income and resources (in the case of an individual residing in a State that imposes an assets test for eligibility for medicare cost-sharing under the medicaid program [116]); and

(B) meeting the applicable eligibility criteria.

(b) COORDINATION WITH STATES.—

(1) IN GENERAL.—In conducting the outreach efforts under this section, the Commissioner shall—

(A) furnish the agency of each State responsible for the administration of the medicaid program and any other appropriate State agency with information consisting of the name and address of individuals residing in the State that the Commissioner determines may be eligible for medical assistance for payment of the cost of medicare cost-sharing under the medicaid program pursuant to sections 1902(a)(10)(E) and 1933, for transitional assistance under section 1860D-31(f), or for premium and cost-sharing subsidies for low-income individuals under section 1860D-14; [117] and

(B) update any such information not less frequently than once per year.

(2) INFORMATION IN PERIODIC UPDATES.—The periodic updates described in paragraph (1)(B) shall include information on individuals who are or may be eligible for the medical assistance, program, and subsidies [118] described in paragraph (1)(A) because such individuals have experienced reductions in benefits under title II.

PROTECTION OF SOCIAL SECURITY AND MEDICARE TRUST FUNDS

SEC. 1145. [42 U.S.C. 1320b–15] (a) IN GENERAL.—No officer or employee of the United States shall—

(1) delay the deposit of any amount into (or delay the credit of any amount to) any Federal fund or otherwise vary from the

[114] P.L. 108-173, §103(g)(2)(A)(i), inserted "for the transitional assistance under section 1869D-31(f), or for premium and cost-sharing subsidies under section 1860D-14", effective December 8, 2003.

[115] P.L. 108-173, §103(g)(2)(A)(ii), inserted "program, and subsidies" after "medical assistance", effective December 8, 2003.

[116] P.L. 108-173, §103(g)(2)(B)(i), inserted "the transitional assistance under section 1860D-31(f), or premium and cost-sharing subsidies under section 1860D-14", effective December 8, 2003.

[117] P.L. 108-173, §103(g)(2)(B)(ii), struck out "such eligibility" inserted "eligibility for medicare cost-sharing under the medicaid program", effective December 8, 2003.

[118] P.L. 108-173, §103(g)(3)(A), inserted "for transitional assistance under section 1860D-31(f), or for premium and cost-sharing subsidies for low-income individuals under section 1860D-14".

[119] P.L. 108-173, §103(g)(3)(B), inserted ", program, and subsidies".

normal terms, procedures, or timing for making such deposits or credits,

(2) refrain from the investment in public debt obligations of amounts in any Federal fund, or

(3) redeem prior to maturity amounts in any Federal fund which are invested in public debt obligations for any purpose other than the payment of benefits or administrative expenses from such Federal fund.

(b) PUBLIC DEBT OBLIGATION.—For purposes of this section, the term "public debt obligation" means any obligation subject to the public debt limit established under section 3101 of title 31, United States Code [119].

(c) FEDERAL FUND.—For purposes of this section, the term "Federal fund" means—

(1) the Federal Old–Age and Survivors Insurance Trust Fund;

(2) the Federal Disability Insurance Trust Fund;

(3) the Federal Hospital Insurance Trust Fund; and

(4) the Federal Supplementary Medical Insurance Trust Fund.

PUBLIC DISCLOSURE OF CERTAIN INFORMATION ON HOSPITAL FINANCIAL INTEREST AND REFERRAL PATTERNS

SEC. 1146. [42 U.S.C. 1320b–16] The Secretary shall make available to the public, in a form and manner specified by the Secretary, information disclosed to the Secretary pursuant to section 1866(a)(1)(S).

RECOVERY OF SSI OVERPAYMENTS FROM OTHER BENEFITS [120]

SEC. 1147. [42 U.S.C. 1320b–17] (a) IN GENERAL.—Subject to subsection (b), whenever the Commissioner of Social Security determines that more than the correct amount of any payment has been made to a person under a program described in subsection (e), the Commissioner of Social Security may recover the amount incorrectly paid by decreasing any amount which is payable to such person under any other program specified in that subsection.

(b) LIMITATION APPLICABLE TO CURRENT BENEFITS.—

(1) IN GENERAL.—In carrying out subsection (a), the Commissioner of Social Security may not decrease the monthly amount payable to an individual under a program described in subsection (e) that is paid when regularly due—

(A) in the case of benefits under title II or VIII, by more than 10 percent of the amount of the benefit payable to the person for that month under such title; and

(B) in the case of benefits under title XVI, by an amount greater than the lesser of—

(i) the amount of the benefit payable to the person for that month; or

(ii) an amount equal to 10 percent of the person's income for that month (including such monthly benefit but excluding payments under title II when recovery

[120] See Vol. II, Title 31, §3101.

[121] P.L. 108-203, §210(a), amended §1147 in its entirety, effective with respect to overpayments under Titles II, VIII, and XVI that are outstanding on or after March 2, 2004. For §1147 as it formerly read, see Vol. II, Appendix J, Superseded Provisions.

is also made from title II payments and excluding income excluded pursuant to section 1612(b)).

(2) EXCEPTION.—Paragraph (1) shall not apply if—

(A) the person or the spouse of the person was involved in willful misrepresentation or concealment of material information in connection with the amount incorrectly paid; or

(B) the person so requests.

(c) NO EFFECT ON ELIGIBILITY OR BENEFIT AMOUNT UNDER TITLE VIII OR XVI.—In any case in which the Commissioner of Social Security takes action in accordance with subsection (a) to recover an amount incorrectly paid to any person, neither that person, nor (with respect to the program described in subsection (e)(3)) any individual whose eligibility for benefits under such program or whose amount of such benefits, is determined by considering any part of that person's income, shall, as a result of such action—

(1) become eligible for benefits under the program described in paragraph (2) or (3) of subsection (e); or

(2) if such person or individual is otherwise so eligible, become eligible for increased benefits under such program.

(d) INAPPLICABILITY OF PROHIBITION AGAINST ASSESSMENT AND LEGAL PROCESS.—Section 207 shall not apply to actions taken under the provisions of this section to decrease amounts payable under titles II and XVI.

(e) PROGRAMS DESCRIBED.—The programs described in this subsection are the following:

(1) The old-age, survivors, and disability insurance benefits program under title II.

(2) The special benefits for certain World War II veterans program under title VIII.

(3) The supplemental security income benefits program under title XVI (including, for purposes of this section, State supplementary payments paid by the Commissioner pursuant to an agreement under section 1616(a) of this Act or section 212(b) of Public Law 93-66).

SEC. 1147A. [Repealed.[121]]

THE TICKET TO WORK AND SELF–SUFFICIENCY PROGRAM[122]

SEC. 1148. [42 U.S.C. 1320b–19] (a) IN GENERAL.—The Commissioner shall establish a Ticket to Work and Self–Sufficiency Program, under which a disabled beneficiary may use a ticket to work and self–sufficiency issued by the Commissioner in accordance with this section to obtain employment services, vocational rehabilitation services, or other support services from an employment network which is of the beneficiary's choice and which is willing to provide such services to such beneficiary.

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[122] P.L. 108-203, §210(b)(3), repealed §1147A, effective with respect to overpayments under Titles II, VIII, and XVI that are outstanding on or after March 2, 2004. For §1147A as it formerly read, see Vol. II, Appendix J, Superseded Provisions.

[123] See Vol. II, P.L. 106–170, §2, with respect to Congress's findings and purposes with regard to providing assistance to individuals with disabilities to lead productive work lives; §101(e), with respect to specific regulations required to implement the amendments made by §101; and §101(f) with respect to the Ticket to Work and Work Incentives Advisory Panel.

(b) TICKET SYSTEM.—

(1) DISTRIBUTION OF TICKETS.—The Commissioner may issue a ticket to work and self–sufficiency to disabled beneficiaries for participation in the Program.

(2) ASSIGNMENT OF TICKETS.—A disabled beneficiary holding a ticket to work and self–sufficiency may assign the ticket to any employment network of the beneficiary's choice which is serving under the Program and is willing to accept the assignment.

(3) TICKET TERMS.—A ticket issued under paragraph (1) shall consist of a document which evidences the Commissioner's agreement to pay (as provided in paragraph (4)) an employment network, which is serving under the Program and to which such ticket is assigned by the beneficiary, for such employment services, vocational rehabilitation services, and other support services as the employment network may provide to the beneficiary.

(4) PAYMENTS TO EMPLOYMENT NETWORKS.—The Commissioner shall pay an employment network under the Program in accordance with the outcome payment system under subsection (h)(2) or under the outcome—milestone payment system under subsection (h)(3) (whichever is elected pursuant to subsection (h)(1)). An employment network may not request or receive compensation for such services from the beneficiary.

(c) STATE PARTICIPATION.—

(1) IN GENERAL.—Each State agency administering or supervising the administration of the State plan approved under title I of the Rehabilitation Act of 1973 (29 U.S.C. 720 et seq.) may elect to participate in the Program as an employment network with respect to a disabled beneficiary. If the State agency does elect to participate in the Program, the State agency also shall elect to be paid under the outcome payment system or the outcome–milestone payment system in accordance with subsection (h)(1). With respect to a disabled beneficiary that the State agency does not elect to have participate in the Program, the State agency shall be paid for services provided to that beneficiary under the system for payment applicable under section 222(d) and subsections (d) and (e) of section 1615. The Commissioner shall provide for periodic opportunities for exercising such elections.

(2) EFFECT OF PARTICIPATION BY STATE AGENCY.—

(A) STATE AGENCIES PARTICIPATING.—In any case in which a State agency described in paragraph (1) elects under that paragraph to participate in the Program, the employment services, vocational rehabilitation services, and other support services which, upon assignment of tickets to work and self–sufficiency, are provided to disabled beneficiaries by the State agency acting as an employment network shall be governed by plans for vocational rehabilitation services approved under title I of the Rehabilitation Act of 1973 (29 U.S.C. 720 et seq.).

(B) STATE AGENCIES ADMINISTERING MATERNAL AND CHILD HEALTH SERVICES PROGRAMS.—Subparagraph (A) shall not apply with respect to any State agency administering a program under title V of this Act.

(3) AGREEMENTS BETWEEN STATE AGENCIES AND EMPLOYMENT NETWORKS.—State agencies and employment networks shall enter into agreements regarding the conditions under which services will be provided when an individual is referred by an employment network to a State agency for services. The Commissioner shall establish by regulations the timeframe within which such agreements must be entered into and the mechanisms for dispute resolution between State agencies and employment networks with respect to such agreements.

(d) RESPONSIBILITIES OF THE COMMISSIONER.—

(1) SELECTION AND QUALIFICATIONS OF PROGRAM MANAGERS.—The Commissioner shall enter into agreements with 1 or more organizations in the private or public sector for service as a program manager to assist the Commissioner in administering the Program. Any such program manager shall be selected by means of a competitive bidding process, from among organizations in the private or public sector with available expertise and experience in the field of vocational rehabilitation or employment services.

(2) TENURE, RENEWAL, AND EARLY TERMINATION.—Each agreement entered into under paragraph (1) shall provide for early termination upon failure to meet performance standards which shall be specified in the agreement and which shall be weighted to take into account any performance in prior terms. Such performance standards shall include—

(A) measures for ease of access by beneficiaries to services; and

(B) measures for determining the extent to which failures in obtaining services for beneficiaries fall within acceptable parameters, as determined by the Commissioner.

(3) PRECLUSION FROM DIRECT PARTICIPATION IN DELIVERY OF SERVICES IN OWN SERVICE AREA.—Agreements under paragraph (1) shall preclude—

(A) direct participation by a program manager in the delivery of employment services, vocational rehabilitation services, or other support services to beneficiaries in the service area covered by the program manager's agreement; and

(B) the holding by a program manager of a financial interest in an employment network or service provider which provides services in a geographic area covered under the program manager's agreement.

(4) SELECTION OF EMPLOYMENT NETWORKS.—

(A) IN GENERAL.—The Commissioner shall select and enter into agreements with employment networks for service under the Program. Such employment networks shall be in addition to State agencies serving as employment networks pursuant to elections under subsection (c).

(B) ALTERNATE PARTICIPANTS.—In any State where the Program is being implemented, the Commissioner shall enter into an agreement with any alternate participant that is operating under the authority of section 222(d)(2) in the State as of the date of the enactment of this section and chooses to serve as an employment network under the Program.

(5) TERMINATION OF AGREEMENTS WITH EMPLOYMENT NETWORKS.—The Commissioner shall terminate agreements with employment networks for inadequate performance, as determined by the Commissioner.

(6) QUALITY ASSURANCE.—The Commissioner shall provide for such periodic reviews as are necessary to provide for effective quality assurance in the provision of services by employment networks. The Commissioner shall solicit and consider the views of consumers and the program manager under which the employment networks serve and shall consult with providers of services to develop performance measurements. The Commissioner shall ensure that the results of the periodic reviews are made available to beneficiaries who are prospective service recipients as they select employment networks. The Commissioner shall ensure that the periodic surveys of beneficiaries receiving services under the Program are designed to measure customer service satisfaction.

(7) DISPUTE RESOLUTION.—The Commissioner shall provide for a mechanism for resolving disputes between beneficiaries and employment networks, between program managers and employment networks, and between program managers and providers of services. The Commissioner shall afford a party to such a dispute a reasonable opportunity for a full and fair review of the matter in dispute.

(e) PROGRAM MANAGERS.—

(1) IN GENERAL.—A program manager shall conduct tasks appropriate to assist the Commissioner in carrying out the Commissioner's duties in administering the Program.

(2) RECRUITMENT OF EMPLOYMENT NETWORKS.—A program manager shall recruit, and recommend for selection by the Commissioner, employment networks for service under the Program. The program manager shall carry out such recruitment and provide such recommendations, and shall monitor all employment networks serving in the Program in the geographic area covered under the program manager's agreement, to the extent necessary and appropriate to ensure that adequate choices of services are made available to beneficiaries. Employment networks may serve under the Program only pursuant to an agreement entered into with the Commissioner under the Program incorporating the applicable provisions of this section and regulations thereunder, and the program manager shall provide and maintain assurances to the Commissioner that payment by the Commissioner to employment networks pursuant to this section is warranted based on compliance by such employment networks with the terms of such agreement and this section. The program manager shall not impose numerical limits on the number of employment networks to be recommended pursuant to this paragraph.

(3) FACILITATION OF ACCESS BY BENEFICIARIES TO EMPLOYMENT NETWORKS.—A program manager shall facilitate access by beneficiaries to employment networks. The program manager shall ensure that each beneficiary is allowed changes in employment networks without being deemed to have rejected services under the Program. When such a change occurs, the program manager shall reassign the ticket based on the choice of the beneficiary. Upon the request of the employment net-

work, the program manager shall make a determination of the allocation of the outcome or milestone–outcome payments based on the services provided by each employment network. The program manager shall establish and maintain lists of employment networks available to beneficiaries and shall make such lists generally available to the public. The program manager shall ensure that all information provided to disabled beneficiaries pursuant to this paragraph is provided in accessible formats.

(4) ENSURING AVAILABILITY OF ADEQUATE SERVICES.—The program manager shall ensure that employment services, vocational rehabilitation services, and other support services are provided to beneficiaries throughout the geographic area covered under the program manager's agreement, including rural areas.

(5) REASONABLE ACCESS TO SERVICES.—The program manager shall take such measures as are necessary to ensure that sufficient employment networks are available and that each beneficiary receiving services under the Program has reasonable access to employment services, vocational rehabilitation services, and other support services. Services provided under the Program may include case management, work incentives planning, supported employment, career planning, career plan development, vocational assessment, job training, placement, follow–up services, and such other services as may be specified by the Commissioner under the Program. The program manager shall ensure that such services are available in each service area.

(f) EMPLOYMENT NETWORKS.—

(1) QUALIFICATIONS FOR EMPLOYMENT NETWORKS.—

(A) IN GENERAL.—Each employment network serving under the Program shall consist of an agency or instrumentality of a State (or a political subdivision thereof) or a private entity, that assumes responsibility for the coordination and delivery of services under the Program to individuals assigning to the employment network tickets to work and self–sufficiency issued under subsection (b).

(B) ONE–STOP DELIVERY SYSTEMS.—An employment network serving under the Program may consist of a one–stop delivery system established under subtitle B of title I of the Workforce Investment Act of 1998 (29 U.S.C. 2811 et seq.).

(C) COMPLIANCE WITH SELECTION CRITERIA.—No employment network may serve under the Program unless it meets and maintains compliance with both general selection criteria (such as professional and educational qualifications, where applicable) and specific selection criteria (such as substantial expertise and experience in providing relevant employment services and supports).

(D) SINGLE OR ASSOCIATED PROVIDERS ALLOWED.—An employment network shall consist of either a single provider of such services or of an association of such providers organized so as to combine their resources into a single entity. An employment network may meet the requirements of subsection (e)(4) by providing services directly, or by entering into agreements with other individuals or entities

providing appropriate employment services, vocational rehabilitation services, or other support services.

(2) REQUIREMENTS RELATING TO PROVISION OF SERVICES.—Each employment network serving under the Program shall be required under the terms of its agreement with the Commissioner to—

(A) serve prescribed service areas; and

(B) take such measures as are necessary to ensure that employment services, vocational rehabilitation services, and other support services provided under the Program by, or under agreements entered into with, the employment network are provided under appropriate individual work plans that meet the requirements of subsection (g).

(3) ANNUAL FINANCIAL REPORTING.—Each employment network shall meet financial reporting requirements as prescribed by the Commissioner.

(4) PERIODIC OUTCOMES REPORTING.—Each employment network shall prepare periodic reports, on at least an annual basis, itemizing for the covered period specific outcomes achieved with respect to specific services provided by the employment network. Such reports shall conform to a national model prescribed under this section. Each employment network shall provide a copy of the latest report issued by the employment network pursuant to this paragraph to each beneficiary upon enrollment under the Program for services to be received through such employment network. Upon issuance of each report to each beneficiary, a copy of the report shall be maintained in the files of the employment network. The program manager shall ensure that copies of all such reports issued under this paragraph are made available to the public under reasonable terms.

(g) INDIVIDUAL WORK PLANS.—

(1) REQUIREMENTS.—Each employment network shall—

(A) take such measures as are necessary to ensure that employment services, vocational rehabilitation services, and other support services provided under the Program by, or under agreements entered into with, the employment network are provided under appropriate individual work plans that meet the requirements of subparagraph (C);

(B) develop and implement each such individual work plan, in partnership with each beneficiary receiving such services, in a manner that affords such beneficiary the opportunity to exercise informed choice in selecting an employment goal and specific services needed to achieve that employment goal;

(C) ensure that each individual work plan includes at least—

(i) a statement of the vocational goal developed with the beneficiary, including, as appropriate, goals for earnings and job advancement;

(ii) a statement of the services and supports that have been deemed necessary for the beneficiary to accomplish that goal;

(iii) a statement of any terms and conditions related to the provision of such services and supports; and

(iv) a statement of understanding regarding the beneficiary's rights under the Program (such as the right to retrieve the ticket to work and self–sufficiency if the beneficiary is dissatisfied with the services being provided by the employment network) and remedies available to the individual, including information on the availability of advocacy services and assistance in resolving disputes through the State grant program authorized under section 1150;

(D) provide a beneficiary the opportunity to amend the individual work plan if a change in circumstances necessitates a change in the plan; and

(E) make each beneficiary's individual work plan available to the beneficiary in, as appropriate, an accessible format chosen by the beneficiary.

(2) EFFECTIVE UPON WRITTEN APPROVAL.—A beneficiary's individual work plan shall take effect upon written approval by the beneficiary or a representative of the beneficiary and a representative of the employment network that, in providing such written approval, acknowledges assignment of the beneficiary's ticket to work and self–sufficiency.

(h) EMPLOYMENT NETWORK PAYMENT SYSTEMS.—

(1) ELECTION OF PAYMENT SYSTEM BY EMPLOYMENT NETWORKS.—

(A) IN GENERAL.—The Program shall provide for payment authorized by the Commissioner to employment networks under either an outcome payment system or an outcome–milestone payment system. Each employment network shall elect which payment system will be utilized by the employment network, and, for such period of time as such election remains in effect, the payment system so elected shall be utilized exclusively in connection with such employment network (except as provided in subparagraph (B)).

(B) NO CHANGE IN METHOD OF PAYMENT FOR BENEFICIARIES WITH TICKETS ALREADY ASSIGNED TO THE EMPLOYMENT NETWORKS.—Any election of a payment system by an employment network that would result in a change in the method of payment to the employment network for services provided to a beneficiary who is receiving services from the employment network at the time of the election shall not be effective with respect to payment for services provided to that beneficiary and the method of payment previously selected shall continue to apply with respect to such services.

(2) OUTCOME PAYMENT SYSTEM.—

(A) IN GENERAL.—The outcome payment system shall consist of a payment structure governing employment networks electing such system under paragraph (1)(A) which meets the requirements of this paragraph.

(B) PAYMENTS MADE DURING OUTCOME PAYMENT PERIOD.—The outcome payment system shall provide for a schedule of payments to an employment network, in connection with each individual who is a beneficiary, for each month, during the individual's outcome payment period, for which benefits (described in paragraphs (3) and (4) of

subsection (k)) are not payable to such individual because of work or earnings.

(C) COMPUTATION OF PAYMENTS TO EMPLOYMENT NETWORK.—The payment schedule of the outcome payment system shall be designed so that—

(i) the payment for each month during the outcome payment period for which benefits (described in paragraphs (3) and (4) of subsection (k)) are not payable is equal to a fixed percentage of the payment calculation base for the calendar year in which such month occurs; and

(ii) such fixed percentage is set at a percentage which does not exceed 40 percent.

(3) OUTCOME–MILESTONE PAYMENT SYSTEM.—

(A) IN GENERAL.—The outcome–milestone payment system shall consist of a payment structure governing employment networks electing such system under paragraph (1)(A) which meets the requirements of this paragraph.

(B) EARLY PAYMENTS UPON ATTAINMENT OF MILESTONES IN ADVANCE OF OUTCOME PAYMENT PERIODS.—The outcome– milestone payment system shall provide for 1 or more milestones, with respect to beneficiaries receiving services from an employment network under the Program, that are directed toward the goal of permanent employment. Such milestones shall form a part of a payment structure that provides, in addition to payments made during outcome payment periods, payments made prior to outcome payment periods in amounts based on the attainment of such milestones.

(C) LIMITATION ON TOTAL PAYMENTS TO EMPLOYMENT NETWORK.—The payment schedule of the outcome milestone payment system shall be designed so that the total of the payments to the employment network with respect to each beneficiary is less than, on a net present value basis (using an interest rate determined by the Commissioner that appropriately reflects the cost of funds faced by providers), the total amount to which payments to the employment network with respect to the beneficiary would be limited if the employment network were paid under the outcome payment system.

(4) DEFINITIONS.—In this subsection:

(A) PAYMENT CALCULATION BASE.—The term "payment calculation base" means, for any calendar year—

(i) in connection with a title II disability beneficiary, the average disability insurance benefit payable under section 223 for all beneficiaries for months during the preceding calendar year; and

(ii) in connection with a title XVI disability beneficiary (who is not concurrently a title II disability beneficiary), the average payment of supplemental security income benefits based on disability payable under title XVI (excluding State supplementation) for months during the preceding calendar year to all beneficiaries who have attained 18 years of age but have not attained 65 years of age.

(B) OUTCOME PAYMENT PERIOD.—The term "outcome payment period" means, in connection with any individual who had assigned a ticket to work and self–sufficiency to an employment network under the Program, a period—

(i) beginning with the first month, ending after the date on which such ticket was assigned to the employment network, for which benefits (described in paragraphs (3) and (4) of subsection (k)) are not payable to such individual by reason of engagement in substantial gainful activity or by reason of earnings from work activity; and

(ii) ending with the 60th month (consecutive or otherwise), ending after such date, for which such benefits are not payable to such individual by reason of engagement in substantial gainful activity or by reason of earnings from work activity.

(5) PERIODIC REVIEW AND ALTERATIONS OF PRESCRIBED SCHEDULES.—

(A) PERCENTAGES AND PERIODS.—The Commissioner shall periodically review the percentage specified in paragraph (2)(C), the total payments permissible under paragraph (3)(C), and the period of time specified in paragraph (4)(B) to determine whether such percentages, such permissible payments, and such period provide an adequate incentive for employment networks to assist beneficiaries to enter the workforce, while providing for appropriate economies. The Commissioner may alter such percentage, such total permissible payments, or such period of time to the extent that the Commissioner determines, on the basis of the Commissioner's review under this paragraph, that such an alteration would better provide the incentive and economies described in the preceding sentence.

(B) NUMBER AND AMOUNTS OF MILESTONE PAYMENTS.—The Commissioner shall periodically review the number and amounts of milestone payments established by the Commissioner pursuant to this section to determine whether they provide an adequate incentive for employment networks to assist beneficiaries to enter the workforce, taking into account information provided to the Commissioner by program managers, the Ticket to Work and Work Incentives Advisory Panel established by section 101(f) of the Ticket to Work and Work Incentives Improvement Act of 1999, and other reliable sources. The Commissioner may from time to time alter the number and amounts of milestone payments initially established by the Commissioner pursuant to this section to the extent that the Commissioner determines that such an alteration would allow an adequate incentive for employment networks to assist beneficiaries to enter the workforce. Such alteration shall be based on information provided to the Commissioner by program managers, the Ticket to Work and Work Incentives Advisory Panel established by section 101(f) of the Ticket to Work and Work Incentives Improvement Act of 1999, or other reliable sources.

(C) REPORT ON THE ADEQUACY OF INCENTIVES.—The Commissioner shall submit to the Congress not later than

36 months after the date of the enactment of the Ticket to Work and Work Incentives Improvement Act of 1999 a report with recommendations for a method or methods to adjust payment rates under subparagraphs (A) and (B), that would ensure adequate incentives for the provision of services by employment networks of—

(i) individuals with a need for ongoing support and services;

(ii) individuals with a need for high–cost accommodations;

(iii) individuals who earn a subminimum wage; and

(iv) individuals who work and receive partial cash benefits.

The Commissioner shall consult with the Ticket to Work and Work Incentives Advisory Panel established under section 101(f) of the Ticket to Work and Work Incentives Improvement Act of 1999 during the development and evaluation of the study. The Commissioner shall implement the necessary adjusted payment rates prior to full implementation of the Ticket to Work and Self–Sufficiency Program.

(i) SUSPENSION OF DISABILITY REVIEWS.—During any period for which an individual is using, as defined by the Commissioner, a ticket to work and self–sufficiency issued under this section, the Commissioner (and any applicable State agency) may not initiate a continuing disability review or other review under section 221 of whether the individual is or is not under a disability or a review under title XVI similar to any such review under section 221.

(j) AUTHORIZATIONS.—

(1) PAYMENTS TO EMPLOYMENT NETWORKS.—

(A) TITLE II DISABILITY BENEFICIARIES.—There are authorized to be transferred from the Federal Old–Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund each fiscal year such sums as may be necessary to make payments to employment networks under this section. Money paid from the Trust Funds under this section with respect to title II disability beneficiaries who are entitled to benefits under section 223 or who are entitled to benefits under section 202(d) on the basis of the wages and self–employment income of such beneficiaries, shall be charged to the Federal Disability Insurance Trust Fund, and all other money paid from the Trust Funds under this section shall be charged to the Federal Old–Age and Survivors Insurance Trust Fund.

(B) TITLE XVI DISABILITY BENEFICIARIES.—Amounts authorized to be appropriated to the Social Security Administration under section 1601 (as in effect pursuant to the amendments made by section 301 of the Social Security Amendments of 1972) shall include amounts necessary to carry out the provisions of this section with respect to title XVI disability beneficiaries.

(2) ADMINISTRATIVE EXPENSES.—The costs of administering this section (other than payments to employment networks) shall be paid from amounts made available for the administration of title II and amounts made available for the administra-

tion of title XVI, and shall be allocated among such amounts as appropriate.

(k) DEFINITIONS.—In this section:

(1) COMMISSIONER.—The term "Commissioner" means the Commissioner of Social Security.

(2) DISABLED BENEFICIARY.—The term "disabled beneficiary" means a title II disability beneficiary or a title XVI disability beneficiary.

(3) TITLE II DISABILITY BENEFICIARY.—The term "title II disability beneficiary" means an individual entitled to disability insurance benefits under section 223 or to monthly insurance benefits under section 202 based on such individual's disability (as defined in section 223(d)). An individual is a title II disability beneficiary for each month for which such individual is entitled to such benefits.

(4) TITLE XVI DISABILITY BENEFICIARY.—The term "title XVI disability beneficiary" means an individual eligible for supplemental security income benefits under title XVI on the basis of blindness (within the meaning of section 1614(a)(2)) or disability (within the meaning of section 1614(a)(3)). An individual is a title XVI disability beneficiary for each month for which such individual is eligible for such benefits.

(5) SUPPLEMENTAL SECURITY INCOME BENEFIT.—The term "supplemental security income benefit under title XVI" means a cash benefit under section 1611 or 1619(a), and does not include a State supplementary payment, administered federally or otherwise.

(l) REGULATIONS.—Not later than 1 year after the date of the enactment of the Ticket to Work and Work Incentives Improvement Act of 1999, the Commissioner shall prescribe such regulations as are necessary to carry out the provisions of this section.

WORK INCENTIVES OUTREACH PROGRAM

SEC. 1149. [42 U.S.C. 1320b–20] (a) ESTABLISHMENT.—

(1) IN GENERAL.—The Commissioner, in consultation with the Ticket to Work and Work Incentives Advisory Panel established under section 101(f) of the Ticket to Work and Work Incentives Improvement Act of 1999, shall establish a community–based work incentives planning and assistance program for the purpose of disseminating accurate information to disabled beneficiaries on work incentives programs and issues related to such programs.

(2) GRANTS, COOPERATIVE AGREEMENTS, CONTRACTS, AND OUTREACH.—Under the program established under this section, the Commissioner shall—

(A) establish a competitive program of grants, cooperative agreements, or contracts to provide benefits planning and assistance, including information on the availability of protection and advocacy services, to disabled beneficiaries, including individuals participating in the Ticket to Work and Self–Sufficiency Program established under section 1148, the program established under section 1619, and other programs that are designed to encourage disabled beneficiaries to work;

(B) conduct directly, or through grants, cooperative agreements, or contracts, ongoing outreach efforts to disabled beneficiaries (and to the families of such beneficiaries) who are potentially eligible to participate in Federal or State work incentive programs that are designed to assist disabled beneficiaries to work, including—

(i) preparing and disseminating information explaining such programs; and

(ii) working in cooperation with other Federal, State, and private agencies and nonprofit organizations that serve disabled beneficiaries, and with agencies and organizations that focus on vocational rehabilitation and work–related training and counseling;

(C) establish a corps of trained, accessible, and responsive work incentives specialists within the Social Security Administration who will specialize in disability work incentives under titles II and XVI for the purpose of disseminating accurate information with respect to inquiries and issues relating to work incentives to—

(i) disabled beneficiaries;

(ii) benefit applicants under titles II and XVI; and

(iii) individuals or entities awarded grants under subparagraphs (A) or (B); and

(D) provide—

(i) training for work incentives specialists and individuals providing planning assistance described in subparagraph (C); and

(ii) technical assistance to organizations and entities that are designed to encourage disabled beneficiaries to return to work.

(3) COORDINATION WITH OTHER PROGRAMS.—The responsibilities of the Commissioner established under this section shall be coordinated with other public and private programs that provide information and assistance regarding rehabilitation services and independent living supports and benefits planning for disabled beneficiaries including the program under section 1619, the plans for achieving self–support program (PASS), and any other Federal or State work incentives programs that are designed to assist disabled beneficiaries, including educational agencies that provide information and assistance regarding rehabilitation, school–to–work programs, transition services (as defined in, and provided in accordance with, the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.)), a one–stop delivery system established under subtitle B of title I of the Workforce Investment Act of 1998 (29 U.S.C. 2811 et seq.), and other services.

(b) CONDITIONS.—

(1) SELECTION OF ENTITIES.—

(A) APPLICATION.—An entity shall submit an application for a grant, cooperative agreement, or contract to provide benefits planning and assistance to the Commissioner at such time, in such manner, and containing such information as the Commissioner may determine is necessary to meet the requirements of this section.

(B) STATEWIDENESS.—The Commissioner shall ensure that the planning, assistance, and information described in paragraph (2) shall be available on a statewide basis.

(C) ELIGIBILITY OF STATES AND PRIVATE ORGANIZATIONS.—

(i) IN GENERAL.—The Commissioner may award a grant, cooperative agreement, or contract under this section to a State or a private agency or organization (other than Social Security Administration Field Offices and the State agency administering the State medicaid program under title XIX, including any agency or entity described in clause (ii), that the Commissioner determines is qualified to provide the planning, assistance, and information described in paragraph (2)).

(ii) AGENCIES AND ENTITIES DESCRIBED.—The agencies and entities described in this clause are the following:

(I) Any public or private agency or organization (including Centers for Independent Living established under title VII of the Rehabilitation Act of 1973 (29 U.S.C. 796 et seq.), protection and advocacy organizations, client assistance programs established in accordance with section 112 of the Rehabilitation Act of 1973 (29 U.S.C. 732), and State Developmental Disabilities Councils established in accordance with section 124 of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6024)) that the Commissioner determines satisfies the requirements of this section.

(II) The State agency administering the State program funded under part A of title IV.

(D) EXCLUSION FOR CONFLICT OF INTEREST.—The Commissioner may not award a grant, cooperative agreement, or contract under this section to any entity that the Commissioner determines would have a conflict of interest if the entity were to receive a grant, cooperative agreement, or contract under this section.

(2) SERVICES PROVIDED.—A recipient of a grant, cooperative agreement, or contract to provide benefits planning and assistance shall select individuals who will act as planners and provide information, guidance, and planning to disabled beneficiaries on the—

(A) availability and interrelation of any Federal or State work incentives programs designed to assist disabled beneficiaries that the individual may be eligible to participate in;

(B) adequacy of any health benefits coverage that may be offered by an employer of the individual and the extent to which other health benefits coverage may be available to the individual; and

(C) availability of protection and advocacy services for disabled beneficiaries and how to access such services.

(3) AMOUNT OF GRANTS, COOPERATIVE AGREEMENTS, OR CONTRACTS.—

(A) BASED ON POPULATION OF DISABLED BENEFICIARIES.—Subject to subparagraph (B), the Commissioner shall award a grant, cooperative agreement, or contract under this section to an entity based on the percentage of the population of the State where the entity is located who are disabled beneficiaries.

(B) LIMITATIONS.—

(i) PER GRANT.—No entity shall receive a grant, cooperative agreement, or contract under this section for a fiscal year that is less than $50,000 or more than $300,000.

(ii) TOTAL AMOUNT FOR ALL GRANTS, COOPERATIVE AGREEMENTS, AND CONTRACTS.—The total amount of all grants, cooperative agreements, and contracts awarded under this section for a fiscal year may not exceed $23,000,000.

(4) ALLOCATION OF COSTS.—The costs of carrying out this section shall be paid from amounts made available for the administration of title II and amounts made available for the administration of title XVI, and shall be allocated among those amounts as appropriate.

(c) DEFINITIONS.—In this section:

(1) COMMISSIONER.—The term "Commissioner" means the Commissioner of Social Security.

(2)[123] DISABLED BENEFICIARY.—The term "disabled beneficiary" means an individual—

(A) who is a disabled beneficiary as defined in section 1148(k)(2) of this Act;

(B) who is receiving a cash payment described in section 1616(a) of this Act or a supplementary payment described in section 212(a)(3) of Public Law 93-66 (without regard to whether such payment is paid by the Commissioner pursuant to an agreement under section 1616(a) of this Act or under section 212(b) of Public Law 93-66);

(C) who, pursuant to section 1619(b) of this Act, is considered to be receiving benefits under title XVI of this Act; or

(D) who is entitled to benefits under part A of title XVIII of this Act by reason of the penultimate sentence of section 226(b) of this Act.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $23,000,000 for each of the fiscal years 2000 through 2004.

STATE GRANTS FOR WORK INCENTIVES ASSISTANCE TO DISABLED BENEFICIARIES

SEC. 1150. [42 U.S.C. 1320b–21] (a) IN GENERAL.—Subject to subsection (c), the Commissioner may make payments in each State to the protection and advocacy system established pursuant to part C of title I of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6041 et seq.) for the purpose of providing services to disabled beneficiaries.

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[124] P.L. 108-203, §404(a)(1), amended paragraph (2) in its entirety, applicable with respect to grants, cooperative agreements, or contracts entered into on or after March 2, 2004.

For §1129(c)(2) as it formerly read, see Vol. II, Appendix J, Superseded Provisions.

(b) SERVICES PROVIDED.—Services provided to disabled beneficiaries pursuant to a payment made under this section may include—

(1) information and advice about obtaining vocational rehabilitation and employment services; and

(2) advocacy or other services that a disabled beneficiary may need to secure or regain gainful employment.

(c) APPLICATION.—In order to receive payments under this section, a protection and advocacy system shall submit an application to the Commissioner, at such time, in such form and manner, and accompanied by such information and assurances as the Commissioner may require.

(d) AMOUNT OF PAYMENTS.—

(1) IN GENERAL.—Subject to the amount appropriated for a fiscal year for making payments under this section, a protection and advocacy system shall not be paid an amount that is less than—

(A) in the case of a protection and advocacy system located in a State (including the District of Columbia and Puerto Rico) other than Guam, American Samoa, the United States Virgin Islands, and the Commonwealth of the Northern Mariana Islands, the greater of—

(i) $100,000; or

(ii) ⅓ of 1 percent of the amount available for payments under this section; and

(B) in the case of a protection and advocacy system located in Guam, American Samoa, the United States Virgin Islands, and the Commonwealth of the Northern Mariana Islands, $50,000.

(2) INFLATION ADJUSTMENT.—For each fiscal year in which the total amount appropriated to carry out this section exceeds the total amount appropriated to carry out this section in the preceding fiscal year, the Commissioner shall increase each minimum payment under subparagraphs (A) and (B) of paragraph (1) by a percentage equal to the percentage increase in the total amount so appropriated to carry out this section.

(e) ANNUAL REPORT.—Each protection and advocacy system that receives a payment under this section shall submit an annual report to the Commissioner and the Ticket to Work and Work Incentives Advisory Panel established under section 101(f) of the Ticket to Work and Work Incentives Improvement Act of 1999 on the services provided to individuals by the system.

(f) FUNDING.—

(1) ALLOCATION OF PAYMENTS.—Payments under this section shall be made from amounts made available for the administration of title II and amounts made available for the administration of title XVI, and shall be allocated among those amounts as appropriate.

(2) CARRYOVER.—Any amounts allotted for payment to a protection and advocacy system under this section for a fiscal year shall remain available for payment to or on behalf of the protection and advocacy system until the end of the succeeding fiscal year.

(g) DEFINITIONS.—In this section:

(1) COMMISSIONER.—The term "Commissioner" means the Commissioner of Social Security.

(2) DISABLED BENEFICIARY.—The term "disabled beneficiary" has the meaning given that term in section 1148(k)(2).

(3) PROTECTION AND ADVOCACY SYSTEM.—The term "protection and advocacy system" means a protection and advocacy system established pursuant to part C of title I of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6041 et seq.).

(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $7,000,000 for each of the fiscal years 2000 through 2004.

PART B—PEER REVIEW OF THE UTILIZATION AND QUALITY OF HEALTH CARE SERVICES [124]

PURPOSE

SEC. 1151. [42 U.S.C. 1320c] The purpose of this part is to establish the contracting process which the Secretary must follow pursuant to the requirements of section 1862(g) of this Act, including the definition of the utilization and quality control peer review organizations with which the Secretary shall contract, the functions such peer review organizations are to perform, the confidentiality of medical records, and related administrative matters to facilitate the carrying out of the purposes of this part.

DEFINITION OF UTILIZATION AND QUALITY CONTROL PEER REVIEW ORGANIZATION

SEC. 1152. [42 U.S.C. 1320c–1] The term "utilization and quality control peer review organization" means an entity which—

(1)(A) is composed of a substantial number of the licensed doctors of medicine and osteopathy engaged in the practice of medicine or surgery in the area and who are representative of the practicing physicians in the area, designated by the Secretary under section 1153, with respect to which the entity shall perform services under this part, or (B) has available to it, by arrangement or otherwise, the services of a sufficient number of licensed doctors of medicine or osteopathy engaged in the practice of medicine or surgery in such area to assure that adequate peer review of the services provided by the various medical specialties and subspecialties can be assured;

(2) is able, in the judgment of the Secretary, to perform review functions required under section 1154 in a manner consistent with the efficient and effective administration of this part and to perform reviews of the pattern of quality of care in an area of medical practice where actual performance is measured against objective criteria which define acceptable and adequate practice; and

(3) has at least one individual who is a representative of consumers on its governing body.

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[125] See Vol. II, P.L. 99–509, §9353(a)(4), with respect to contracts for small-area analysis.

See Vol. II, P.L. 100–203, §4091(a)(1), with respect to the one-time extensions to permit staggering of contract expiration dates; and §4094(e), with respect to the telecommunications demonstration projects.

See Vol. II, P.L. 108-173, §109(d), with respect to an Institute of Medicine study of quality improvement organizations.

CONTRACTS WITH UTILIZATION AND QUALITY CONTROL PEER REVIEW ORGANIZATIONS

SEC. 1153. [42 U.S.C. 1320c–2] (a)(1) The Secretary shall establish throughout the United States geographic areas with respect to which contracts under this part will be made. In establishing such areas, the Secretary shall use the same areas as established under section 1152 of this Act as in effect immediately prior to the date of the enactment of the Peer Review Improvement Act of 1982[125], but subject to the provisions of paragraph (2).

(2) As soon as practicable after the date of the enactment of the Peer Review Improvement Act of 1982, the Secretary shall consolidate such geographic areas, taking into account the following criteria:

(A) Each State shall generally be designated as a geographic area for purposes of paragraph (1).

(B) The Secretary shall establish local or regional areas rather than State areas only where the volume of review activity or other relevant factors (as determined by the Secretary) warrant such an establishment, and the Secretary determines that review activity can be carried out with equal or greater efficiency by establishing such local or regional areas. In applying this subparagraph the Secretary shall take into account the number of hospital admissions within each State for which payment may be made under title XVIII or a State plan approved under title XIX, with any State having fewer than 180,000 such admissions annually being established as a single statewide area, and no local or regional area being established which has fewer than 60,000 total hospital admissions (including public and private pay patients) under review annually, unless the Secretary determines that other relevant factors warrant otherwise.

(C) No local or regional area shall be designated which is not a self-contained medical service area, having a full spectrum of services, including medical specialists' services.

(b)(1) The Secretary shall enter into a contract with a utilization and quality control peer review organization for each area established under subsection (a) if a qualified organization is available in such area and such organization and the Secretary have negotiated a proposed contract which the Secretary determines will be carried out by such organization in a manner consistent with the efficient and effective administration of this part. If more than one such qualified organization meets the requirements of the preceding sentence, priority shall be given to any such organization which is described in section 1152(1)(A).

(2)(A) Prior to November 15, 1984, the Secretary shall not enter into a contract under this part with any entity which is, or is affiliated with (through management, ownership, or common control), an entity (other than a self-insured employer) which directly or indirectly makes payments to any practitioner or provider whose health care services are reviewed by such entity or would be reviewed by such entity if it entered into a contract with the Secretary under this part. For purposes of this paragraph, an entity shall not be considered to be affiliated with another entity which makes payments (directly or indirectly) to any practitioner or pro-

[126] September 3, 1982 [P.L. 97–248, Title I, Subtitle C; 96 Stat. 381].

vider, by reason of management, ownership, or common control, if the management, ownership, or common control consists only of members of the governing board being affiliated (through management, ownership, or common control) with a health maintenance organization or competitive medical plan which is an "eligible organization" as defined in section 1876(b).

(B) If, after November 14, 1984, the Secretary determines that there is no other entity available for an area with which the Secretary can enter into a contract under this part, the Secretary may then enter into a contract under this part with an entity described in subparagraph (A) for such area if such entity otherwise meets the requirements of this part.

(3)(A) The Secretary shall not enter into a contract under this part with any entity which is, or is affiliated with (through management, ownership, or common control), a health care facility, or association of such facilities, within the area served by such entity or which would be served by such entity if it entered into a contract with the Secretary under this part.

(B) For purposes of subparagraph (A), an entity shall not be considered to be affiliated with a health care facility or association of facilities by reason of management, ownership, or common control if the management, ownership, or common control consists only of not more than 20 percent of the members of the governing board of the entity being affiliated (through management, ownership, or common control) with one or more of such facilities or associations.

(c) Each contract with an organization under this section shall provide that—

(1) the organization shall perform the functions set forth in section 1154(a), or may subcontract for the performance of all or some of such functions (and for purposes of paragraphs (2) and (3) of subsection (b), a subcontract under this paragraph shall not constitute an affiliation with the subcontractor);

(2) the Secretary shall have the right to evaluate the quality and effectiveness of the organization in carrying out the functions specified in the contract;

(3) the contract shall be for an initial term of three years and shall be renewable on a triennial basis thereafter;

(4) if the Secretary intends not to renew a contract, he shall notify the organization of his decision at least 90 days prior to the expiration of the contract term, and shall provide the organization an opportunity to present data, interpretations of data, and other information pertinent to its performance under the contract, which shall be reviewed in a timely manner by the Secretary;

(5) the organization may terminate the contract upon 90 days notice to the Secretary;

(6) the Secretary may terminate the contract prior to the expiration of the contract term upon 90 days notice to the organization if the Secretary determines that—

(A) the organization does not substantially meet the requirements of section 1152; or

(B) the organization has failed substantially to carry out the contract or is carrying out the contract in a manner inconsistent with the efficient and effective administration of this part, but only after such organization has had an op-

portunity to submit data and have such data reviewed by the panel established under subsection (d);

(7) the Secretary shall include in the contract negotiated objectives against which the organization's performance will be judged, and negotiated specifications for use of regional norms, or modifications thereof based on national norms, for performing review functions under the contract; and

(8) reimbursement shall be made to the organization on a monthly basis, with payments for any month being made not later than 15 days after the close of such month.

In evaluating the performance of utilization and quality control peer review organizations under contracts under this part, the Secretary shall place emphasis on the performance of such organizations in educating providers and practitioners (particularly those in rural areas) concerning the review process and criteria being applied by the organization.

(d)(1) Prior to making any termination under subsection (c)(6)(B), the Secretary must provide the organization with an opportunity to provide data, interpretations of data, and other information pertinent to its performance under the contract. Such data and other information shall be reviewed in a timely manner by a panel appointed by the Secretary, and the panel shall submit a report of its findings to the Secretary in a timely manner. The Secretary shall make a copy of the report available to the organization.

(2) The Secretary may accept or not accept the findings of the panel. After the panel has submitted a report with respect to an organization, the Secretary may, with the concurrence of the organization, amend the contract to modify the scope of the functions to be carried out by the organization, or in any other manner. The Secretary may terminate a contract under the authority of subsection (c)(6)(B) upon 90 days notice after the panel has submitted a report, or earlier if the organization so agrees.

(3) A panel appointed by the Secretary under this subsection shall consist of not more than five individuals, each of whom shall be a member of a utilization and quality control peer review organization having a contract with the Secretary under this part. While serving on such panel individuals shall be paid at a per diem rate not to exceed the current per diem equivalent at the time that service on the panel is rendered for grade GS-18 under section 5332 of title 5, United States Code. Appointments shall be made without regard to title 5, United States Code.

(4) During the period after the Secretary has given notice of intent to terminate a contract, and prior to the time that the Secretary enters into a contract with another utilization and quality control peer review organization, the Secretary may transfer review responsibilities of the organization under the contract being terminated to another utilization and quality control peer review organization, or to an intermediary or carrier having an agreement under section 1816 or a contract under section 1842.

(e)(1) Except as provided in paragraph (2), contracting authority of the Secretary under this section may be carried out without regard to any provision of law relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the purposes of this part. The Secretary may use different contracting methods with respect to different geographical areas.

(2) If a peer review organization with a contract under this section is required to carry out a review function in addition to any function required to be carried out at the time the Secretary entered into or renewed the contract with the organization, the Secretary shall, before requiring such organization to carry out such additional function, negotiate the necessary contractual modifications, including modifications that provide for an appropriate adjustment (in light of the cost of such additional function) to the amount of reimbursement made to the organization.

(f) Any determination by the Secretary to terminate or not to renew a contract under this section shall not be subject to judicial review.

(g) The Secretary shall provide that fiscal intermediaries furnish to peer review organizations, each month on a timely basis, data necessary to initiate the review process under section 1154(a) on a timely basis. If the Secretary determines that a fiscal intermediary is unable to furnish such data on a timely basis, the Secretary shall require the hospital to do so.

(h)(1) The Secretary shall publish in the Federal Register any new policy or procedure adopted by the Secretary that affects substantially the performance of contract obligations under this section not less than 30 days before the date on which such policy or procedure is to take effect. This paragraph shall not apply to the extent it is inconsistent with a statutory deadline.

(2) The Secretary shall publish in the Federal Register the general criteria and standards used for evaluating the efficient and effective performance of contract obligations under this section and shall provide opportunity for public comment with respect to such criteria and standards.

(3) The Secretary shall regularly furnish each peer review organization with a contract under this section with a report that documents the performance of the organization in relation to the performance of other such organizations.

(i)(1) Notwithstanding any other provision of this section, the Secretary shall not renew a contract with any organization that is not an in-State organization (as defined in paragraph (3)) unless the Secretary has first complied with the requirements of paragraph (2).

(2)(A) Not later than six months before the date on which a contract period ends with respect to an organization that is not an in-State organization, the Secretary shall publish in the Federal Register—

(i) the date on which such period ends; and

(ii) the period of time in which an in-State organization may submit a proposal for the contract ending on such date.

(B) If one or more qualified in-State organizations submits a proposal within the period of time specified under subparagraph (A)(ii), the Secretary shall not automatically renew the current contract on a noncompetitive basis, but shall provide for competition for the contract in the same manner as a new contract under subsection (b).

(3) For purposes of this subsection, an in-State organization is an organization that has its primary place of business in the State in which review will be conducted (or, which is owned by

a parent corporation the headquarters of which is located in such State).

FUNCTIONS OF PEER REVIEW ORGANIZATIONS

SEC. 1154. [42 U.S.C. 1320c–3] (a) Any utilization and quality control peer review organization entering into a contract with the Secretary under this part must perform the following functions:

(1) The organization shall review some or all of the professional activities in the area, subject to the terms of the contract and subject to the requirements of subsection (d), of physicians and other health care practitioners and institutional and noninstitutional providers of health care services in the provision of health care services and items for which payment may be made (in whole or in part) under title XVIII (including where payment is made for such services to eligible organizations pursuant to contracts under section 1876, to Medicare Advantage organizations pursuant to contracts under part C, and to prescription drug sponsors pursuant to contracts under part D)[126] for the purpose of determining whether—

(A) such services and items are or were reasonable and medically necessary and whether such services and items are not allowable under subsection (a)(1) or (a)(9) of section 1862;

(B) the quality of such services meets professionally recognized standards of health care; and

(C) in case such services and items are proposed to be provided in a hospital or other health care facility on an inpatient basis, such services and items could, consistent with the provision of appropriate medical care, be effectively provided more economically on an outpatient basis or in an inpatient health care facility of a different type.

If the organization performs such reviews with respect to a type of health care practitioner other than medical doctors, the organization shall establish procedures for the involvement of health care practitioners of that type in such reviews.

(2) The organization shall determine, on the basis of the review carried out under subparagraphs (A), (B), and (C) of paragraph (1), whether payment shall be made for services under title XVIII. Such determination shall constitute the conclusive determination on those issues for purposes of payment under title XVIII, except that payment may be made if—

(A) such payment is allowed by reason of section 1879;

(B) in the case of inpatient hospital services or extended care services, the peer review organization determines that additional time is required in order to arrange for postdischarge care, but payment may be continued under this subparagraph for not more than two days, but only in the case where the provider of such services did not know and could not reasonably have been expected to know (as determined under section 1879) that payment would not otherwise be made for such services under title XVIII prior to notification by the organization under paragraph (3);

[126] P.L. 108-173, §109(a), inserted ", to Medicare Advantage organizations pursuant to contracts under part C, and to prescription drug sponsors pursuant to contracts under part D", applicable on and after January 1, 2004.

(C) such determination is changed as the result of any hearing or review of the determination under section 1155; or

(D) such payment is authorized under section 1861(v)(1)(G).

The organization shall identify cases for which payment should not be made by reason of paragraph (1)(B) only through the use of criteria developed pursuant to guidelines established by the Secretary.

(3)(A) Subject to subparagraphs (B) and (D), whenever the organization makes a determination that any health care services or items furnished or to be furnished to a patient by any practitioner or provider are disapproved, the organization shall promptly notify such patient and the agency or organization responsible for the payment of claims under title XVIII of this Act of such determination.

(B) The notification under subparagraph (A) with respect to services or items disapproved by reason of subparagraph (A) or (C) of paragraph (1) shall not occur until 20 days after the date that the organization has—

(i) made a preliminary notification to such practitioner or provider of such proposed determination, and

(ii) provided such practitioner or provider an opportunity for discussion and review of the proposed determination.

(C) The discussion and review conducted under subparagraph (B)(ii) shall not affect the rights of a practitioner or provider to a formal reconsideration of a determination under this part (as provided under section 1155).

(D) The notification under subparagraph (A) with respect to services or items disapproved by reason of paragraph (1)(B) shall not occur until after—

(i) the organization has notified the practitioner or provider involved of the determination and of the practitioner's or provider's right to a formal reconsideration of the determination under section 1155, and

(ii) if the provider or practitioner requests such a reconsideration, the organization has made such a reconsideration.

If a provider or practitioner is provided a reconsideration, such reconsideration shall be in lieu of any subsequent reconsideration to which the provider or practitioner may be otherwise entitled under section 1155, but shall not affect the right of a beneficiary from seeking reconsideration under such section of the organization's determination (after any reconsideration requested by the provider or physician under clause (ii)).

(E)(i) In the case of services and items provided by a physician that were disapproved by reason of paragraph (1)(B), the notice to the patient shall state the following: "In the judgment of the peer review organization, the medical care received was not acceptable under the medicare program. The reasons for the denial have been discussed with your physician.

(ii) In the case of services or items provided by an entity or practitioner other than a physician, the Secretary may substitute the entity or practitioner which

provided the services or items for the term "physician" in the notice described in clause (i).

(4)(A) The organization shall, after consultation with the Secretary, determine the types and kinds of cases (whether by type of health care or diagnosis involved, or whether in terms of other relevant criteria relating to the provision of health care services) with respect to which such organization will, in order to most effectively carry out the purposes of this part, exercise review authority under the contract. The organization shall notify the Secretary periodically with respect to such determinations. Each peer review organization shall provide that a reasonable proportion of its activities are involved with reviewing, under paragraph (1)(B), the quality of services and that a reasonable allocation of such activities is made among the different cases and settings (including post-acute-care settings, ambulatory settings, and health maintenance organizations). In establishing such allocation, the organization shall consider (i) whether there is reason to believe that there is a particular need for reviews of particular cases or settings because of previous problems regarding quality of care, (ii) the cost of such reviews and the likely yield of such reviews in terms of number and seriousness of quality of care problems likely to be discovered as a result of such reviews, and (iii) the availability and adequacy of alternative quality review and assurance mechanisms.

(B) The contract of each organization shall provide for the review of services (including both inpatient and outpatient services) provided by eligible organizations pursuant to a risk-sharing contract under section 1876 (or that is subject to review under section 1882(t)(3)) for the purpose of determining whether the quality of such services meets professionally recognized standards of health care, including whether appropriate health care services have not been provided or have been provided in inappropriate settings and whether individuals enrolled with an eligible organization have adequate access to health care services provided by or through such organization (as determined, in part, by a survey of individuals enrolled with the organization who have not yet used the organization to receive such services). The contract of each organization shall also provide that with respect to health care provided by a health maintenance organization or competitive medical plan under section 1876, the organization shall maintain a beneficiary outreach program designed to apprise individuals receiving care under such section of the role of the peer review system, of the rights of the individual under such system, and of the method and purposes for contacting the organization. The previous two sentences shall not apply with respect to a contract year if another entity has been awarded a contract under subparagraph (C). Under the contract the level of effort expended by the organization on reviews under this subparagraph shall be equivalent, on a per enrollee basis, to the level of effort expended by the organization on utilization and quality reviews performed with respect to individuals not enrolled with an eligible organization.

(C) The Secretary may provide, by contract under competitive procurement procedures on a State-by-State basis in up to 25 States, for the review described in subparagraph (B) by an appropriate entity (which may be a peer review organization described in that subparagraph). In selecting among States in which to conduct such competitive procurement procedures, the Secretary may not select States which, as a group, have more than 50 percent of the total number of individuals enrolled with eligible organizations under section 1876. Under a contract with an entity under this subparagraph—

(i) the entity must be, or must meet all the requirements under section 1152 to be, a utilization and quality control peer review organization (other than the ability to perform review functions under this section that are not described in subparagraph (B)),

(ii) the contract must meet the requirement of section 1153(b)(3), and

(iii) the level of effort expended under the contract shall be, to the extent practicable, not less than the level of effort that would otherwise be required under the third sentence of subparagraph (B) if this subparagraph did not apply.

(5) The organization shall consult with nurses and other professional health care practitioners (other than physicians described in section 1861(r)(1)) and with representatives of institutional and noninstitutional providers of health care services, with respect to the organization's responsibility for the review under paragraph (1) of the professional activities of such practitioners and providers.

(6)(A) The organization shall, consistent with the provisions of its contract under this part, apply professionally developed norms of care, diagnosis, and treatment based upon typical patterns of practice within the geographic area served by the organization as principal points of evaluation and review, taking into consideration national norms where appropriate. Such norms with respect to treatment for particular illnesses or health conditions shall include—

(i) the types and extent of the health care services which, taking into account differing, but acceptable, modes of treatment and methods of organizing and delivering care, are considered within the range of appropriate diagnosis and treatment of such illness or health condition, consistent with professionally recognized and accepted patterns of care; and

(ii) the type of health care facility which is considered, consistent with such standards, to be the type in which health care services which are medically appropriate for such illness or condition can most economically be provided.

As a component of the norms described in clause (i) or (ii), the organization shall take into account the special problems associated with delivering care in remote rural areas, the availability of service alternatives to inpatient hospitalization, and other appropriate factors (such as the distance from a patient's residence to the site of care, family support, availability of

proximate alternative sites of care, and the patient's ability to carry out necessary or prescribed self-care regimens) that could adversely affect the safety or effectiveness of treatment provided on an outpatient basis.

(B) The organization shall—

(i) offer to provide, several times each year, for a physician representing the organization to meet (at a hospital or at a regional meeting) with medical and administrative staff of each hospital (the services of which are reviewed by the organization) respecting the organization's review of the hospital's services for which payment may be made under title XVIII, and

(ii) publish (not less often than annually) and distribute to providers and practitioners whose services are subject to review a report that describes the organization's findings with respect to the types of cases in which the organization has frequently determined that (I) inappropriate or unnecessary care has been provided, (II) services were rendered in an inappropriate setting, or (III) services did not meet professionally recognized standards of health care.

(7) The organization, to the extent necessary and appropriate to the performance of the contract, shall—

(A)(i) make arrangements to utilize the services of persons who are practitioners of, or specialists in, the various areas of medicine (including dentistry, optometry, and podiatry, or other types of health care, which persons shall, to the maximum extent practicable, be individuals engaged in the practice of their profession within the area served by such organization; and

(ii) in the case of psychiatric and physical rehabilitation services, make arrangements to ensure that (to the extent possible) initial review of such services be made by a physician who is trained in psychiatry or physical rehabilitation (as appropriate).[127]

(B) undertake such professional inquiries either before or after, or both before and after, the provision of services with respect to which such organization has a responsibility for review which in the judgment of such organization will facilitate its activities;

(C) examine the pertinent records of any practitioner or provider of health care services providing services with respect to which such organization has a responsibility for review under paragraph (1); and

(D) inspect the facilities in which care is rendered or services are provided (which are located in such area) of any practitioner or provider of health care services providing services with respect to which such organization has a responsibility for review under paragraph (1).

(8) The organization shall perform such duties and functions and assume such responsibilities and comply with such other requirements as may be required by this part or under regulations of the Secretary promulgated to carry out the provisions

[128] Punctuation as in original.

of this part or as may be required to carry out section 1862(a)(15).

(9)(A) The organization shall collect such information relevant to its functions, and keep and maintain such records, in such form as the Secretary may require to carry out the purposes of this part, and shall permit access to and use of any such information and records as the Secretary may require for such purposes, subject to the provisions of section 1160.

(B) If the organization finds, after reasonable notice to and opportunity for discussion with the physician or practitioner concerned, that the physician or practitioner has furnished services in violation of section 1156(a) and the organization determines that the physician or practitioner should enter into a corrective action plan under section 1156(b)(1), the organization shall notify the State board or boards responsible for the licensing or disciplining of the physician or practitioner of its finding and of any action taken as a result of the finding.

(10) The organization shall coordinate activities, including information exchanges, which are consistent with economical and efficient operation of programs among appropriate public and private agencies or organizations including—

(A) agencies under contract pursuant to sections 1816 and 1842 of this Act;

(B) other peer review organizations having contracts under this part; and

(C) other public or private review organizations as may be appropriate.

(11) The organization shall make available its facilities and resources for contracting with private and public entities paying for health care in its area for review, as feasible and appropriate, of services reimbursed by such entities.

(12) [Stricken.[128]]

(13) Notwithstanding paragraph (4), the organization shall perform the review described in paragraph (1) with respect to early readmission cases to determine if the previous inpatient hospital services and the post-hospital services met professionally recognized standards of health care. Such reviews may be performed on a sample basis if the organization and the Secretary determine it to be appropriate. In this paragraph, an "early readmission case" is a case in which an individual, after discharge from a hospital, is readmitted to a hospital less than 31 days after the date of the most recent previous discharge.

(14) The organization shall conduct an appropriate review of all written complaints about the quality of services (for which payment may otherwise be made under title XVIII) not meeting professionally recognized standards of health care, if the complaint is filed with the organization by an individual entitled to benefits for such services under such title (or a person acting on the individual's behalf). The organization shall inform the individual (or representative) of the organization's final disposition of the complaint. Before the organization concludes that the quality of services does not meet professionally recognized standards of health care, the organization must pro-

[129] P.L. 103–432, §156(a)(2)(A)(i); 108 Stat. 4440.

vide the practitioner or person concerned with reasonable notice and opportunity for discussion.

(15) During each year of the contract entered into under section 1153(b), the organization shall perform significant on-site review activities, including on-site review in at least 20 percent of the rural hospitals in the organization's area.

(16) The organization shall provide for a review and report to the Secretary when requested by the Secretary under section 1867(d)(3). The organization shall provide reasonable notice of the review to the physician and hospital involved. Within the time period permitted by the Secretary, the organization shall provide a reasonable opportunity for discussion with the physician and hospital involved, and an opportunity for the physician and hospital to submit additional information, before issuing its report to the Secretary under such section.

(17)[129] The organization shall execute its responsibilities under subparagraphs (A) and (B) of paragraph (1) by offering to providers, practitioners, Medicare Advantage organizations offering Medicare Advantage plans under part C, and prescription drug sponsors offering prescription drug plans under part D quality improvement assistance pertaining to prescription drug therapy. For purposes of this part and title XVIII, the functions described in this paragraph shall be treated as a review function.

(b)(1) No physician shall be permitted to review—

(A) health care services provided to a patient if he was directly responsible for providing such services; or

(B) health care services provided in or by an institution, organization, or agency, if he or any member of his family has, directly or indirectly, a significant financial interest in such institution, organization, or agency.

(2) For purposes of this subsection, a physician's family includes only his spouse (other than a spouse who is legally separated from him under a decree of divorce or separate maintenance), children (including legally adopted children), grandchildren, parents, and grandparents.

(c) No utilization and quality control peer review organization shall utilize the services of any individual who is not a duly licensed doctor of medicine, osteopathy, dentistry, optometry, or podiatry to make final determinations of denial decisions in accordance with its duties and functions under this part with respect to the professional conduct of any other duly licensed doctor of medicine, osteopathy, dentistry, optometry, or podiatry, or any act performed by any duly licensed doctor of medicine, osteopathy, dentistry, optometry, or podiatry in the exercise of his profession.

(d) Each contract under this part shall require that the utilization and quality control peer review organization's review responsibility pursuant to subsection (a)(1) will include review of all ambulatory surgical procedures specified pursuant to section 1833(i)(1)(A) which are performed in the area, or, at the discretion of the Secretary a sample of such procedures.

(e)(1) If—

(A) a hospital has determined that a patient no longer requires inpatient hospital care, and

[130] P.L. 108-173, §109(b), added paragraph (17), applicable on and after January 1, 2004.

(B) the attending physician has agreed with the hospital's determination,

the hospital may provide the patient (or the patient's representative) with a notice (meeting conditions prescribed by the Secretary under section 1879) of the determination.

(2)-(4) [Stricken.] [130]

(5) [Stricken. [131]]

(f) The Secretary, in consultation with appropriate experts, shall identify methods that would be available to assist peer review organizations (under subsection (a)(4)) in identifying those cases which are more likely than others to be associated with a quality of services which does not meet professionally recognized standards of health care.

RIGHT TO HEARING AND JUDICIAL REVIEW

SEC. 1155. [42 U.S.C. 1320c–4] Any beneficiary who is entitled to benefits under title XVIII, and, subject to section 1154(a)(3)(D), any practitioner or provider, who is dissatisfied with a determination made by a contracting peer review organization in conducting its review responsibilities under this part, shall be entitled to a reconsideration of such determination by the reviewing organization. Where the reconsideration is adverse to the beneficiary and where the matter in controversy is $200 or more, such beneficiary shall be entitled to a hearing by the Secretary (to the same extent as beneficiaries under title II are entitled to a hearing by the Commissioner of Social Security under section 205(b)). For purposes of the preceding sentence, subsection (l) of section 205 shall apply, except that any reference in such subsection to the Commissioner of Social Security or the Social Security Administration shall be deemed a reference to the Secretary or the Department of Health and Human Services, respectively. Where the amount in controversy is $2,000 or more, such beneficiary shall be entitled to judicial review of any final decision relating to a reconsideration described in this subsection.

OBLIGATIONS OF HEALTH CARE PRACTITIONERS AND PROVIDERS OF HEALTH CARE SERVICES; SANCTIONS AND PENALTIES; HEARINGS AND REVIEW

SEC. 1156. [42 U.S.C. 1320c–5] (a) It shall be the obligation of any health care practitioner and any other person (including a hospital or other health care facility, organization, or agency) who provides health care services for which payment may be made (in whole or in part) under this Act, to assure, to the extent of his authority that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under this Act—

(1) will be provided economically and only when, and to the extent, medically necessary;

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[131] P.L. 106-554, Appendix F, §521(c), struck out paragraphs (2), (3), and (4), applicable with respect to initial determinations made on or after October 1, 2002. For paragraphs (2), (3) and (4) as they formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L. 106-554.

[132] P.L. 108-173, §948(d), struck out paragraph (5), effective as if included in P.L. 106-554, Appendix F, §521(c), applicable with respect to iniital determinations made on or after October 1, 2002.

For paragraph (c) as it formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L. 108-173.

(2) will be of a quality which meets professionally recognized standards of health care; and

(3) will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing peer review organization in the exercise of its duties and responsibilities.

(b)(1) If after reasonable notice and opportunity for discussion with the practitioner or person concerned, and, if appropriate, after the practitioner or person has been given a reasonable opportunity to enter into and complete a corrective action plan (which may include remedial education) agreed to by the organization, and has failed successfully to complete such plan, any organization having a contract with the Secretary under this part determines that such practitioner or person has—

(A) failed in a substantial number of cases substantially to comply with any obligation imposed on him under subsection (a), or

(B) grossly and flagrantly violated any such obligation in one or more instances,

such organization shall submit a report and recommendations to the Secretary. If the Secretary agrees with such determination, the Secretary (in addition to any other sanction provided under law) may exclude (permanently or for such period as the Secretary may prescribe, except that such period may not be less than 1 year) such practitioner or person from eligibility to provide services under this Act on a reimbursable basis. If the Secretary fails to act upon the recommendations submitted to him by such organization within 120 days after such submission, such practitioner or person shall be excluded from eligibility to provide services on a reimbursable basis until such time as the Secretary determines otherwise.

(2) A determination made by the Secretary under this subsection to exclude a practitioner or person shall be effective on the same date and in the same manner as an exclusion from participation under the programs under this Act becomes effective under section 1128(c), and shall (subject to the minimum period specified in the second sentence of paragraph (1)) remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

(3) In lieu of the sanction authorized by paragraph (1), the Secretary may require that (as a condition to the continued eligibility of such practitioner or person to provide such health care services on a reimbursable basis) such practitioner or person pays to the United States, in case such acts or conduct involved the provision or ordering by such practitioner or person of health care services which were medically improper or unnecessary, an amount not in excess of up to $10,000 for each instance of the medically improper or unnecessary services so provided. Such amount may be deducted from any sums owing by the United States (or any instrumentality thereof) to the practitioner or person from whom such amount is claimed.

(4) Any practitioner or person furnishing services described in paragraph (1) who is dissatisfied with a determination made by the Secretary under this subsection shall be entitled to reasonable notice and opportunity for a hearing thereon by the

Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

(5) Before the Secretary may effect an exclusion under paragraph (2) in the case of a provider or practitioner located in a rural health professional shortage area or in a county with a population of less than 70,000, the provider or practitioner adversely affected by the determination is entitled to a hearing before an administrative law judge (described in section 205(b)) respecting whether the provider or practitioner should be able to continue furnishing services to individuals entitled to benefits under this Act, pending completion of the administrative review procedure under paragraph (4). If the judge does not determine, by a preponderance of the evidence, that the provider or practitioner will pose a serious risk to such individuals if permitted to continue furnishing such services, the Secretary shall not effect the exclusion under paragraph (2) until the provider or practitioner has been provided reasonable notice and opportunity for an administrative hearing thereon under paragraph (4).

(6) When the Secretary effects an exclusion of a physician under paragraph (2), the Secretary shall notify the State board responsible for the licensing of the physician of the exclusion.

(c) It shall be the duty of each utilization and quality control peer review organization to use such authority or influence it may possess as a professional organization, and to enlist the support of any other professional or governmental organization having influence or authority over health care practitioners and any other person (including a hospital or other health care facility, organization, or agency) providing health care services in the area served by such review organization, in assuring that each practitioner or person (referred to in subsection (a)) providing health care services in such area shall comply with all obligations imposed on him under subsection (a).

LIMITATION ON LIABILITY

SEC. 1157. [42 U.S.C. 1320c–6] (a) Notwithstanding any other provision of law, no person providing information to any organization having a contract with the Secretary under this part shall be held, by reason of having provided such information, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) unless—

(1) such information is unrelated to the performance of the contract of such organization; or

(2) such information is false and the person providing it knew, or had reason to believe, that such information was false.

(b) No organization having a contract with the Secretary under this part and no person who is employed by, or who has a fiduciary relationship with, any such organization or who furnishes professional services to such organization, shall be held by reason of the performance of any duty, function, or activity required or authorized pursuant to this part or to a valid contract entered into under this part, to have violated any criminal law, or to be civilly liable

under any law of the United States or of any State (or political subdivision thereof) provided due care was exercised in the performance of such duty, function, or activity.

(c) No doctor of medicine or osteopathy and no provider (including directors, trustees, employees, or officials thereof) of health care services shall be civilly liable to any person under any law of the United States or of any State (or political subdivision thereof) on account of any action taken by him in compliance with or reliance upon professionally developed norms of care and treatment applied by an organization under contract pursuant to section 1153 operating in the area where such doctor of medicine or osteopathy or provider took such action; but only if—

(1) he takes such action in the exercise of his profession as a doctor of medicine or osteopathy or in the exercise of his functions as a provider of health care services; and

(2) he exercised due care in all professional conduct taken or directed by him and reasonably related to, and resulting from, the actions taken in compliance with or reliance upon such professionally accepted norms of care and treatment.

(d) The Secretary shall make payment to an organization under contract with him pursuant to this part, or to any member or employee thereof, or to any person who furnishes legal counsel or services to such organization, in an amount equal to the reasonable amount of the expenses incurred, as determined by the Secretary, in connection with the defense of any suit, action, or proceeding brought against such organization, member, or employee related to the performance of any duty or function under such contract by such organization, member, or employee.

APPLICATION OF THIS PART TO CERTAIN STATE PROGRAMS RECEIVING FEDERAL FINANCIAL ASSISTANCE

SEC. 1158. [42 U.S.C. 1320c–7] (a) A State plan approved under title XIX of this Act may provide that the functions specified in section 1154 may be performed in an area by contract with a utilization and quality control peer review organization that has entered into a contract with the Secretary in accordance with the provisions of section 1862(g).

(b) In the event a State enters into a contract in accordance with subsection (a), the Federal share of the expenditures made to the contracting organization for its costs in the performance of its functions under the State plan shall be 75 percent (as provided in section 1903(a)(3)(C)).

AUTHORIZATION FOR USE OF CERTAIN FUNDS TO ADMINISTER THE PROVISIONS OF THIS PART

SEC. 1159. [42 U.S.C. 1320c–8] Expenses incurred in the administration of the contracts described in section 1862(g) shall be payable from—

(1) funds in the Federal Hospital Insurance Trust Fund; and

(2) funds in the Federal Supplementary Medical Insurance Trust Fund,

in such amounts from each of such Trust Funds as the Secretary shall deem to be fair and equitable after taking into consideration the expenses attributable to the administration of this part with respect to each of such programs. The Secretary shall make such

transfers of moneys between such Trust Funds as may be appropriate to settle accounts between them in cases where expenses properly payable from one such Trust Fund have been paid from the other such Trust Fund.

PROHIBITION AGAINST DISCLOSURE OF INFORMATION

SEC. 1160. [42 U.S.C. 1320c–9] (a) An organization, in carrying out its functions under a contract entered into under this part, shall not be a Federal agency for purposes of the provisions of section 552 of title 5, United States Code [132] (commonly referred to as the Freedom of Information Act). Any data or information acquired by any such organization in the exercise of its duties and functions shall be held in confidence and shall not be disclosed to any person except—

(1) to the extent that may be necessary to carry out the purposes of this part,

(2) in such cases and under such circumstances as the Secretary shall by regulations provide to assure adequate protection of the rights and interests of patients, health care practitioners, or providers of health care, or

(3) in accordance with subsection (b).

(b) An organization having a contract with the Secretary under this part shall provide in accordance with procedures and safeguards established by the Secretary, data and information—

(1) which may identify specific providers or practitioners as may be necessary—

(A) to assist Federal and State agencies recognized by the Secretary as having responsibility for identifying and investigating cases or patterns of fraud or abuse, which data and information shall be provided by the peer review organization to any such agency at the request of such agency relating to a specific case or pattern;

(B) to assist appropriate Federal and State agencies recognized by the Secretary as having responsibility for identifying cases or patterns involving risks to the public health, which data and information shall be provided by the peer review organization to any such agency—

(i) at the discretion of the peer review organization, at the request of such agency relating to a specific case or pattern with respect to which such agency has made a finding, or has a reasonable belief, that there may be a substantial risk to the public health, or

(ii) upon a finding by, or the reasonable belief of, the peer review organization that there may be a substantial risk to the public health;

(C) to assist appropriate State agencies recognized by the Secretary as having responsibility for licensing or certification of providers or practitioners or to assist national accreditation bodies acting pursuant to section 1865 in accrediting providers for purposes of meeting the conditions described in title XVIII, which data and information shall be provided by the peer review organization to any such agency or body at the request of such agency or body relating to a specific case or to a possible pattern of sub-

[133] See Vol. II, Title 5.

standard care, but only to the extent that such data and information are required by the agency or body to carry out its respective function which is within the jurisdiction of the agency or body under State law or under section 1865; and

(D) to provide notice in accordance with section 1154(a)(9)(B);

(2) to assist the Secretary, and such Federal and State agencies recognized by the Secretary as having health planning or related responsibilities under Federal or State law (including health systems agencies and State health planning and development agencies), in carrying out appropriate health care planning and related activities, which data and information shall be provided in such format and manner as may be prescribed by the Secretary or agreed upon by the responsible Federal and State agencies and such organization, and shall be in the form of aggregate statistical data (without explicitly identifying any individual) on a geographic, institutional, or other basis reflecting the volume and frequency of services furnished, as well as the demographic characteristics of the population subject to review by such organization.

The penalty provided in subsection (c) shall not apply to the disclosure of any information received under this subsection, except that such penalty shall apply to the disclosure (by the agency receiving such information) of any such information described in paragraph (1) unless such disclosure is made in a judicial, administrative, or other formal legal proceeding resulting from an investigation conducted by the agency receiving the information. An organization may require payment of a reasonable fee for providing information under this subsection in response to a request for such information.

(c) It shall be unlawful for any person to disclose any such information described in subsection (a) other than for the purposes provided in subsections (a) and (b), and any person violating the provisions of this section shall, upon conviction, be fined not more than $1,000, and imprisoned for not more than 6 months, or both, and shall be required to pay the costs of prosecution.

(d) No patient record in the possession of an organization having a contract with the Secretary under this part shall be subject to subpoena or discovery proceedings in a civil action. No document or other information produced by such an organization in connection with its deliberations in making determinations under section 1154(a)(1)(B) or 1156(a)(2) shall be subject to subpoena or discovery in any administrative or civil proceeding; except that such an organization shall provide, upon request of a practitioner or other person adversely affected by such a determination, a summary of the organization's findings and conclusions in making the determination.

(e) For purposes of this section and section 1157, the term "organization with a contract with the Secretary under this part" includes an entity with a contract with the Secretary under section 1154(a)(4)(C).

ANNUAL REPORTS

SEC. 1161. [42 U.S.C. 1320c–10] The Secretary shall submit to the Congress not later than April 1 of each year, a full and com-

plete report on the administration, impact, and cost of the program under this part during the preceding fiscal year, including data and information on—

(1) the number, status, and service areas of all utilization and quality control peer review organizations participating in the program;

(2) the number of health care institutions and practitioners whose services are subject to review by such organizations, and the number of beneficiaries and recipients who received services subject to such review during such year;

(3) the various methods of reimbursement utilized in contracts under this part, and the relative efficiency of each such method of reimbursement;

(4) the imposition of penalties and sanctions under this title for violations of law and for failure to comply with the obligations imposed by this part;

(5) the total costs incurred under titles XVIII and XIX of this Act in the implementation and operation of all procedures required by such titles for the review of services to determine their medical necessity, appropriateness of use, and quality; and

(6) descriptions of the criteria upon which decisions are made, and the selection and relative weights of such criteria.

EXEMPTIONS FOR RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTIONS

SEC. 1162. [42 U.S.C. 1320c–11] The provisions of this part shall not apply with respect to a religious nonmedical health care institution (as defined in section 1861(ss)(1)).

MEDICAL OFFICERS IN AMERICAN SAMOA, THE NORTHERN MARIANA ISLANDS, AND THE TRUST TERRITORY OF THE PACIFIC ISLANDS TO BE INCLUDED IN THE UTILIZATION AND QUALITY CONTROL PEER REVIEW PROGRAM

SEC. 1163. [42 U.S.C 1320c–12] For purposes of applying this part to American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands, individuals licensed to practice medicine in those places shall be considered to be physicians and doctors of medicine.

Part C—Administrative Simplification

DEFINITIONS

SEC. 1171. [42 U.S.C. 1320d] For purposes of this part:

(1) CODE SET.—The term "code set" means any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

(2) HEALTH CARE CLEARINGHOUSE.—The term "health care clearinghouse" means a public or private entity that processes or facilitates the processing of nonstandard data elements of health information into standard data elements.

(3) HEALTH CARE PROVIDER.—The term "health care provider" includes a provider of services (as defined in section

1861(u)), a provider of medical or other health services (as defined in section 1861(s)), and any other person furnishing health care services or supplies.

(4) HEALTH INFORMATION.—The term "health information" means any information, whether oral or recorded in any form or medium, that—

(A) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and

(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

(5) HEALTH PLAN.—The term "health plan" means an individual or group plan that provides, or pays the cost of, medical care (as such term is defined in section 2791 of the Public Health Service Act). Such term includes the following, and any combination thereof:

(A) A group health plan (as defined in section 2791(a) of the Public Health Service Act), but only if the plan—

(i) has 50 or more participants (as defined in section 3(7) of the Employee Retirement Income Security Act of 1974); or

(ii) is administered by an entity other than the employer who established and maintains the plan.

(B) A health insurance issuer (as defined in section 2791(b) of the Public Health Service Act).

(C) A health maintenance organization (as defined in section 2791(b) of the Public Health Service Act).

(D) Part A, B, or C of the Medicare program under title XVIII.

(E) The medicaid program under title XIX.

(F) A Medicare supplemental policy (as defined in section 1882(g)(1)).

(G) A long–term care policy, including a nursing home fixed indemnity policy (unless the Secretary determines that such a policy does not provide sufficiently comprehensive coverage of a benefit so that the policy should be treated as a health plan).

(H) An employee welfare benefit plan or any other arrangement which is established or maintained for the purpose of offering or providing health benefits to the employees of 2 or more employers.

(I) The health care program for active military personnel under title 10, United States Code.

(J) The veterans health care program under chapter 17 of title 38, United States Code.

(K) The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), as defined in section 1072(4) of title 10, United States Code.

(L) The Indian health service program under the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

(M) The Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code.

(6) INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.—The term "individually identifiable health information" means any information, including demographic information collected from an individual, that—

(A) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and—

(i) identifies the individual; or

(ii) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

(7) STANDARD.—The term "standard", when used with reference to a data element of health information or a transaction referred to in section 1173(a)(1), means any such data element or transaction that meets each of the standards and implementation specifications adopted or established by the Secretary with respect to the data element or transaction under sections 1172 through 1174.

(8) STANDARD SETTING ORGANIZATION.—The term "standard setting organization" means a standard setting organization accredited by the American National Standards Institute, including the National Council for Prescription Drug Programs, that develops standards for information transactions, data elements, or any other standard that is necessary to, or will facilitate, the implementation of this part.

GENERAL REQUIREMENTS FOR ADOPTION OF STANDARDS

SEC. 1172. [42 U.S.C. 1320d–1] (a) APPLICABILITY.—Any standard adopted under this part shall apply, in whole or in part, to the following persons:

(1) A health plan.

(2) A health care clearinghouse.

(3) A health care provider who transmits any health information in electronic form in connection with a transaction referred to in section 1173(a)(1).

(b) REDUCTION OF COSTS.—Any standard adopted under this part shall be consistent with the objective of reducing the administrative costs of providing and paying for health care.

(c) ROLE OF STANDARD SETTING ORGANIZATIONS.—

(1) IN GENERAL.—Except as provided in paragraph (2), any standard adopted under this part shall be a standard that has been developed, adopted, or modified by a standard setting organization.

(2) SPECIAL RULES.—

(A) DIFFERENT STANDARDS.—The Secretary may adopt a standard that is different from any standard developed, adopted, or modified by a standard setting organization, if—

(i) the different standard will substantially reduce administrative costs to health care providers and health plans compared to the alternatives; and

(ii) the standard is promulgated in accordance with the rulemaking procedures of subchapter III of chapter 5 of title 5, United States Code.

(B) NO STANDARD BY STANDARD SETTING ORGANIZATION.—If no standard setting organization has developed, adopted, or modified any standard relating to a standard that the Secretary is authorized or required to adopt under this part—

(i) paragraph (1) shall not apply; and

(ii) subsection (f) shall apply.

(3) CONSULTATION REQUIREMENT.—

(A) IN GENERAL.—A standard may not be adopted under this part unless—

(i) in the case of a standard that has been developed, adopted, or modified by a standard setting organization, the organization consulted with each of the organizations described in subparagraph (B) in the course of such development, adoption, or modification; and

(ii) in the case of any other standard, the Secretary, in complying with the requirements of subsection (f), consulted with each of the organizations described in subparagraph (B) before adopting the standard.

(B) ORGANIZATIONS DESCRIBED.—The organizations referred to in subparagraph (A) are the following:

(i) The National Uniform Billing Committee.

(ii) The National Uniform Claim Committee.

(iii) The Workgroup for Electronic Data Interchange.

(iv) The American Dental Association.

(d) IMPLEMENTATION SPECIFICATIONS.—The Secretary shall establish specifications for implementing each of the standards adopted under this part.

(e) PROTECTION OF TRADE SECRETS.—Except as otherwise required by law, a standard adopted under this part shall not require disclosure of trade secrets or confidential commercial information by a person required to comply with this part.

(f) ASSISTANCE TO THE SECRETARY.—In complying with the requirements of this part, the Secretary shall rely on the recommendations of the National Committee on Vital and Health Statistics established under section 306(k) of the Public Health Service Act (42 U.S.C. 242k(k)), and shall consult with appropriate Federal and State agencies and private organizations. The Secretary shall publish in the Federal Register any recommendation of the National Committee on Vital and Health Statistics regarding the adoption of a standard under this part.

(g) APPLICATION TO MODIFICATIONS OF STANDARDS.—This section shall apply to a modification to a standard (including an addition to a standard) adopted under section 1174(b) in the same manner as it applies to an initial standard adopted under section 1174(a).

STANDARDS FOR INFORMATION TRANSACTIONS AND DATA ELEMENTS

SEC. 1173. [42 U.S.C. 1320d–2] (a) STANDARDS TO ENABLE ELECTRONIC EXCHANGE.—

(1) IN GENERAL.—The Secretary shall adopt standards for transactions, and data elements for such transactions, to en-

able health information to be exchanged electronically, that are appropriate for—

(A) the financial and administrative transactions described in paragraph (2); and

(B) other financial and administrative transactions determined appropriate by the Secretary, consistent with the goals of improving the operation of the health care system and reducing administrative costs.

(2) TRANSACTIONS.—The transactions referred to in paragraph (1)(A) are transactions with respect to the following:

(A) Health claims or equivalent encounter information.

(B) Health claims attachments.

(C) Enrollment and disenrollment in a health plan.

(D) Eligibility for a health plan.

(E) Health care payment and remittance advice.

(F) Health plan premium payments.

(G) First report of injury.

(H) Health claim status.

(I) Referral certification and authorization.

(3) ACCOMMODATION OF SPECIFIC PROVIDERS.—The standards adopted by the Secretary under paragraph (1) shall accommodate the needs of different types of health care providers.

(b) UNIQUE HEALTH IDENTIFIERS.—

(1) IN GENERAL.—The Secretary shall adopt standards providing for a standard unique health identifier for each individual, employer, health plan, and health care provider for use in the health care system. In carrying out the preceding sentence for each health plan and health care provider, the Secretary shall take into account multiple uses for identifiers and multiple locations and specialty classifications for health care providers.

(2) USE OF IDENTIFIERS.—The standards adopted under paragraph (1) shall specify the purposes for which a unique health identifier may be used.

(c) CODE SETS.—

(1) IN GENERAL.—The Secretary shall adopt standards that—

(A) select code sets for appropriate data elements for the transactions referred to in subsection (a)(1) from among the code sets that have been developed by private and public entities; or

(B) establish code sets for such data elements if no code sets for the data elements have been developed.

(2) DISTRIBUTION.—The Secretary shall establish efficient and low–cost procedures for distribution (including electronic distribution) of code sets and modifications made to such code sets under section 1174(b).

(d) SECURITY STANDARDS FOR HEALTH INFORMATION.—

(1) SECURITY STANDARDS.—The Secretary shall adopt security standards that—

(A) take into account—

(i) the technical capabilities of record systems used to maintain health information;

(ii) the costs of security measures;

(iii) the need for training persons who have access to health information;

(iv) the value of audit trails in computerized record systems; and

(v) the needs and capabilities of small health care providers and rural health care providers (as such providers are defined by the Secretary); and

(B) ensure that a health care clearinghouse, if it is part of a larger organization, has policies and security procedures which isolate the activities of the health care clearinghouse with respect to processing information in a manner that prevents unauthorized access to such information by such larger organization.

(2) SAFEGUARDS.—Each person described in section 1172(a) who maintains or transmits health information shall maintain reasonable and appropriate administrative, technical, and physical safeguards—

(A) to ensure the integrity and confidentiality of the information;

(B) to protect against any reasonably anticipated—

(i) threats or hazards to the security or integrity of the information; and

(ii) unauthorized uses or disclosures of the information; and

(C) otherwise to ensure compliance with this part by the officers and employees of such person.

(e) ELECTRONIC SIGNATURE.—

(1) STANDARDS.—The Secretary, in coordination with the Secretary of Commerce, shall adopt standards specifying procedures for the electronic transmission and authentication of signatures with respect to the transactions referred to in subsection (a)(1).

(2) EFFECT OF COMPLIANCE.—Compliance with the standards adopted under paragraph (1) shall be deemed to satisfy Federal and State statutory requirements for written signatures with respect to the transactions referred to in subsection (a)(1).

(f) TRANSFER OF INFORMATION AMONG HEALTH PLANS.—The Secretary shall adopt standards for transferring among health plans appropriate standard data elements needed for the coordination of benefits, the sequential processing of claims, and other data elements for individuals who have more than one health plan.

TIMETABLES FOR ADOPTION OF STANDARDS

SEC. 1174. [42 U.S.C. 1320d–3] (a) INITIAL STANDARDS.—The Secretary shall carry out section 1173 not later than 18 months after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996, except that standards relating to claims attachments shall be adopted not later than 30 months after such date.

(b) ADDITIONS AND MODIFICATIONS TO STANDARDS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall review the standards adopted under section 1173, and shall adopt modifications to the standards (including additions to the standards), as determined appropriate, but not more frequently than once every 12 months. Any addition or modification to a standard shall be completed in a manner which minimizes the disruption and cost of compliance.

(2) SPECIAL RULES.—

(A) FIRST 12–MONTH PERIOD.—Except with respect to additions and modifications to code sets under subparagraph (B), the Secretary may not adopt any modification to a standard adopted under this part during the 12–month period beginning on the date the standard is initially adopted, unless the Secretary determines that the modification is necessary in order to permit compliance with the standard.

(B) ADDITIONS AND MODIFICATIONS TO CODE SETS.—

(i) IN GENERAL.—The Secretary shall ensure that procedures exist for the routine maintenance, testing, enhancement, and expansion of code sets.

(ii) ADDITIONAL RULES.—If a code set is modified under this subsection, the modified code set shall include instructions on how data elements of health information that were encoded prior to the modification may be converted or translated so as to preserve the informational value of the data elements that existed before the modification. Any modification to a code set under this subsection shall be implemented in a manner that minimizes the disruption and cost of complying with such modification.

REQUIREMENTS

SEC. 1175. [42 U.S.C. 1320d–4] (a) CONDUCT OF TRANSACTIONS BY PLANS.—

(1) IN GENERAL.—If a person desires to conduct a transaction referred to in section 1173(a)(1) with a health plan as a standard transaction—

(A) the health plan may not refuse to conduct such transaction as a standard transaction;

(B) the insurance plan may not delay such transaction, or otherwise adversely affect, or attempt to adversely affect, the person or the transaction on the ground that the transaction is a standard transaction; and

(C) the information transmitted and received in connection with the transaction shall be in the form of standard data elements of health information.

(2) SATISFACTION OF REQUIREMENTS.—A health plan may satisfy the requirements under paragraph (1) by—

(A) directly transmitting and receiving standard data elements of health information; or

(B) submitting nonstandard data elements to a health care clearinghouse for processing into standard data elements and transmission by the health care clearinghouse, and receiving standard data elements through the health care clearinghouse.

(3) TIMETABLE FOR COMPLIANCE.—Paragraph (1) shall not be construed to require a health plan to comply with any standard, implementation specification, or modification to a standard or specification adopted or established by the Secretary under sections 1172 through 1174 at any time prior to the date on which the plan is required to comply with the standard or specification under subsection (b).

(b) COMPLIANCE WITH STANDARDS.—

(1) INITIAL COMPLIANCE.—

(A) IN GENERAL.—Not later than 24 months after the date on which an initial standard or implementation specification is adopted or established under sections 1172 and 1173, each person to whom the standard or implementation specification applies shall comply with the standard or specification.

(B) SPECIAL RULE FOR SMALL HEALTH PLANS.—In the case of a small health plan, paragraph (1) shall be applied by substituting "36 months" for "24 months". For purposes of this subsection, the Secretary shall determine the plans that qualify as small health plans.

(2) COMPLIANCE WITH MODIFIED STANDARDS.—If the Secretary adopts a modification to a standard or implementation specification under this part, each person to whom the standard or implementation specification applies shall comply with the modified standard or implementation specification at such time as the Secretary determines appropriate, taking into account the time needed to comply due to the nature and extent of the modification. The time determined appropriate under the preceding sentence may not be earlier than the last day of the 180–day period beginning on the date such modification is adopted. The Secretary may extend the time for compliance for small health plans, if the Secretary determines that such extension is appropriate.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed to prohibit any person from complying with a standard or specification by—

(A) submitting nonstandard data elements to a health care clearinghouse for processing into standard data elements and transmission by the health care clearinghouse; or

(B) receiving standard data elements through a health care clearinghouse.

GENERAL PENALTY FOR FAILURE TO COMPLY WITH REQUIREMENTS AND STANDARDS

SEC. 1176. [42 U.S.C. 1320d–5] (a) GENERAL PENALTY.—

(1) IN GENERAL.—Except as provided in subsection (b), the Secretary shall impose on any person who violates a provision of this part a penalty of not more than $100 for each such violation, except that the total amount imposed on the person for all violations of an identical requirement or prohibition during a calendar year may not exceed $25,000.

(2) PROCEDURES.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to the imposition of a civil money penalty under this subsection in the same manner as such provisions apply to the imposition of a penalty under such section 1128A.

(b) LIMITATIONS.—

(1) OFFENSES OTHERWISE PUNISHABLE.—A penalty may not be imposed under subsection (a) with respect to an act if the act constitutes an offense punishable under section 1177.

(2) NONCOMPLIANCE NOT DISCOVERED.—A penalty may not be imposed under subsection (a) with respect to a provision of this part if it is established to the satisfaction of the Secretary that the person liable for the penalty did not know, and by exercising reasonable diligence would not have known, that such person violated the provision.

(3) FAILURES DUE TO REASONABLE CAUSE.—

(A) IN GENERAL.—Except as provided in subparagraph (B), a penalty may not be imposed under subsection (a) if—

(i) the failure to comply was due to reasonable cause and not to willful neglect; and

(ii) the failure to comply is corrected during the 30–day period beginning on the first date the person liable for the penalty knew, or by exercising reasonable diligence would have known, that the failure to comply occurred.

(B) EXTENSION OF PERIOD.—

(i) NO PENALTY.—The period referred to in subparagraph (A)(ii) may be extended as determined appropriate by the Secretary based on the nature and extent of the failure to comply.

(ii) ASSISTANCE.—If the Secretary determines that a person failed to comply because the person was unable to comply, the Secretary may provide technical assistance to the person during the period described in subparagraph (A)(ii). Such assistance shall be provided in any manner determined appropriate by the Secretary.

(4) REDUCTION.—In the case of a failure to comply which is due to reasonable cause and not to willful neglect, any penalty under subsection (a) that is not entirely waived under paragraph (3) may be waived to the extent that the payment of such penalty would be excessive relative to the compliance failure involved.

WRONGFUL DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

SEC. 1177. [42 U.S.C. 1320d–6] (a) OFFENSE.—A person who knowingly and in violation of this part—

(1) uses or causes to be used a unique health identifier;

(2) obtains individually identifiable health information relating to an individual; or

(3) discloses individually identifiable health information to another person,

shall be punished as provided in subsection (b).

(b) PENALTIES.—A person described in subsection (a) shall—

(1) be fined not more than $50,000, imprisoned not more than 1 year, or both;

(2) if the offense is committed under false pretenses, be fined not more than $100,000, imprisoned not more than 5 years, or both; and

(3) if the offense is committed with intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, be fined not more than $250,000, imprisoned not more than 10 years, or both.

EFFECT ON STATE LAW

SEC. 1178. [42 U.S.C. 1320d–7] (a) GENERAL EFFECT.—

(1) GENERAL RULE.—Except as provided in paragraph (2), a provision or requirement under this part, or a standard or implementation specification adopted or established under sections 1172 through 1174, shall supersede any contrary provision of State law, including a provision of State law that requires medical or health plan records (including billing information) to be maintained or transmitted in written rather than electronic form.

(2) EXCEPTIONS.—A provision or requirement under this part, or a standard or implementation specification adopted or established under sections 1172 through 1174, shall not supersede a contrary provision of State law, if the provision of State law—

(A) is a provision the Secretary determines—

(i) is necessary—

(I) to prevent fraud and abuse;

(II) to ensure appropriate State regulation of insurance and health plans;

(III) for State reporting on health care delivery or costs; or

(IV) for other purposes; or

(ii) addresses controlled substances; or

(B) subject to section 264(c)(2) of the Health Insurance Portability and Accountability Act of 1996, relates to the privacy of individually identifiable health information.

(b) PUBLIC HEALTH.—Nothing in this part shall be construed to invalidate or limit the authority, power, or procedures established under any law providing for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention.

(c) STATE REGULATORY REPORTING.—Nothing in this part shall limit the ability of a State to require a health plan to report, or to provide access to, information for management audits, financial audits, program monitoring and evaluation, facility licensure or certification, or individual licensure or certification.

PROCESSING PAYMENT TRANSACTIONS BY FINANCIAL INSTITUTIONS

SEC. 1179. [42 U.S.C. 1320d–8] To the extent that an entity is engaged in activities of a financial institution (as defined in section 1101 of the Right to Financial Privacy Act of 1978), or is engaged in authorizing, processing, clearing, settling, billing, transferring, reconciling, or collecting payments, for a financial institution, this part, and any standard adopted under this part, shall not apply to the entity with respect to such activities, including the following:

(1) The use or disclosure of information by the entity for authorizing, processing, clearing, settling, billing, transferring, reconciling or collecting, a payment for, or related to, health plan premiums or health care, where such payment is made by any means, including a credit, debit, or other payment card, an account, check, or electronic funds transfer.

(2) The request for, or the use of disclosure of, information by the entity with respect to a payment described in paragraph (1)—

(A) for transferring receivables;
(B) for auditing;
(C) in connection with—
(i) a customer dispute; or
(ii) an inquiry from, or to, a customer;
(D) in a communication to a customer of the entity regarding the customer's transactions, payment card, account, check, or electronic funds transfer;
(E) for reporting to consumer reporting agencies; or
(F) for complying with—
(i) a civil or criminal subpoena; or
(ii) a Federal or State law regulating the entity.

TITLE XII—ADVANCES TO STATE UNEMPLOYMENT FUNDS [1]

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ADVANCES TO STATE UNEMPLOYMENT FUNDS [3]

SEC. 1201. [42 U.S.C. 1321] (a)(1) Advances shall be made to the States from the Federal unemployment account in the Unemployment Trust Fund as provided in this section, and shall be repayable, with interest to the extent provided in section 1202(b), in the manner provided in sections 901(d)(1), 903(b)(2), and 1202. An advance to a State for the payment of compensation in any 3-month period may be made if—

(A) the Governor of the State applies therefor no earlier than the first day of the month preceding the first month of such 3-month period, and

(B) he furnishes to the Secretary of Labor his estimate of the amount of an advance which will be required by the State for the payment of compensation in each month of such 3-month period.

(2) In the case of any application for an advance under this section to any State for any 3-month period, the Secretary of Labor shall—

(A) determine the amount (if any) which he finds will be required by such State for the payment of compensation in each month of such 3-month period, and

(B) certify to the Secretary of the Treasury the amount (not greater than the amount estimated by the Governor of the State) determined under subparagraph (A).

The aggregate of the amounts certified by the Secretary of Labor with respect to any 3-month period shall not exceed the amount which the Secretary of the Treasury reports to the Secretary of

[1] Title XII of the Social Security Act is administered by the Department of Labor.

Title XII appears in the United States Code as §§1321–1324, subchapter XII, chapter 7, Title 42.

Regulations of the Secretary of Labor relating to Title XII are contained in chapter V, Title 20, Code of Federal Regulations.

[2] This table of contents does not appear in the law.

[3] See P.L. 83–591, §3302(c)(3)(this volume), with respect to advances to a State or State agency.

See Vol. II, P.L. 95–521, §102(i), with respect to reporting of benefits received under the Social Security Act.

See Vol. II, P.L. 96–499, §1025, with respect to withholding certification of State unemployment laws.

Labor is available in the Federal unemployment account for advances with respect to each month of such 3-month period.

(3) For purposes of this subsection—

(A) an application for an advance shall be made on such forms, and shall contain such information and data (fiscal and otherwise) concerning the operation and administration of the State unemployment compensation law, as the Secretary of Labor deems necessary or relevant to the performance of his duties under this title,

(B) the amount required by any State for the payment of compensation in any month shall be determined with due allowance for contingencies and taking into account all other amounts that will be available in the State's unemployment fund for the payment of compensation in such month, and

(C) the term "compensation" means cash benefits payable to individuals with respect to their unemployment, exclusive of expenses of administration.

(b) The Secretary of the Treasury shall, prior to audit or settlement by the General Accounting Office[4], transfer in monthly installments from the Federal unemployment account to the account of the State in the Unemployment Trust Fund the amount certified under subsection (a) by the Secretary of Labor (but not exceeding that portion of the balance in the Federal unemployment account at the time of the transfer which is not restricted as to use pursuant to section 903(b)(1)). The amount of any monthly installment so transferred shall not exceed the amount estimated by the State to be required for the payment of compensation for the month with respect to which such installment is made.

REPAYMENT BY STATES OF ADVANCES TO STATE UNEMPLOYMENT FUNDS

SEC. 1202. [42 U.S.C. 1322] (a) The Governor of any State may at any time request that funds be transferred from the account of such State to the Federal unemployment account in repayment of part or all of that balance of advances, made to such State under section 1201, specified in the request. The Secretary of Labor shall certify to the Secretary of the Treasury the amount and balance specified in the request; and the Secretary of the Treasury shall promptly transfer such amount in reduction of such balance.

(b)(1) Except as otherwise provided in this subsection, each State shall pay interest on any advance made to such State under section 1201. Interest so payable with respect to periods during any calendar year shall be at the rate determined under paragraph (4) for such calendar year.

(2) No interest shall be required to be paid under paragraph (1) with respect to any advance or advances made during any calendar year if—

(A) such advances are repaid in full before the close of September 30 of the calendar year in which the advances were made,

[4] P.L. 108-271, §8(b), provided that "Any reference to the General Accounting Office in any law, rule, regulation, certificate, directive, instruction, or other official paper in force on the date of enactment of this Act (July 7, 2004) shall be considered to refer and apply to the Government Accountability Office."

(B) no other advance was made to such State under section 1201 during such calendar year and after the date on which the repayment of the advances was completed, and

(C) such State meets funding goals, established under regulations issued by the Secretary of Labor, relating to the accounts of the States in the Unemployment Trust Fund.

(3)(A) Interest payable under paragraph (1) which was attributable to periods during any fiscal year shall be paid by the State to the Secretary of the Treasury prior to the first day of the following fiscal year. If interest is payable under paragraph (1) on any advance (hereinafter in this subparagraph referred to as the "first advance") by reason of another advance made to such State after September 30 of the calendar year in which the first advance was made, interest on such first advance attributable to periods before such September 30 shall be paid not later than the day after the date on which the other advance was made.

(B) Notwithstanding subparagraph (A), in the case of any advance made during the last 5 months of any fiscal year, interest on such advance attributable to periods during such fiscal year shall not be required to be paid before the last day of the succeeding taxable year. Any interest the time for payment of which is deferred by the preceding sentence shall bear interest in the same manner as if it were an advance made on the day on which it would have been required to be paid but for this subparagraph.

(C)(i) In the case of any State which meets the requirements of clause (ii) for any calendar year, any interest otherwise required to be paid under this subsection during such calendar year shall be paid as follows—

(I) 25 percent of the amount otherwise required to be paid on or before any day during such calendar year shall be paid on or before such day; and

(II) 25 percent of the amount otherwise required to be paid on or before such day shall be paid on or before the corresponding day in each of the 3 succeeding calendar years.

No interest shall accrue on such deferred interest.

(ii) A State meets the requirements of this clause for any calendar year if the rate of insured unemployment (as determined for purposes of section 203 of the Federal-State Extended Unemployment Compensation Act of 1970[5]) under the State law of the period consisting of the first 6 months of the preceding calendar year equaled or exceeded 7.5 percent.

(4) The interest rate determined under this paragraph with respect to any calendar year is a percentage (but not in excess of 10 percent) determined by dividing—

(A) the aggregate amount credited under section 904(e) to State accounts on the last day of the last calendar quarter of the immediately preceding calendar year, by

[5] See Vol. II, P.L. 91–373, Title II.

(B) the aggregate of the average daily balances of the State accounts for such quarter as determined under section 904(e).

(5) Interest required to be paid under paragraph (1) shall not be paid (directly or indirectly) by a State from amounts in its unemployment fund. If the Secretary of Labor determines that any State action results in the paying of such interest directly or indirectly (by an equivalent reduction in State unemployment taxes or otherwise) from such unemployment fund, the Secretary of Labor shall not certify such State's unemployment compensation law under section 3304 of the Internal Revenue Code of 1954[6]. Such noncertification shall be made in accordance with section 3304(c) of such Code.

(6)(A) For purposes of paragraph (2), any voluntary repayment shall be applied against advances made under section 1201 on the last made first repaid basis. Any other repayment of such an advance shall be applied against advances on a first made first repaid basis.

(B) For purposes of this paragraph, the term "voluntary repayment" means any repayment made under subsection (a).

(7) This subsection shall only apply to advances made on or after April 1, 1982.

(8)(A) With respect to interest due under this section on September 30 of 1983, 1984, or 1985 (other than interest previously deferred under paragraph (3)(C)), a State may pay 80 percent of such interest in four annual installments of at least 20 percent beginning with the year after the year in which it is otherwise due, if such State meets the criteria of subparagraph (B). No interest shall accrue on such deferred interest.

(B) To meet the criteria of this subparagraph a State must—

(i) have taken no action since October 1, 1982, which would reduce its net unemployment tax effort or the net solvency of its unemployment system (as determined for purposes of section 3302(f) of the Internal Revenue Code of 1954[7]); and

(ii)(I) have taken an action (as certified by the Secretary of Labor) after March 31, 1982, which would have increased revenue liabilities and decreased benefits under the State's unemployment compensation system (hereinafter referred to as a "solvency effort") by a combined total of the applicable percentage (as compared to such revenues and benefits as would have been in effect without such State action) for the calendar year for which the deferral is requested; or

(II) have had, for taxable year 1982, an average unemployment tax rate which was equal to or greater than 2.0 percent of the total of the wages (as determined without any limitation on amount) attributable to such State subject to contribution under the State unemployment compensation law with respect to such taxable year.

[6] See P.L. 83–591, §3304 (this volume).
[7] See P.L. 83–591, §3302(f) (this volume).

In the case of the first year for which there is a deferral (over a 4-year period) of the interest otherwise payable for such year, the applicable percentage shall be 25 percent. In the case of the second such year, the applicable percentage shall be 35 percent. In the case of the third such year, the applicable percentage shall be 50 percent.

(C)(i) The base year is the first year for which deferral under this provision is requested and subsequently granted. The Secretary of Labor shall estimate the unemployment rate for the base year. To determine whether a State meets the requirements of subparagraph (B)(ii)(I), the Secretary of Labor shall determine the percentage by which the benefits and taxes in the base year with the application of the action referred to in subparagraph (B)(ii)(I) are lower or greater, as the case may be, than such benefits and taxes would have been without the application of such action. In making this determination, the Secretary shall deem the application of the action referred to in subparagraph (B)(ii)(I) to have been effective for the base year to the same extent as such action is effective for the year following the year for which the deferral is sought. Once a deferral is approved under clause (ii)(I) of subparagraph (B) a State must continue to maintain its solvency effort. Failure to do so shall result in the State being required to make immediate payment of all deferred interest.

(ii) Increases in the taxable wage base from $6,000 to $7,000 or increases after 1984 in the maximum tax rate to 5.4 percent shall not be counted for purposes of meeting the requirement of subparagraph (B).

(D) In the case of a State which produces a solvency effort of 50 percent, 80 percent, and 90 percent rather than the 25 percent, 35 percent, and 50 percent required under subparagraph (B), the interest shall be computed at an interest rate which is 1 percentage point less than the otherwise applicable interest rate.

(9) Any interest otherwise due from a State on September 30 of a calendar year after 1982 may be deferred (and no interest shall accrue on such deferred interest) for a grace period of not to exceed 9 months if, for the most recent 12-month period for which data are available before the date such interest is otherwise due, the State had an average total unemployment rate of 13.5 percent or greater.

(c) Interest paid by States in accordance with this section shall be credited to the Federal unemployment account established by section 904(g) in the Unemployment Trust Fund.

ADVANCES TO FEDERAL UNEMPLOYMENT ACCOUNT

SEC. 1203. [42 U.S.C. 1323] There are hereby authorized to be appropriated to the Federal unemployment account, as repayable advances, such sums as may be necessary to carry out the purposes of this title. Amounts appropriated as repayable advances shall be repaid by transfers from the Federal unemployment account to the general fund of the Treasury, at such times as the amount in the Federal unemployment account is determined by the Secretary of the Treasury, in consultation with the Secretary of Labor, to be

adequate for such purpose. Any amount transferred as a repayment under this section shall be credited against, and shall operate to reduce, any balance of advances repayable under this section. Whenever, after the application of sections 901(f)(3) and 902(a) with respect to the excess in the employment security administration account as of the close of any fiscal year, there remains any portion of such excess, so much of such remainder as does not exceed the balance of advances made pursuant to this section shall be transferred to the general fund of the Treasury and shall be credited against, and shall operate to reduce, such balance of advances. Amounts appropriated as repayable advances for purposes of this subsection shall bear interest at a rate equal to the average rate of interest, computed as of the end of the calendar month next preceding the date of such advance, borne by all interest bearing obligations of the United States then forming part of the public debt; except that in cases in which such average rate is not a multiple of one-eighth of 1 percent, the rate of interest shall be the multiple of one-eighth of 1 percent next lower than such average rate.

DEFINITION OF GOVERNOR

SEC. 1204. [42 U.S.C. 1324] When used in this title, the term "Governor" includes the Commissioners[8] of the District of Columbia.

[8] P.L. 93–198, §711, abolished the office of Commissioner of the District of Columbia and §421 replaced it with the office of Mayor of the District of Columbia.

[TITLE XIII—RECONVERSION UNEMPLOYMENT BENEFITS FOR SEAMEN] [1]

[1] P.L. 79–719 (60 Stat. 978, approved August 10, 1946), §306, added this title.

P.L. 98–369, §2663(f), repealed Title XIII, effective July 18, 1984, but this amendment shall not be construed as changing or affecting any right, liability, status, or interpretation which existed under this provision before that date.

[TITLE XIV—GRANTS TO STATES FOR AID TO THE PERMANENTLY AND TOTALLY DISABLED] [1]

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APPROPRIATION

SEC. 1401. [42 U.S.C. 1351] For the purpose of enabling each State to furnish financial assistance, as far as practicable under the conditions in such State, to needy individuals eighteen years of age and older who are permanently and totally disabled, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Administrator, State plans for aid to the permanently and totally disabled.

STATE PLANS FOR AID TO THE PERMANENTLY AND TOTALLY DISABLED

SEC. 1402. [42 U.S.C. 1352] (a) A State plan for aid to the permanently and totally disabled must (1) except to the extent permitted by the Secretary with respect to services, provide that it shall be in effect in all political subdivisions of the State, and, if

[1] P.L. 92–603, §303, *repealed* Title XIV, effective January 1, 1974, *except* with respect to Puerto Rico, Guam, and the Virgin Islands. The Commonwealth of the Northern Marianas may elect to initiate a Title XIV social services program if it chooses; see Vol. II, P.L. 94–241, [Covenant to Establish a Commonwealth of the Northern Marianas].

Title XIV of the Social Security Act is administered by the Department of Health and Human Services. The Office of Family Assistance, Family Support Administration, administers benefit payments under Title XIV. The Office of Human Development Services administers social services under Title XIV.

Title XIV appears in the United States Code as §§1351–1355, subchapter XIV, chapter 7, Title 42.

Regulations of the Secretary of Health and Human Services relating to Title XIV are contained in chapter 1, Title 42, and subtitle A and chapter XIII, Title 45, Code of Federal Regulations.

See Vol. II, 31 U.S.C. 6504–6505 with respect to intergovernmental cooperation.

See Vol. II, 31 U.S.C. 7501–7507 with respect to uniform audit requirements for State and local governments receiving Federal financial assistance.

See Vol. II, P.L. 82–183, §618, for the "Jenner Amendment", which prohibits denial of grants-in-aid under certain conditions.

See Vol. II, P.L. 88–352, §601, for prohibition against discrimination in Federally assisted programs.

See Vol. II, P.L. 89–97, §121(b), with respect to restrictions on payment to a State receiving payments under Title XIX.

See Vol. II, P.L. 95–521, §102(i), with respect to reporting of benefits received under the Social Security Act.

[2] This table of contents does not appear in the law.

administered by them, be mandatory upon them; (2) provide for financial participation by the State; (3) either provide for the establishment or designation of a single State agency to administer the plan, or provide for the establishment or designation of a single State agency to supervise the administration of the plan; (4) provide (A) for granting an opportunity for a fair hearing before the State agency to any individual whose claim for aid to the permanently and totally disabled is denied or is not acted upon with reasonable promptness, and (B) that if the State plan is administered in each of the political subdivisions of the State by a local agency and such local agency provides a hearing at which evidence may be presented prior to a hearing before the State agency, such local agency may put into effect immediately upon issuance its decision upon the matter considered at such hearing; (5) 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) as are found by the Secretary to be necessary for the proper and efficient operation of the plan[3], and (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; (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 that no aid will be furnished any individual under the plan with respect to any period with respect to which he is receiving old-age assistance under the State plan approved under section 2 of this Act, assistance under a State program funded under part A of title IV or aid to the blind under the State plan approved under section 1002 of this Act; (8) provide that the State agency shall, in determining need, take into consideration any other income and resources of an individual claiming aid to the permanently and totally disabled, as well as any expenses reasonably attributable to the earning of any such income; except that, in making such determination, (A) the State agency may disregard not more than $7.50 of any income, (B) of the first $80 per month of additional income which is earned the State agency may disregard not more than the first $20 thereof plus one-half of the remainder, and (C) the State agency may, for a period not in excess of 36 months, disregard such additional amounts of other income and resources, in the case of an individual who has a plan for achieving self-support approved by the State agency, as may be necessary for the fulfillment of such plan, but only with respect to the part or parts of such period during substantially all of which he is actually undergoing vocational rehabilitation;[4] (9) provide safeguards which permit the use or dis-

[3] 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).

[4] See Vol. II, 10 U.S.C. 2546 with respect to shelter for the homeless at military installations.

closure of information concerning applicants or recipients only (A) to public officials who require such information in connection with their official duties, or (B) to other persons for purposes directly

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See Vol. II, P.L. 81–171, §521(a)(1)(E), with respect to exclusion from income and resources of certain assistance rendered to provide occupant-owned, rental and cooperative housing.

See Vol. II, P.L. 87–543, §141(b), with respect to ineligibility to receive payments under Title XIV where payments have been made under Title XVI.

See Vol. II, P.L. 88–525, §8(b), with respect to exclusion from income and resources of the value of food stamps.

See Vol. II, P.L. 89–73, §210(b), with respect to exclusion from income of the costs of any project under that act.

See Vol. II, P.L. 89–329, §479B, with respect to exclusion from income or resources of certain student financial assistance.

See Vol. II, P.L. 90–248, §248(c), effective July 1, 1969, with respect to income disregards applicable to Guam, Puerto Rico, and the Virgin Islands.

See Vol. II, P.L. 91–646, §216, with respect to exclusion from income of payments made under that act.

See Vol. II, P.L. 93–112, §613(c), for the conditional exclusion from income of wages, allowances, transportation reimbursement, and attendant care provided to handicapped individuals under community service employment pilot programs.

See Vol. II, P.L. 93–113, §404(g), with respect to exclusion from income and resources of payments to volunteers under that act.

See Vol. II, P.L. 93–134, §§7 and 8, with respect to exclusion from income and resources of certain judgment funds to any Indian tribe.

See Vol. II, P.L. 93–288, §312(d), with respect to exclusion from income and resources of certain Federal major disaster and emergency assistance.

See Vol. II, P.L. 94–114, §6, with respect to exclusion from income and resources of property and receipts from submarginal land to certain Indians.

See Vol. II, P.L. 95–433, §2, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 95–498, §6, with respect to an income and resources exclusion applicable to the Pueblo of Santa Ana Indians, New Mexico.

See Vol. II, P.L. 95–499, §6, with respect to an income and resources exclusion applicable to the Pueblo of Zia Indians, New Mexico.

See Vol. II, P.L. 95–557, §410(b), with respect to exclusion from income of services (but not of wages) provided to a public housing resident or to a resident of a housing project assisted under the "Housing Act of 1959" (see Vol. II, P.L. 86–372, §202).

See Vol. II, P.L. 97–35, §2605(f), with respect to exclusion from income and resources of home energy assistance payments or allowances.

See Vol. II, P.L. 98–64, §2(a), with respect to exclusion from income and resources of per capita payments to Indians.

See Vol. II, P.L. 98–432, §5(e), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 98–500, §8, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 98–602, §106(d), with respect to exclusion from income and resources of certain funds distributed per capita.

See Vol. II, P.L. 99–130, §8, with respect to exclusion from income and resources of certain funds.

See Vol. II, P.L. 99–146, §6(b), with respect to exclusion from income and resources of certain funds.

See Vol. II, P.L. 99–264, §16, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 99–346, §6(b), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 99–377, §4(b), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 100–139, §4(h)(6), with respect to exclusion of benefits as basis for denial of eligibility.

See Vol. II, P.L. 100–407, §105(g), with respect to the effect of financial assistance under that Act.

See Vol. II, P.L. 100–409, §5, with respect to the effect of this Act on P.L. 92–203 or P.L. 96–487.

See Vol. II, P.L. 100–411, §2(d)(3)(B), with respect to the effect of per capita payments.

See Vol. II, P.L. 100–581, §§501, 502(b)(1), and 503, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 101–41, §10(b)-(d), with respect to eligibility for Federal programs and treatment of funds, assets, and income.

See Vol. II, P.L. 101–42, §3, with respect to the restoration of Federal recognition, rights, and privileges.

See Vol. II, P.L. 101–201, with respect to Agent Orange settlement payments.

See Vol. II, P.L. 101–239, §10405, with respect to Agent Orange settlement payments excluded from countable income and resources under Federal means-tested programs.

See Vol. II, P.L. 101–277, §8(b), with respect to exclusion, from income or resources, of funds held in trust or distributed to Seminole Indians.

connected with the administration of the State plan;[5] (10) provide that all individuals wishing to make application for aid to the permanently and totally disabled shall have opportunity to do so, and that aid to the permanently and totally disabled shall be furnished with reasonable promptness to all eligible individuals; (11) effective July 1, 1953, provide, if the plan includes payments to individuals in private or public institutions, for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for such institutions; (12) provide a description of the services (if any) which the State agency makes available (using whatever internal organizational arrangement it finds appropriate for this purpose) to applicants for and recipients of aid to the permanently and totally disabled to help them attain self-support or self-care, including a description of the steps taken to assure, in the provision of such services, maximum utilization of other agencies providing similar or related services; and (13) 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.

(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a), except that he shall not approve any plan which imposes, as a condition of eligibility for aid to the permanently and totally disabled under the plan—

(1) Any residence requirement which excludes any resident of the State who has resided therein five years during the nine years immediately preceding the application for aid to the permanently and totally disabled and has resided therein continuously for one year immediately preceding the application;

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

At the option of the State, the plan may provide that manuals and other policy issuances will be furnished to persons without charge for the reasonable cost of such materials, but such provision shall not be required by the Secretary as a condition for the approval of such plan under this title.

PAYMENT TO STATES

SEC. 1403. [42 U.S.C. 1353] (a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has an approved plan for aid to the permanently and totally disabled, for each quarter, beginning with the quarter commencing October 1, 1958—

(1) [Stricken.[6]]

(2) in the case of Puerto Rico, the Virgin Islands, and Guam, an amount equal to one-half of the total of the sums expended during such quarter as aid to the permanently and totally disabled under the State plan, not counting so much of any expenditure with respect to any month as exceeds $37.50 multiplied by the total number of recipients of aid to the permanently and totally disabled for such month; and

[5] See Vol. II, P.L. 82–183, §618, for the "Jenner Amendment", with respect to denial of grants-in-aid under certain conditions.

[6] P.L. 97–35, §2184(c)(2)(A); 95 Stat. 817.

(3) in the case of any State, an amount equal to 50 percent of the total amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

(b) The method of computing and paying such amounts shall be as follows:

(1) The Administrator shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (a), such estimate to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, (B) records showing the number of permanently and totally disabled individuals in the State, and (C) such other investigation as the Administrator may find necessary.

(2) The Administrator shall then certify to the Secretary of the Treasury the amount so estimated by the Administrator, (A) reduced or increased, as the case may be, by any sum by which he finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State under subsection (a) for such quarter, and (B) reduced by a sum equivalent to the pro rata share to which the United States is equitably entitled, as determined by the Administrator, of the net amount recovered during a prior quarter by the State or any political subdivision thereof with respect to aid to the permanently and totally disabled furnished under the State plan; except that such increases or reductions shall not be made to the extent that such sums have been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Administrator for such prior quarter: *Provided* , That any part of the amount recovered from the estate of a deceased recipient which is not in excess of the amount expended by the State or any political subdivision thereof for the funeral expenses of the deceased shall not be considered as a basis for reduction under clause(B) of this paragraph.[7]

(3) The Secretary of the Treasury shall thereupon, through the Fiscal Service of the Treasury Department, and prior to audit or settlement by the General Accounting Office[8], pay to the State, at the time or times fixed by the Administrator, the amount so certified.[9]

OPERATION OF STATE PLANS

SEC. 1404. **[**42 U.S.C. 1354**]** In the case of any State plan for aid to the permanently and totally disabled which has been approved

[7] Alignment as in original.

[8] P.L. 108-271, §8(b), provided that "Any reference to the General Accounting Office in any law, rule, regulation, certificate, directive, instruction, or other official paper in force on the date of enactment of this Act (July 7, 2004) shall be considered to refer and apply to the Government Accountability Office."

[9] Alignment as in original.

by the Secretary of Health, Education, and Welfare, if the Secretary after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, finds—

(1) that the plan has been so changed as to impose any residence or citizenship requirement prohibited by section 1402(b), or that in the administration of the plan any such prohibited requirement is imposed, with the knowledge of such State agency, in a substantial number of cases; or

(2) that in the administration of the plan there is a failure to comply substantially with any provision required by section 1402(a) to be included in the plan;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure) until he is satisfied that such prohibited requirement is no longer so imposed, and that there is no longer any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

DEFINITION

SEC. 1405. [42 U.S.C. 1355] For the purposes of this title, the term "aid to the permanently and totally disabled" means money payments to needy individuals eighteen years of age or older who are permanently and totally disabled, but does not include any such payments to or care in behalf of any individual who is an inmate of a public institution (except as a patient in a medical institution) or any individual who is a patient in an institution for tuberculosis or mental diseases. Such term also includes payments which are not included within the meaning of such term under the preceding sentence, but which would be so included except that they are made on behalf of such a needy individual to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such needy individual, but only with respect to a State whose State plan approved under section 1402 includes provision for—

(1) determination by the State agency that such needy individual has, by reason of his physical or mental condition, such inability to manage funds that making payments to him would be contrary to his welfare and, therefore, it is necessary to provide such aid through payments described in this sentence;

(2) making such payments only in cases in which such payments will, under the rules otherwise applicable under the State plan for determining need and the amount of aid to the permanently and totally disabled to be paid (and in conjunction with other income and resources), meet all the need[10] of the individuals with respect to whom such payments are made;

(3) undertaking and continuing special efforts to protect the welfare of such individual and to improve, to the extent possible, his capacity for self-care and to manage funds;

(4) periodic review by such State agency of the determination under paragraph (1) to ascertain whether conditions justifying

[10] As in original. Should be "needs".

such determination still exist, with provision for termination of such payments if they do not and for seeking judicial appointment of a guardian or other legal representative, as described in section 1111, if and when it appears that such action will best serve the interests of such needy individual; and

(5) opportunity for a fair hearing before the State agency on the determination referred to in paragraph (1) for any individual with respect to whom it is made.

At the option of a State (if its plan approved under this title so provides), such term (i) need not include money payments to an individual who has been absent from such State for a period in excess of ninety consecutive days (regardless of whether he has maintained his residence in such State during such period) until he has been present in such State for thirty consecutive days in the case of such an individual who has maintained his residence in such State during such period or ninety consecutive days in the case of any other such individual, and (ii) may include rent payments made directly to a public housing agency on behalf of a recipient or a group or groups of recipients of aid under such plan.

[TITLE XV—UNEMPLOYMENT COMPENSATION FOR FEDERAL EMPLOYEES] [1]

[1] P.L. 83–767 (68 Stat. 1130, approved September 1, 1954), §4(a), added Title XV to the Social Security Act.

P.L. 89–554 (80 Stat. 378, approved September 6, 1966), §8, repealed Title XV. Now see 5 U.S.C. 8501 et seq. (may be found in Vol. II).

[TITLE XVI—GRANTS TO STATES FOR AID TO THE AGED, BLIND, OR DISABLED] [1]

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APPROPRIATION

SEC. 1601. [42 U.S.C. 1381 note] For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish financial assistance to needy individuals who are 65 years of age or over, are blind, or are 18 years of age or over and permanently and totally disabled, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for aid to the aged, blind, or disabled.

STATE PLANS FOR AID TO THE AGED, BLIND, OR DISABLED

SEC. 1602. [42 U.S.C. 1382 note] (a) A State plan for aid to the aged, blind, or disabled, must—

(1) except to the extent permitted by the Secretary with respect to services, provide that it shall be in effect in all politi-

[1] This Title XVI of the Social Security Act is administered by the Department of Health and Human Services. The Office of Family Assistance, Family Support Administration, administers benefit payments under this Title XVI. The Office of Human Development Services administers social services under this Title XVI.

This Title XVI appears in the United States Code as §§1381 note - 1385 note, subchapter XVI, chapter 7, Title 42.

Regulations of the Secretary of Health and Human Services with respect to this Title XVI are contained in subtitle A and chapter XIII, Title 45, Code of Federal Regulations.

P.L. 92–603, §§301 and 303, *repealed* this title effective January 1, 1974, except with respect to Guam, Puerto Rico, and the Virgin Islands. The Commonwealth of the Northern Marianas may elect to initiate a Title XVI social services program if it chooses.

See Vol. II, 31 U.S.C. 6504–6505 with respect to intergovernmental cooperation and 31 U.S.C. 7501–7507 with respect to uniform audit requirements for State and local governments receiving Federal financial assistance.

See Vol. II, P.L. 82–183, §618, for the "Jenner Amendment", with respect to prohibition against denial of grants-in-aid under certain conditions.

See Vol. II, P.L. 88–352, §601, with respect to prohibition against discrimination in federally assisted programs.

See Vol. II, P.L. 89–97, §121(b), with respect to restrictions on payment to a State receiving payments under Title XIX.

See Vol. II, P.L. 95–521, §102(i), with respect to reporting of benefits received under the Social Security Act.

[2] This table of contents does not appear in the law.

cal subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State;

(3) either provide for the establishment or designation of a single State agency to administer the plan, or provide for the establishment or designation of a single State agency to supervise the administration of the plan;

(4) provide (A) for granting an opportunity for a fair hearing before the State agency to any individual whose claim for aid or assistance under the plan is denied or is not acted upon with reasonable promptness, and (B) that if the State plan is administered in each of the political subdivisions of the State by a local agency and such local agency provides a hearing at which evidence may be presented prior to a hearing before the State agency, such local agency may put into effect immediately upon issuance its decision upon the matter considered at such hearing;

(5) 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) as are found by the Secretary to be necessary for the proper and efficient operation of the plan [3], and (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;

(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 permit the use or disclosure of information concerning applicants or recipients only (A) to public officials who require such information in connection with their official duties, or (B) to other persons for purposes directly connected with the administration of the State plan;

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

(9) provide, if the plan includes aid or assistance to or on behalf of individuals in private or public institutions, for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for such institutions;

(10) provide a description of the services (if any) which the State agency makes available (using whatever internal organi-

[3] 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).

zational arrangement it finds appropriate for this purpose) to applicants for or recipients of aid or assistance under the plan to help them attain self-support or self-care, including a description of the steps taken to assure, in the provision of such services, maximum utilization of other agencies providing similar or related services;

(11) provide that no aid or assistance will be furnished any individual under the plan with respect to any period with respect to which he is receiving assistance under the State plan approved under title I or aid under a State program funded under part A of title IV or under title X or XIV;

(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) include reasonable standards, consistent with the objectives of this title, for determining eligibility for and the extent of aid or assistance under the plan;

(14) provide that the State agency shall, in determining need for aid to the aged, blind, or disabled, take into consideration any other income and resources of an individual claiming such aid, as well as any expenses reasonably attributable to the earning of any such income; except that, in making such determination with respect to any individual—

(A) if such individual is blind, the State agency (i) shall disregard the first $85 per month of earned income plus one-half of earned income in excess of $85 per month, and (ii) shall, for a period not in excess of 12 months, and may, for a period not in excess of 36 months, disregard such additional amounts of other income and resources, in the case of any such individual who has a plan for achieving self-support approved by the State agency, as may be necessary for the fulfillment of such plan,

(B) if such individual is not blind but is permanently and totally disabled, (i) of the first $80 per month of earned income, the State agency may disregard not more than the first $20 thereof plus one-half of the remainder, and (ii) the State agency may, for a period not in excess of 36 months, disregard such additional amounts of other income and resources, in the case of any such individual who has a plan for achieving self-support approved by the State agency, as may be necessary for the fulfillment of such plan, but only with respect to the part or parts of such period during substantially all of which he is actually undergoing vocational rehabilitation,

(C) if such individual has attained age 65 and is neither blind nor permanently and totally disabled, of the first $80 per month of earned income the State agency may disregard not more than the first $20 thereof plus one-half of the remainder, and

(D) the State agency may, before disregarding the amounts referred to above in this paragraph (14), disregard not more than $7.50 of any income;[4] and

[4] See Vol. II, 10 U.S.C. 2546 with respect to exclusion from income and resources for shelter for the homeless at military installations.

Continued

(15) 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.

Notwithstanding paragraph (3), if on January 1, 1962, and on the date on which a State submits its plan for approval under this title, the State agency which administered or supervised the ad-

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See Vol. II, P.L. 81–171, §521(a)(1)(E), with respect to exclusion from income and resources of certain assistance rendered to provide occupant-owned, rental and cooperative housing.

See Vol. II, P.L. 88–525, §8(b), with respect to the exclusion from income and resources of the value of food stamps.

See Vol. II, P.L. 89–73, §210(b), with respect to exclusion from income of the costs of any project under that act.

See Vol. II, P.L. 89–329, §479B, with respect to exclusion from income or resources of certain student financial assistance.

See Vol. II, P.L. 90–248, §248(c), effective July 1, 1969, with respect to income disregards applicable to Guam, Puerto Rico, and the Virgin Islands.

See Vol. II, P.L. 91–646, §216, with respect to exclusion from income of payments made.

See Vol. II, P.L. 93–112, §613(c), with respect to conditional exclusion of wages, allowances, transportation reimbursement, and attendant care costs.

See Vol. II, P.L. 93–113, §404(g), with respect to the exclusion from income and resources of payments to volunteers.

See Vol. II, P.L. 93–134, §§7 and 8, with respect to exclusion from income and resources of certain judgment funds to any Indian tribe.

See Vol. II, P.L. 93–288, §312(d), with respect to exclusion from income and resources of certain Federal major disaster and emergency assistance.

See Vol. II, P.L. 94–114, §6, with respect to exclusion from income and resources of property and receipts from submarginal land to certain Indians.

See Vol. II, P.L. 95–433, §2, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 95–498, §6, with respect to an income and resources exclusion applicable to the Pueblo of Santa Ana Indians, New Mexico.

See Vol. II, P.L. 95–499, §6, with respect to an income and resources exclusion applicable to the Pueblo of Zia Indians, New Mexico.

See Vol. II, P.L. 95–557, §410(b), with respect to exclusion from income of services (but not of wages) provided to a public housing resident or to a resident of a housing project assisted under the "Housing Act of 1959" (See Vol. II, P.L. 86–372, §202.)

See Vol. II, P.L. 97–35, §2605(f), with respect to exclusion from income and resources of home energy assistance payments or allowances.

See Vol. II, P.L. 98–64, §2(a), with respect to exclusion from income and resources of per capita payments to Indians.

See Vol. II, P.L. 98–432, §5(e), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 98–500, §8, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 98–602, §106(d), with respect to exclusion from income and resources of certain funds distributed per capita.

See Vol. II, P.L. 99–130, §8, with respect to exclusion from income and resources of certain funds.

See Vol. II, P.L. 99–146, §6(b), with respect to exclusion from income and resources of certain funds.

See Vol. II, P.L. 99–264, §16, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 99–346, §6(b), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 99–377, §4(b), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 100–139, §4(h)(6), with respect to exclusion of benefits as basis for denial of eligibility.

See Vol. II, P.L. 100–407, §105(g), with respect to the effect of financial assistance under that Act.

See Vol. II, P.L. 100–409, §5, with respect to the effect of this Act on P.L. 92–203 or P.L. 96–487.

See Vol. II, P.L. 100–411, §2(d)(3)(B), with respect to the effect of per capita payments.

See Vol. II, P.L. 100–581, §§501, 502(b)(1), and 503, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 101–41, §10(b)-(d), with respect to eligibility for Federal programs and treatment of funds, assets, and income.

See Vol. II, P.L. 101–42, §3, with respect to the restoration of Federal recognition, rights, and privileges.

See Vol. II, P.L. 101–201, with respect to Agent Orange settlement payments.

See Vol. II, P.L. 101–239, §10405, with respect to Agent Orange settlement payments excluded from countable income and resources under Federal means-tested programs.

See Vol. II, P.L. 101–277, §8(b), with respect to exclusion, from income or resources, of funds held in trust or distributed to Seminole Indians.

ministration of the plan of such State approved under title X was different from the State agency which administered or supervised the administration of the plan of such State approved under title I and the State agency which administered or supervised the administration of the plan of such State approved under title XIV, the State agency which administered or supervised the administration of such plan approved under title X may be designated to administer or supervise the administration of the portion of the State plan for aid to the aged, blind, or disabled which relates to blind individuals and a separate State agency may be established or designated to administer or supervise the administration of the rest of such plan; 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.

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

(1) an age requirement of more than sixty-five years; or

(2) any residence requirement which excludes any resident of the State who has resided therein five years during the nine years immediately preceding the application for such aid and has resided therein continuously for one year immediately preceding the application,[5] ; or

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

At the option of the State, the plan may provide that manuals and other policy issuances will be furnished to persons without charge for the reasonable cost of such materials, but such provision shall not be required by the Secretary as a condition for the approval of such plan under this title. In the case of any State to which the provisions of section 344 of the Social Security Act Amendments of 1950[6] were applicable on January 1, 1962, and to which the sentence of section 1002(b) following paragraph (2) thereof is applicable on the date on which its State plan for aid to the aged, blind, or disabled was submitted for approval under this title, the Secretary shall approve the plan of such State for aid to the aged, blind, or disabled for purposes of this title, even though it does not meet the requirements of paragraph (14) of subsection (a), if it meets all other requirements of this title for an approved plan for aid to the aged, blind, or disabled; but payments under section 1603 shall be made, in the case of any such plan, only with respect to expenditures thereunder which would be included as expenditures for the purposes of section 1603 under a plan approved under this section without regard to the provisions of this sentence.

(c) Subject to the last sentence of subsection (a), nothing in this title shall be construed to permit a State to have in effect with respect to any period more than one State plan approved under this title.

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[5] As in original. Comma should be stricken.

[6] P.L. 87–543, §136(b), [76 Stat. 197], repealed §344, effective July 25, 1962.

PAYMENTS TO STATES

SEC. 1603. [42 U.S.C. 1383 note] (a) From the sums appropriated therefor, the Secretary shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing October 1, 1962—

(1) [Stricken.[7]]

(2) in the case of Puerto Rico, the Virgin Islands, and Guam, an amount equal to—

(A) one-half of the total of the sums expended during such quarter as aid to the aged, blind, or disabled under the State plan, not counting so much of any expenditure with respect to any month as exceeds $37.50 multiplied by the total number of recipients of aid to the aged, blind, or disabled for such month; plus

(B) one-half of the amount by which such expenditures exceed the maximum which may be counted under clause[8] (A), not counting so much of any expenditure with respect to any month as exceeds the product of $45 multiplied by the total number of such recipients of aid to the aged, blind, or disabled for such month; and

(3) [Stricken.[9]]

(4) in the case of any State, an amount equal to 50 percent of the total amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

(b)(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsection (a) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

(2) The Secretary shall then pay, in such installments as he may determine, to the State the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

(3) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to aid or assistance furnished under the State plan, but excluding any amount of such aid or assistance recovered from the estate of a deceased recipient which is not in excess of the amount expended by the State or any political subdivision thereof for the funeral expenses of the deceased, shall be considered an overpayment to be adjusted under this subsection.

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[7] P.L. 97–35, §2184(d)(5)(A); 95 Stat. 818.
[8] As in original. Possibly, should be "subparagraph".
[9] P.L. 97–35, §2184(d)(5)(A); 95 Stat. 818.

(4) Upon the making of any estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

OPERATION OF STATE PLANS

SEC. 1604. [42 U.S.C. 1384 note] If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this title, finds—

(1) that the plan has been so changed that it no longer complies with the provisions of section 1602; or

(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

DEFINITIONS

SEC. 1605. [42 U.S.C. 1385 note] (a)[10] For purposes of this title, the term "aid to the aged, blind, or disabled" means money payments to needy individuals who are 65 years of age or older, are blind, or are 18 years of age or over and permanently and totally disabled, but such term does not include—

(1) any such payments to or care in behalf of any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(2) any such payments to or care in behalf of any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases.

Such term also includes payments which are not included within the meaning of such term under the preceding sentence, but which would be so included except that they are made on behalf of such a needy individual to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such needy individual, but only with respect to a State whose State plan approved under section 1602 includes provision for—

(A) determination by the State agency that such needy individual has, by reason of his physical or mental condition, such inability to manage funds that making payments to him would be contrary to his welfare and, therefore, it is necessary to provide such aid through payments described in this sentence;

(B) making such payments only in cases in which such payments will, under the rules otherwise applicable under the State plan for determining need and the amount of aid to the aged, blind, or disabled to be paid (and in conjunction with

[10] As in original; "(a)" should be stricken.

other income and resources), meet all the need[11] of the individuals with respect to whom such payments are made;

(C) undertaking and continuing special efforts to protect the welfare of such individual and to improve, to the extent possible, his capacity for self-care and to manage funds;

(D) periodic review by such State agency of the determination under clause[12] (A) to ascertain whether conditions justifying such determination still exist, with provision for termination of such payments if they do not and for seeking judicial appointment of a guardian or other legal representative, as described in section 1111, if and when it appears that such action will best serve the interests of such needy individual; and

(E) opportunity for a fair hearing before the State agency on the determination referred to in clause[13] (A) for any individual with respect to whom it is made.

At the option of a State (if its plan approved under this title so provides), such term (i) need not include money payments to an individual who has been absent from such State for a period in excess of ninety consecutive days (regardless of whether he has maintained his residence in such State during such period) until he has been present in such State for thirty consecutive days in the case of such an individual who has maintained his residence in such State during such period or ninety consecutive days in the case of any other such individual, and (ii) may include rent payments made directly to a public housing agency on behalf of a recipient or a group or groups of recipients of aid under such plan.

[11] As in original. Should be "needs".
[12] As in original. Possibly, should be "subparagraph".
[13] As in original. Possibly, should be "subparagraph".

TITLE XVI—SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED [1]

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[1] This Title XVI of the Social Security Act is administered by the Social Security Administration.

This Title XVI appears in the United States Code as §§1381–1383f, subchapter XVI, chapter 7, Title 42.

Regulations with respect to this Title XVI are contained in chapter III, Title 20, Code of Federal Regulations.

See Vol. II, 31 U.S.C. 3720 and 3720A, with respect to collection of payments due to Federal agencies.

See Vol. II, P.L. 88–525, §11(i), with respect to the acceptance by social security offices of applications for participation in the food stamp program from recipients of supplemental security income.

P.L. 94–241, §1 (§502 of Covenant to Establish a Commonwealth of the Northern Mariana Islands in Political Union with the United States of America), approved March 24, 1976, provides that this Title XVI is applicable to the Northern Mariana Islands.

See Vol. II, P.L. 95–521, §102(i), with respect to reporting of benefits received under the Social Security Act.

See Vol. II, P.L. 96–223, §102, with respect to allocation of funds for programs to assist SSI recipients.

See Vol. II, P.L. 97–300, §106(e), with respect to performance standards; and §§501–505, with respect to the payment of a bonus for the successful job placement of certain employable dependent individuals.

See Vol. II, P.L. 100–203, §9117, with respect to the demonstration program to assist homeless individuals.

See Vol. II, P.L. 100–204, §724(d), with respect to furnishing information to the United States Commission on Improving the Effectiveness of the United Nations; and §725(b), with respect to the detailing of Government personnel.

See Vol. II, P.L. 100–235, §§5–8, with respect to responsibilities of each Federal agency for computer systems security and privacy.

See Vol. II, P.L. 100–690, §5301(a)(1)(C) and (d)(1)(B), with respect to benefits of drug traffickers and possessors.

See Vol. II, P.L. 101–239, §10405, with respect to Agent Orange settlement payments excluded from countable income and resources under Federal means-tested programs.

See Vol. II, P.L. 101–508, §5041(2)-(4), with respect to notification of certain individuals eligible to receive retroactive benefits.

See Vol. II, P.L. 103–296, §201(c) with respect to demonstration projects designed to explore innovative referral, monitoring, and treatment approaches in disability determinations in which alcoholism or drug addiction is a contributing factor; §202, with respect to the establishment of a Commission on the Evaluation of Disability in children; §207, with respect to disability review for recipients who are 18 years of age; and §208, with respect to continuing disability reviews.

See Vol. II, P.L. 108-203, §103, with respect to disqualification from service as representative payee of persons convicted of offenses resulting in imprisonment for more than 1 year or fleeing prosecution, custody, or confinement.

[2] This table of contents does not appear in the law.

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PURPOSE; APPROPRIATIONS

SEC. 1601. [42 U.S.C. 1381] For the purpose of establishing a national program to provide supplemental security income to individuals who have attained age 65 or are blind or disabled, there are authorized to be appropriated sums sufficient to carry out this title.

BASIC ELIGIBILITY FOR BENEFITS

SEC. 1602. [42 U.S.C. 1381a] Every aged, blind, or disabled individual who is determined under part A to be eligible on the basis of his income and resources shall, in accordance with and subject to the provisions of this title, be paid benefits by the Commissioner of Social Security.

Part A—Determination of Benefits

ELIGIBILITY FOR AND AMOUNT OF BENEFITS[3]

Definition of Eligible Individual

SEC. 1611. [42 U.S.C. 1382] (a)(1) Each aged, blind, or disabled individual who does not have an eligible spouse and—

(A) whose income, other than income excluded pursuant to section 1612(b), is at a rate of not more than $1,752 (or, if greater, the amount determined under section 1617) for the calendar year 1974 or any calendar year thereafter, and

(B) whose resources, other than resources excluded pursuant to section 1613(a), are not more than (i) in case such individual has a spouse with whom he is living, the applicable amount determined under paragraph (3)(A), or (ii) in case such individual has no spouse with whom he is living, the applicable amount determined under paragraph (3)(B),

shall be an eligible individual for purposes of this title.

[3] See Vol. II, P.L. 93–66, §211, with respect to supplemental security income benefits for essential persons.

(2) Each aged, blind, or disabled individual who has an eligible spouse and—

(A) whose income (together with the income of such spouse), other than income excluded pursuant to section 1612(b), is at a rate of not more than $2,628 (or, if greater, the amount determined under section 1617) for the calendar year 1974, or any calendar year thereafter, and

(B) whose resources (together with the resources of such spouse), other than resources excluded pursuant to section 1613(a), are not more than the applicable amount determined under paragraph (3)(A),

shall be an eligible individual for purposes of this title.

(3)(A) The dollar amount referred to in clause (i) of paragraph (1)(B), and in paragraph (2)(B), shall be $2,250 prior to January 1, 1985, and shall be increased to $2,400 on January 1, 1985, to $2,550 on January 1, 1986, to $2,700 on January 1, 1987, to $2,850 on January 1, 1988, and to $3,000 on January 1, 1989.

(B) The dollar amount referred to in clause (ii) of paragraph (1)(B), shall be $1,500 prior to January 1, 1985, and shall be increased to $1,600 on January 1, 1985, to $1,700 on January 1, 1986, to $1,800 on January 1, 1987, to $1,900 on January 1, 1988, and to $2,000 on January 1, 1989.

Amounts of Benefits [4]

(b)(1) The benefit under this title for an individual who does not have an eligible spouse shall be payable at the rate of $1,752 (or, if greater, the amount determined under section 1617) for the calendar year 1974 and any calendar year thereafter, reduced by the amount of income, not excluded pursuant to section 1612(b), of such individual.

(2) The benefit under this title for an individual who has an eligible spouse shall be payable at the rate of $2,628 (or, if greater, the amount determined under section 1617) for the calendar year 1974 and any calendar year thereafter, reduced by the amount of income, not excluded pursuant to section 1612(b), of such individual and spouse.

Period for Determination of Benefits

(c)(1) An individual's eligibility for a benefit under this title for a month shall be determined on the basis of the individual's (and eligible spouse's, if any) income, resources, and other relevant characteristics in such month, and, except as provided in paragraphs (2), (3), (4), (5), and (6), the amount of such benefit shall be determined for such month on the basis of income and other characteristics in the first or, if the Commissioner of Social Security so determines, second month preceding such month. Eligibility for and the amount of such benefits shall be redetermined at such time or times as may be provided by the Commissioner of Social Security.

(2) The amount of such benefit for the month in which an application for benefits becomes effective (or, if the Commissioner of Social Security so determines, for such month and the fol-

[4] See. Vol. II, Appendices A and B, for Cost–of–Living Increase information.

lowing month) and for any month immediately following a month of ineligibility for such benefits (or, if the Commissioner of Social Security so determines, for such month and the following month) shall—

(A) be determined on the basis of the income of the individual and the eligible spouse, if any, of such individual and other relevant circumstances in such month; and

(B) in the case of the month in which an application becomes effective or the first month following a period of ineligibility, if such application becomes effective, or eligibility is restored, after the first day of such month, bear the same ratio to the amount of the benefit which would have been payable to such individual if such application had become effective, or eligibility had been restored, on the first day of such month as the number of days in such month including and following the effective date of such application or restoration of eligibility bears to the total number of days in such month.

(3) For purposes of this subsection, an increase in the benefit amount payable under title II (over the amount payable in the preceding month, or, at the election of the Commissioner of Social Security, the second preceding month) to an individual receiving benefits under this title shall be included in the income used to determine the benefit under this title of such individual for any month which is—

(A) the first month in which the benefit amount payable to such individual under this title is increased pursuant to section 1617, or

(B) at the election of the Commissioner of Social Security, the month immediately following such month.

(4)(A) Notwithstanding paragraph (3), if the Commissioner of Social Security determines that reliable information is currently available with respect to the income and other circumstances of an individual for a month (including information with respect to a class of which such individual is a member and information with respect to scheduled cost–of–living adjustments under other benefit programs), the benefit amount of such individual under this title for such month may be determined on the basis of such information.

(B) The Commissioner of Social Security shall prescribe by regulation the circumstances in which information with respect to an event may be taken into account pursuant to subparagraph (A) in determining benefit amounts under this title.

(5) Notwithstanding paragraphs (1) and (2), any income which is paid to or on behalf of an individual in any month pursuant to (A) a State program funded under part A of title IV, (B) section 472 of this Act (relating to foster care assistance), (C) section 412(e) of the Immigration and Nationality Act (relating to assistance for refugees), (D) section 501(a) of Public Law 96–422 (relating to assistance for Cuban and Haitian entrants), or (E) the Act of November 2, 1921 (42 Stat. 208)[5], as amended (relating to assistance furnished by the Bu-

[5] See Vol. II for P.L. 82–414, §412(e), P.L. 96–422, §501(a), and P.L. 67–85, the Act of November 2, 1921.

reau of Indian Affairs), shall be taken into account in determining the amount of the benefit under this title of such individual (and his eligible spouse, if any) only for that month, and shall not be taken into account in determining the amount of the benefit for any other month.

(6) The dollar amount in effect under subsection (b) as a result of any increase in benefits under this title by reason of section 1617 shall be used to determine the value of any in–kind support and maintenance required to be taken into account in determining the benefit payable under this title to an individual (and the eligible spouse, if any, of the individual) for the 1st 2 months for which the increase in benefits applies.

(7) For purposes of this subsection, an application of an individual for benefits under this title shall be effective on the later of—

(A) the first day of the month following the date such application is filed, or

(B) the first day of the month following the date such individual becomes eligible for such benefits with respect to such application.

(8) The Commissioner of Social Security may waive the limitations specified in subparagraphs (A) and (B) of subsection (e)(1) on an individual's eligibility and benefit amount for a month (to the extent either such limitation is applicable by reason of such individual's presence throughout such month in a hospital, extended care facility, nursing home, or intermediate care facility) if such waiver would promote the individual's removal from such institution or facility. Upon waiver of such limitations, the Commissioner of Social Security shall apply, to the month preceding the month of removal, or, if the Commissioner of Social Security so determines, the two months preceding the month of removal, the benefit rate that is appropriate to such individual's living arrangement subsequent to his removal from such institution or facility.

(9)[6](A) Notwithstanding paragraphs (1) and (2), any nonrecurring income which is paid to an individual in the first month of any period of eligibility shall be taken into account in determining the amount of the benefit under this title of such indiviudal (and his eligible spouse, if any) only for that month, shall not be taken into account in determining the amount of the benefit for any other month.

(B) For purposes of subparagraph (A), payments to an individual in varying amounts from the same or similar source for the same or similar purpose shall not be considered to be nonrecurring income.

(10)[7] For purposes of this subsection, renumeration for service performed as a member of a uniformed service may be treated as received in the month in which it was earned, if the Commissioner of Social Security determines that such treatment would promote the economical and efficient adminstration of the program authorized by this title.

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[6] P.L. 108-203, §433(a), adds paragraph (9), to be effective with respect to benefits payable for months that begin on or after March 2, 2005.

[7] P.L. 108-203, §436(a), added paragraph (10), applicable to benefits payable for months after June 2004.

Special Limits on Gross Income

(d) The Commissioner of Social Security may prescribe the circumstances under which, consistently with the purposes of this title, the gross income from a trade or business (including farming) will be considered sufficiently large to make an individual ineligible for benefits under this title. For purposes of this subsection, the term "gross income" has the same meaning as when used in chapter 1 of the Internal Revenue Code of 1954[8].

Limitation on Eligibility of Certain Individuals

(e)(1)(A) Except as provided in subparagraphs (B), (C), (D), (E), and (G), no person shall be an eligible individual or eligible spouse for purposes of this title with respect to any month if throughout such month he is an inmate of a public institution.

(B) In any case where an eligible individual or his eligible spouse (if any) is, throughout any month (subject to subparagraph (G)), in a medical treatment facility receiving payments (with respect to such individual or spouse) under a State plan approved under title XIX, or an eligible individual is a child described in section 1614(f)(2)(B), or, in the case of an eligible individual who is a child under the age of 18, receiving payments (with respect to such individual) under any health insurance policy issued by a private provider of such insurance the benefit under this title for such individual for such month shall be payable (subject to subparagraph (E))—

(i) at a rate not in excess of $360 per year (reduced by the amount of any income not excluded pursuant to section 1612(b)) in the case of an individual who does not have an eligible spouse;

(ii) in the case of an individual who has an eligible spouse, if only one of them is in such a facility throughout such month, at a rate not in excess of the sum of—

(I) the rate of $360 per year (reduced by the amount of any income, not excluded pursuant to section 1612(b), of the one who is in such facility), and

(II) the applicable rate specified in subsection (b)(1) (reduced by the amount of any income, not excluded pursuant to section 1612(b), of the other); and

(iii) at a rate not in excess of $720 per year (reduced by the amount of any income not excluded pursuant to section 1612(b)) in the case of an individual who has an eligible spouse, if both of them are in such a facility throughout such month.

For purposes of this subsection, a medical treatment facility that provides services described in section 1917(c)(1)(C) shall be considered to be receiving payments with respect to an individual under a State plan approved under title XIX during any period of ineli-

[8] P.L. 83–591.
P.L. 99–514, §2, provides, except when inappropriate, any reference to the Internal Revenue Code of 1954 shall include a reference to the Internal Revenue Code of 1986.

gibility of such individual provided for under the State plan pursuant to section 1917(c).

(C) As used in subparagraph (A), the term "public institution" does not include a publicly operated community residence which serves no more than 16 residents.[9]

(D) A person may be an eligible individual or eligible spouse for purposes of this title with respect to any month throughout which he is a resident of a public emergency shelter for the homeless (as defined in regulations which shall be prescribed by the Commissioner of Social Security); except that no person shall be an eligible individual or eligible spouse by reason of this subparagraph more than 6 months in any 9–month period.

(E) Notwithstanding subparagraphs (A) and (B), any individual who—

(i)(I) is an inmate of a public institution, the primary purpose of which is the provision of medical or psychiatric care, through–out any month as described in subparagraph (A), or

(II) is in a medical treatment facility throughout any month as described in subparagraph (B),

(ii) was eligible under section 1619(a) or (b) for the month preceding such month, and

(iii) under an agreement of the public institution or the medical treatment facility is permitted to retain any benefit payable by reason of this subparagraph,

may be an eligible individual or eligible spouse for purposes of this title (and entitled to a benefit determined on the basis of the rate applicable under subsection (b)) for the month referred to in subclause (I) or (II) of clause (i) and, if such subclause still applies, for the succeeding month.

(F) An individual who is an eligible individual or an eligible spouse for a month by reason of subparagraph (E) shall not be treated as being eligible under section 1619(a) or (b) for such month for purposes of clause (ii) of such subparagraph.

(G) A person may be an eligible individual or eligible spouse for purposes of this title, and subparagraphs (A) and (B) shall not apply, with respect to any particular month throughout which he or she is an inmate of a public institution the primary purpose of which is the provision of medical or psychiatric care, or is in a medical treatment facility receiving payments (with respect to such individual or spouse) under a State plan approved under title XIX or, in the case of an individual who is a child under the age of 18, under any health insurance policy issued by a private provider of such insurance, if it is determined in accordance with subparagraph (H) or (J) that—

(i) such person's stay in that institution or facility (or in that institution or facility and one or more other such institutions or facilities during a continuous period of institutionalization) is likely (as certified by a physician) not to exceed 3 months, and the particular

[9] See Vol. II, P.L. 96–598, §4, with respect to the Boundary County Restorium, Bonner's Ferry, Idaho.

month involved is one of the first 3 months throughout which such person is in such an institution or facility during a continuous period of institutionalization; and

(ii) such person needs to continue to maintain and provide for the expenses of the home or living arrangement to which he or she may return upon leaving the institution or facility.

The benefit of any person under this title (including State supplementation if any) for each month to which this subparagraph applies shall be payable, without interruption of benefit payments and on the date the benefit involved is regularly due, at the rate that was applicable to such person in the month prior to the first month throughout which he or she is in the institution or facility.

(H) The Commissioner of Social Security shall establish procedures for the determinations required by clauses (i) and (ii) of subparagraph (G), and may enter into agreements for making such determinations (or for providing information or assistance in connection with the making of such determinations) with appropriate State and local public and private agencies and organizations. Such procedures and agreements shall include the provision of appropriate assistance to individuals who, because of their physical or mental condition, are limited in their ability to furnish the information needed in connection with the making of such determinations.

(I)(i) The Commissioner shall enter into an agreement, with any interested State or local institution comprising a jail, prison, penal institution, or correctional facility, or with any other interested State or local institution a purpose of which is to confine individuals as described in section 202(x)(1)(A)(ii) [10], under which—

(I) the institution shall provide to the Commissioner, on a monthly basis and in a manner specified by the Commissioner, the names, social security account numbers, dates of birth, confinement commencement dates, and, to the extent available to the institution, such other identifying information concerning the inmates of the institution as the Commissioner may require for the purpose of carrying out this paragraph and the other provisions of this title; and

(II) the Commissioner shall pay to any such institution, with respect to each individual who receives in the month preceding the first month throughout which such individual is an inmate of the jail, prison, penal institution, or correctional facility that furnishes information respecting such individual pursuant to subclause (I), or is confined in the institution (that so furnishes such information) as described in section 202(x)(1)(A)(ii), a benefit under this title for such preceding month, and who is determined by the Commissioner to be ineligible for benefits under

[10] The reference to §202(x)(1)(A)(ii) shall be deemed a reference to such §202(x)(1)(A)(ii) as amended by P.L. 106–170, §402(b)(1)(C).

this title by reason of confinement based on the information provided by such institution, $400 (subject to reduction under clause (ii)) if the institution furnishes the information described in subclause (I) to the Commissioner within 30 days after the date such individual becomes an inmate of such institution, or $200 (subject to reduction under clause (ii)) if the institution furnishes such information after 30 days after such date but within 90 days after such date.

(ii) The dollar amounts specified in clause (i)(II) shall be reduced by 50 percent if the Commissioner is also required to make a payment to the institution with respect to the same individual under an agreement entered into under section 202(x)(3)(B).

(iii) The Commissioner shall maintain, and shall provide on a reimbursable basis, information obtained pursuant to agreements entered into under clause (i) to any Federal or federally–assisted cash, food, or medical assistance program for eligibility and other administrative purposes under such program.

(iv) Payments to institutions required by clause (i)(II) shall be made from funds otherwise available for the payment of benefits under this title and shall be treated as direct spending for purposes of the Balanced Budget and Emergency Deficit Control Act of 1985.

(J) For the purpose of carrying out this paragraph, the Commissioner of Social Security shall conduct periodic computer matches with data maintained by the Secretary of Health and Human Services under title XVIII or XIX. The Secretary shall furnish to the Commissioner, in such form and manner and under such terms as the Commissioner and the Secretary shall mutually agree, such information as the Commissioner may request for this purpose. Information obtained pursuant to such a match may be substituted for the physician's certification otherwise required under subparagraph (G)(i).

(2) No person shall be an eligible individual or eligible spouse for purposes of this title if, after notice to such person by the Commissioner of Social Security that it is likely that such person is eligible for any payments of the type enumerated in section 1612(a)(2)(B), such person fails within 30 days to take all appropriate steps to apply for and (if eligible) obtain any such payments.

(3) Notwithstanding anything to the contrary in the criteria being used by the Commissioner of Social Security in determining when a husband and wife are to be considered two eligible individuals for purposes of this title and when they are to be considered an eligible individual with an eligible spouse, the State agency administering or supervising the administration of a State plan under any other program under this Act may (in the administration of such plan) treat a husband and wife living in the same medical treatment facility described in paragraph (1)(B) as though they were an eligible individual with his or her eligible spouse for purposes of this title (rather than

two eligible individuals), after they have continuously lived in the same such facility for 6 months, if treating such husband and wife as two eligible individuals would prevent either of them from receiving benefits or assistance under such plan or reduce the amount thereof.

(4)(A)[11] No person shall be considered an eligible individual or eligible spouse for purposes of this title with respect to any month if during such month the person is—

(i)[12] fleeing to avoid prosecution, or custody or confinement after conviction, under the laws of the place from which the person flees, for a crime, or an attempt to commit a crime, which is a felony under the laws of the place from which the person flees, or, in jurisdictions that do not define crimes as felonies, is punishable by death or imprisonment for a term exceeding 1 year regardless of the actual sentence imposed[13]; or

(ii)[14] violating a condition of probation or parole imposed under Federal or State law.

(B)[15] Notwithstanding subparagraph (A), the Commissioner shall, for good cause shown, treat the person referred to in subparagraph (A) as an eligible individual or eligible spouse if the Commissioner determines that—

(i) a court of competent jurisdiction has found the person not guilty of the criminal offense, dismissed the charges relating to the criminal offense, vacated the warrant for arrest of the person for the criminal offense, or issued any similar exonerating order (or taken similar exonerating action), or

(ii) the person was erroneously implicated in connection with the criminal offense by reason of identity fraud.

(C)[16] Notwithstanding subparagraph (A), the Commissioner may, for good cause shown based on mitigating circumstances, treat the person referred to in subparagraph (A) as an eligible individual or eligible spouse if the Commissioner determines that—

(i) the offense described in subparagraph (A)(i) or underlying the imposition of the probation or parole described in subparagraph (A)(ii) was nonviolent and not drug-related, and

(ii) in the case of a person who is not considered an eligible individual or eligible spouse pursuant to subparagraph (A)(ii), the action that resulted in the violation of a condition of probation or parole was nonviolent and not drug-related.

(5) Notwithstanding any other provision of law (other than section 6103 of the Internal Revenue Code of 1986[17] and section 1106(c) of this Act), the Commissioner shall furnish any

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[11] P.L. 108-203, §203(b)(1)(B), inserted "(A)".

[12] P.L. 108-203, §203(b)(1)(A), redesignated the former subparagraph (A) as clause (i).

[13] P.L. 108-203, §203(b)(1)(C), struck out, "or which, in the case of the State of New Jersey, is a high misdemeanor under the laws of such State" and substituted "or, in jurisdictions that do not define crimes as felonies, is punishable by death or imprisonment for a term exceeding 1 year regardless of the actual sentence imposed", effective December 1, 2004.

[14] P.L. 108-203, §203(b)(1)(A), redesignated the former subparagraph (B) as clause (ii).

[15] P.L. 108-203, §203(b)(1)(D), added subparagraph (B), effective December 1, 2004.

[16] P.L. 108-203, §203(b)(1)(D), added subparagraph (C), effective December 1, 2004.

[17] See Vol. II, P.L. 83–591.

Federal, State, or local law enforcement officer, upon the written request of the officer, with the current address, Social Security number, and photograph (if applicable) of any recipient of benefits under this title, if the officer furnishes the Commissioner with the name of the recipient, and other identifying information as reasonably required by the Commissioner to establish the unique identity of the recipient, and notifies the Commissioner that—

(A)[18] the recipient is described in clause (i) or (ii) of paragraph (4)(A);

(B)[19] the location or apprehension of the recipient is within the officer's official duties.

Suspension of Payments to Individuals Who Are Outside the United States

(f)(1) Notwithstanding any other provision of this title, no individual (other than a child described in section 1614(a)(1)(B)(ii)) shall be considered an eligible individual for purposes of this title for any month during all of which such individual is outside the United States (and no person shall be considered the eligible spouse of an individual for purposes of this title with respect to any month during all of which such person is outside the United States). For purposes of the preceding sentence, after an individual has been outside the United States for any period of 30 consecutive days, he shall be treated as remaining outside the United States until he has been in the United States for a period of 30 consecutive days.

(2) For a period of not more than 1 year, the first sentence of paragraph (1) shall not apply to any individual who—

(A) was eligible to receive a benefit under this title for the month immediately preceding the first month during all of which the individual was outside the United States; and

(B) demonstrates to the satisfaction of the Commissioner of Social Security that the absence of the individual from the United States will be—

(i) for not more than 1 year; and

(ii) for the purposes of conducting studies as part of an educational program that is—

(I) designed to substantially enhance the ability of the individual to engage in gainful employment;

(II) sponsored by a school, college, or university in the United States; and

(III) not available to the individual in the United States.

Certain Individuals Deemed To Meet Resources Test

(g) In the case of any individual or any individual and his spouse (as the case may be) who—

[18] P.L. 108-203, §203(b)(2), amended subparagraph (A) in its entirety, effective December 1, 2004. For subparagraph (A) as it formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L. 108-203.

[19] P.L. 108-203, §203(b)(2), amended subparagraph (B) in its entirety, effective December 1, 2004. For subparagraph (B) as it formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L. 108-203.

(1) received aid or assistance for December 1973 under a plan of a State approved under title I, X, XIV, or XVI,

(2) has, since December 31, 1973, continuously resided in the State under the plan of which he or they received such aid or assistance for December 1973, and

(3) has, since December 31, 1973, continuously been (except for periods not in excess of six consecutive months) an eligible individual or eligible spouse with respect to whom supplemental security income benefits are payable,

the resources of such individual or such individual and his spouse (as the case may be) shall be deemed not to exceed the amount specified in sections 1611(a)(1)(B) and 1611(a)(2)(B) during any period that the resources of such individual or such individual and his spouse (as the case may be) does not exceed the maximum amount of resources specified in the State plan, as in effect for October 1972, under which he or they received such aid or assistance for December 1973.

Certain Individuals Deemed To Meet Income Test

(h) In determining eligibility for, and the amount of, benefits payable under this section in the case of any individual or any individual and his spouse (as the case may be) who—

(1) received aid or assistance for December 1973 under a plan of a State approved under title X or XVI,

(2) is blind under the definition of that term in the plan, as in effect for October 1972, under which he or they received such aid or assistance for December 1973,

(3) has, since December 31, 1973, continuously resided in the State under the plan of which he or they received such aid or assistance for December 1973, and

(4) has, since December 31, 1973, continuously been (except for periods not in excess of six consecutive months) an eligible individual or an eligible spouse with respect to whom supplemental security income benefits are payable,

there shall be disregarded an amount equal to the greater of (A) the maximum amount of any earned or unearned income which could have been disregarded under the State plan, as in effect for October 1972, under which he or they received such aid or assistance for December 1973, and (B) the amount which would be required to be disregarded under section 1612 without application of this subsection.

Application and Review Requirements for Certain Individuals

(i) For application and review requirements affecting the eligibility of certain individuals, see section 1631(j).

INCOME

Meaning of Income

SEC. 1612. [42 U.S.C. 1382a] (a) For purposes of this title, income means both earned income and unearned income; and—

(1) earned income means only—

(A) wages as determined under section 203(f)(5)(C) but without the application of section 210(j)(3);

(B) net earnings from self–employment, as defined in section 211 (without the application of the second and third sentences following subsection (a)(11), the last paragraph of subsection (a), and section 210(j)(3)), including earnings for services described in paragraphs (4), (5), and (6) of subsection (c);

(C) remuneration received for services performed in a sheltered workshop or work activities center; and

(D) any royalty earned by an individual in connection with any publication of the work of the individual, and that portion of any honorarium which is received for services rendered; and

(2) unearned income means all other income, including—

(A) support and maintenance furnished in cash or kind; except that (i) in the case of any individual (and his eligible spouse, if any) living in another person's household and receiving support and maintenance in kind from such person, the dollar amounts otherwise applicable to such individual (and spouse) as specified in subsections (a) and (b) of section 1611 shall be reduced by 33 ⅓ percent in lieu of including such support and maintenance in the unearned income of such individual (and spouse) as otherwise required by this subparagraph, (ii) in the case of any individual or his eligible spouse who resides in a nonprofit retirement home or similar nonprofit institution, support and maintenance shall not be included to the extent that it is furnished to such individual or such spouse without such institution receiving payment therefor (unless such institution has expressly undertaken an obligation to furnish full support and maintenance to such individual or spouse without any current or future payment therefor) or payment therefor is made by another nonprofit organization, and (iii) support and maintenance shall not be included and the provisions of clause (i) shall not be applicable in the case of any individual (and his eligible spouse, if any) for the period which begins with the month in which such individual (or such individual and his eligible spouse) began to receive support and maintenance while living in a residential facility (including a private household) maintained by another person and ends with the close of the month in which such individual (or such individual and his eligible spouse) ceases to receive support and maintenance while living in such a residential facility (or, if earlier, with the close of the seventeenth month following the month in which such period began), if, not more than 30 days prior to the date on which such individual (or such individual and his eligible spouse) began to receive support and maintenance while living in such a residential facility, (I) such individual (or such individual and his eligible spouse) were residing in a household maintained by such individual (or by such individual and others) as his or their own home, (II) there occurred within the area in which such household is located (and while such individual, or such individual and his spouse, were residing in the household referred to in subclause (I)) a catastrophe on account of which the President declared a major disaster to

exist therein for purposes of the Disaster Relief and Emergency Assistance Act[20], and (III) such individual declares that he (or he and his eligible spouse) ceased to continue living in the household referred to in subclause (II) because of such catastrophe;

(B) any payments received as an annuity, pension, retirement, or disability benefit, including veterans' compensation and pensions, workmen's compensation payments, old–age, survivors, and disability insurance benefits, railroad retirement annuities and pensions, and unemployment insurance benefits;

(C) prizes and awards;

(D) payments to the individual occasioned by the death of another person, to the extent that the total of such payments exceeds the amount expended by such individual for purposes of the deceased person's last illness and burial;

(E) support and alimony payments, and (subject to the provisions of subparagraph (D) excluding certain amounts expended for purposes of a last illness and burial) gifts (cash or otherwise) and inheritances;

(F) rents, dividends, interest, and royalties not described in paragraph (1)(E); and

(G) any earnings of, and additions to, the corpus of a trust established by an individual (within the meaning of section 1613(e)), of which the individual is a beneficiary, to which section 1613(e) applies, and, in the case of an irrevocable trust, with respect to which circumstances exist under which a payment from the earnings or additions could be made to or for the benefit of the individual.

Exclusions From Income[21]

(b) In determining the income of an individual (and his eligible spouse) there shall be excluded—

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[20] P.L. 93–288.

[21] See Vol. II, 10 U.S.C. 2546, with respect to shelter for the homeless at military installations.

See Vol. II, P.L. 79–396, §12(e), with respect to exclusion from income and resources of assistance to children.

See Vol. II, P.L. 81–171, §521(a)(1)(E), with respect to exclusion from income and resources of certain assistance rendered to provide occupant–owned, rental and cooperative housing.

See Vol. II, P.L. 88–525, §8(b), with respect to exclusion from income and resources of the value of food stamps.

See Vol. II, P.L. 89–73, §210(b), with respect to exclusion from income of the costs of any project under that act.

See Vol. II, P.L. 89–329, §479B, with respect to exclusion from income or resources of certain student financial assistance.

See Vol. II, P.L. 89–642, §11(b), with respect to the exclusion from income and resources of the value of assistance to children.

See Vol. II, P.L. 91–646, §216, with respect to exclusion from income of payments under that act.

See Vol. II, P.L. 93–112, §613(c), with respect to the conditional exclusion from income of wages, allowances, transportation reimbursement, and attendant care provided to handicapped individuals under community service employment pilot programs.

See Vol. II, P.L. 93–113, §404(f), with respect to the exclusion from income and resources of payments to volunteers.

See Vol. II, P.L. 93–134, §§7 and 8, with respect to exclusion from income and resources of certain judgment funds to any Indian tribe.

See Vol. II, P.L. 93–288, §312(d), with respect to exclusion from income and resources of certain Federal major disaster and emergency assistance.

See Vol. II, P.L. 94–114, §6, with respect to exclusion from income and resources of property and receipts from submarginal land to certain Indians.

See Vol. II, P.L. 94–375, §2(h), with respect to exclusion from income and resources of the value of assistance paid with respect to a dwelling unit, for purposes of this title of this act. Also see Vol. II:

(1) subject to limitations (as to amount or otherwise) prescribed by the Commissioner of Social Security, if such individual is a child who is, as determined by the Commissioner of Social Security, a student regularly attending a school, college, or university, or a course of vocational or technical training designed to prepare him for gainful employment, the earned income of such individual;

(2)(A) the first $240 per year (or proportionately smaller amounts for shorter periods) of income (whether earned or unearned) other than income which is paid on the basis of the need of the eligible individual, and

(B) monthly (or other periodic) payments received by any individual, under a program established prior to July 1, 1973 (or any program established prior to such date but subsequently amended so as to conform to State or Federal constitutional standards), if (i) such payments are made by the State of which the individual receiving such payments

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P.L. 73–479, §§231(a), (b), and (f); 235(a); 236(a) and (j)(6); and 237(a) and (b);
P.L. 75–412, §§8(j) and 9(b);
P.L. 81–171, §521(a)(1)(B), (C), and (E); and
P.L. 89–117, §101.

See Vol. II, P.L. 95–433, §2, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 95–498, §6, with respect to an income and resources exclusion applicable to the Pueblo of Santa Ana Indians, New Mexico.

See Vol. II, P.L. 95–499, §6, with respect to an income and resources exclusion applicable to the Pueblo of Zia Indians, New Mexico.

See Vol. II, P.L. 95–557, §410(b), with respect to exclusion from income of services (but not of wages) provided to a public housing resident or to a resident of a housing project assisted under the "Housing Act of 1959" (Vol. II, P.L. 86–372, §202).

See Vol. II, P.L. 97–35, §2605(f), with respect to exclusion from income and resources of home energy assistance payments or allowances.

See Vol. II, P.L. 98–64, §2(a), with respect to exclusion from income and resources of per capita payments to Indians.

See Vol. II, P.L. 98–432, §5(e), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 98–500, §8, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 98–602, §106(d), with respect to exclusion from income and resources of certain funds distributed per capita.

See Vol. II, P.L. 99–130, §8, with respect to exclusion from income and resources of certain funds.

See Vol. II, P.L. 99–146, §6(b), with respect to exclusion from income and resources of certain funds.

See Vol. II, P.L. 99–264, §16, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 99–346, §6(b), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 99–377, §4(b), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 100–139, §4(h)(6), with respect to exclusion of benefits as basis for denial of eligibility.

See Vol. II, P.L. 100–383, §§105(f)(2) and 206(d)(2), with respect to exclusion from income and resources of certain payments to certain individuals. See Vol. II, 31 U.S.C. 3803(c)(2)(C), with respect to benefits not affected by P.L. 100–383.

See Vol. II, P.L. 100–407, §105(g), with respect to the effect of financial assistance under that Act.

See Vol. II, P.L. 100–409, §5, with respect to the effect of this Act on P.L. 92–203 or P.L. 96–487.

See Vol. II, P.L. 100–411, §2(d)(3)(B), with respect to the effect of per capita payments.

See Vol. II, P.L. 100–581, §§501, 502(b)(1), and 503, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 101–41, §10(b)-(d), with respect to eligibility for Federal programs and treatment of funds, assets, and income.

See Vol. II, P.L. 101–42, §3, with respect to the restoration of Federal recognition, rights, and privileges.

See Vol. II, P.L. 101–201, §1, with respect to Agent Orange settlement payments.

See Vol. II, P.L. 101–239, §10405, with respect to Agent Orange settlement payments excluded from countable income and resources under Federal means–tested programs.

See Vol. II, P.L. 101–277, §8(b), with respect to exclusion, from income or resources, of funds held in trust or distributed to Seminole Indians.

is a resident, (ii) eligibility of any individual for such payments is not based on need and is based solely on attainment of age 65 or any other age set by the State and residency in such State by such individual, and (iii) on or before September 30, 1985, such individual (I) first becomes an eligible individual or an eligible spouse under this title, and (II) satisfies the twenty–five–year residency requirement of such program as such program was in effect prior to January 1, 1983;

(3)[22] in any calendar quarter, the first—

(A) $60 of unearned income, and

(B) $30 of earned income,

of such individual (and such spouse, if any) which, as determined in accordance with criteria, prescribed by the Commissioner of Social Security, is received too infrequently or irregularly to be included;

(4)(A) if such individual (or such spouse) is blind (and has not attained age 65, or received benefits under this title (or aid under a State plan approved under section 1002 or 1602) for the month before the month in which he attained age 65), (i) the first $780 per year (or proportionately smaller amounts for shorter periods) of earned income not excluded by the preceding paragraphs of this subsection, plus one–half of the remainder thereof, (ii) an amount equal to any expenses reasonably attributable to the earning of any income, and (iii) such additional amounts of other income, where such individual has a plan for achieving self–support approved by the Commissioner of Social Security, as may be necessary for the fulfillment of such plan,

(B) if such individual (or such spouse) is disabled but not blind (and has not attained age 65, or received benefits under this title (or aid under a State plan approved under section 1402 or 1602) for the month before the month in which he attained age 65), (i) the first $780 per year (or proportionately smaller amounts for shorter periods) of earned income not excluded by the preceding paragraphs of this subsection, (ii) such additional amounts of earned income of such individual, if such individual's disability is sufficiently severe to result in a functional limitation requiring assistance in order for him to work, as may be necessary to pay the costs (to such individual) of attendant care services, medical devices, equipment, prostheses, and similar items and services (not including routine drugs or routine medical services unless such drugs or services are necessary for the control of the disabling condition) which are necessary (as determined by the Commissioner of Social Security in regulations) for that purpose, whether or not such assistance is also needed to enable him to carry out his normal daily functions, except that the amounts to be excluded shall be subject to such reasonable limits as the Commissioner of Social Security may prescribe, (iii) one-half of the amount of earned income not excluded after

[22] P.L. 108-203, §430(a), amended paragraph (3) in its entirety, effective with respect to benefits payable for months in calendar quarters that begin more than 90 days after March 2, 2004. For paragraph (3) as it formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L. 108-203.

the application of the preceding provisions of this subparagraph, and (iv) such additional amounts of other income, where such individual has a plan for achieving self–support approved by the Commissioner of Social Security, as may be necessary for the fulfillment of such plan, or

(C) if such individual (or such spouse) has attained age 65 and is not included under subparagraph (A) or (B), the first $780 per year (or proportionately smaller amounts for shorter periods) of earned income not excluded by the preceding paragraphs of this subsection, plus one–half of the remainder thereof;

(5) any amount received from any public agency as a return or refund of taxes paid on real property or on food purchased by such individual (or such spouse);

(6) assistance, furnished to or on behalf of such individual (and spouse), which is based on need and furnished by any State or political subdivision of a State;

(7) any portion of any grant, scholarship, fellowship, or gift (or portion of a gift) used to pay[23] the cost of tuition and fees at any educational (including technical or vocational education) institution;

(8) home produce of such individual (or spouse) utilized by the household for its own consumption;

(9) if such individual is a child, one–third of any payment for his support received from an absent parent;

(10) any amounts received for the foster care of a child who is not an eligible individual but who is living in the same home as such individual and was placed in such home by a public or nonprofit private child–placement or child–care agency;

(11) assistance received under the Disaster Relief and Emergency Assistance Act[24] or other assistance provided pursuant to a Federal statute on account of a catastrophe which is declared to be a major disaster by the President;

(12) interest income received on assistance funds referred to in paragraph (11) within the 9–month period beginning on the date such funds are received (or such longer periods as the Commissioner of Social Security shall by regulations prescribe in cases where good cause is shown by the individual concerned for extending such period);

(13) any support or maintenance assistance furnished to or on behalf of such individual (and spouse if any) which (as determined under regulations of the Commissioner of Social Security by such State agency as the chief executive officer of the State may designate) is based on need for such support or maintenance, including assistance received to assist in meeting the costs of home energy (including both heating and cooling), and which is (A) assistance furnished in kind by a private nonprofit agency, or (B) assistance furnished by a supplier of home heating oil or gas, by an entity providing home energy whose revenues are primarily derived on a rate–of–return basis regulated by a State or Federal governmental entity, or by a municipal utility providing home energy;

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[23] P.L. 108-203, §435(a), struck out "or fellowship received for use in paying" and substituted "fellowship, or gift (or portion of a gift) used to pay", applicable to benefits payable for months that begin more than 90 days after March 2, 2004.

[24] See Vol. II, P.L. 93–288.

(14) assistance paid, with respect to the dwelling unit occupied by such individual (or such individual and spouse), under the United States Housing Act of 1937[25], the National Housing Act[26] , section 101 of the Housing and Urban Development Act of 1965[27], title V of the Housing Act of 1949[28], or section 202(h) of the Housing Act of 1959[29];

(15) the value of any commercial transportation ticket, for travel by such individual (or spouse) among the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands, which is received as a gift by such individual (or such spouse) and is not converted to cash;

(16) interest accrued on the value of an agreement entered into by such individual (or such spouse) representing the purchase of a burial space excluded under section 1613(a)(2)(B), and left to accumulate;

(17) any amount received by such individual (or such spouse) from a fund established by a State to aid victims of crime;

(18) relocation assistance provided by a State or local government to such individual (or such spouse), comparable to assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970 which is subject to the treatment required by section 216 of such Act[30];

(19) any refund of Federal income taxes made to such individual (or such spouse) by reason of section 32 of the Internal Revenue Code of 1986 (relating to earned income tax credit)[31], and any payment made to such individual (or such spouse) by an employer under section 3507 of such Code (relating to advance payment of earned income credit)[32];

(20) special pay received pursuant to section 310 of title 37, United States Code[33];

(21) the interest or other earnings on any account established and maintained in accordance with section 1631(a)(2)(F);[34]

(22) any gift to, or for the benefit of, an individual who has not attained 18 years of age and who has a life–threatening condition, from an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 which is exempt from taxation under section 501(a) of such Code[35]—

(A) in the case of an in–kind gift, if the gift is not converted to cash; or

(B) in the case of a cash gift, only to the extent that the total amount excluded from the income of the individual pursuant to this paragraph in the calendar year in which the gift is made does not exceed $2,000; and[36]

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[25] See Vol. II, P.L. 75–412.
[26] See Vol. II, P.L. 73–479.
[27] See Vol. II, P.L. 89–117.
[28] See Vol. II, P.L. 81–171.
[29] See Vol. II, P.L. 86–372.
[30] See Vol. II, P.L. 91–646, §216.
[31] See Vol. II, P.L. 83–591, §32.
[32] See P.L. 83–591, §3507 (this volume).
[33] See Vol. II, Title 37 U.S.C. 310.
[34] P.L. 108–203, §430(b)(1), struck out "and".
[35] See Vol. II, P.L. 83-591, §501.
[36] P.L. 108–203, §430(b)(2), struck out the period and substituted "; and".

(23)[37] interest or dividend income from resources—
(A) not excluded under section 1613(a), or
(B) excluded pursuant to Federal law other than sections 1613(a).

RESOURCES

Exclusions From Resources[38]

SEC. 1613. [42 U.S.C. 1382b] (a) In determining the resources of an individual (and his eligible spouse, if any) there shall be excluded—

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[37] P.L. 108–203, §430(b)(3), added paragraph (23), effective with respect to benefits payable for months in calendar quarters that begin more than 90 days after March 2, 2004.

[38] See Vol. II, P.L. 79–396, §12(e), with respect to exclusion from income and resources of assistance to children.

See Vol. II, P.L. 81–171, §521(a)(1)(E), with respect to exclusion from income and resources of certain assistance rendered to provide occupant-owned, rental and cooperative housing.

See Vol. II, P.L. 88–525, §8(b), with respect to exclusion from income and resources of the value of food stamps.

See Vol. II, P.L. 89–329, §479B, with respect to exclusion from income or resources of certain student financial assistance.

See Vol. II, P.L. 89–642, §11(b), with respect to the exclusion from income and resources of the value of assistance to children.

See Vol. II, P.L. 93–113, §404(f), with respect to exclusion from income and resources of payments to volunteers.

See Vol. II, P.L. 93–134, §§7 and 8, with respect to exclusion from income and resources of certain judgment funds to any Indian tribe.

See Vol. II, P.L. 93–288, §312(d), with respect to exclusion from income and resources of certain Federal major disaster and emergency assistance.

See Vol. II, P.L. 94–114, §6, with respect to exclusion from income and resources of property and receipts from submarginal land to certain Indians.

See Vol. II, P.L. 94–375, §2(h), with respect to exclusion from income and resources of the value of assistance paid with respect to a dwelling unit, for purposes of this title of this act. Also see Vol. II:

P.L. 73–479, §§231(a), (b), and (f); 235(a); 236(a) and (j)(6); and 237(a) and (b);
P.L. 75–412, §§8(j) and 9(b);
P.L. 81–171, §521(a)(1)(B), (C), and (E); and
P.L. 89–117, §101.

See Vol. II, P.L. 95–433, §2, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 95–498, §6, with respect to an income and resources exclusion applicable to the Pueblo of Santa Ana Indians, New Mexico.

See Vol. II, P.L. 95–499, §6, with respect to an income and resources exclusion applicable to the Pueblo of Zia Indians, New Mexico.

See Vol. II, P.L. 97–35, §2605(f), with respect to exclusion from income and resources of home energy assistance payments or allowances.

See Vol. II, P.L. 98–64, §2(a), with respect to exclusion from income and resources of per capita payments to Indians.

See Vol. II, P.L. 98–432, §5(e), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 98–500, §8, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 98–602, §106(d), with respect to exclusion from income and resources of certain funds distributed per capita.

See Vol. II, P.L. 99–130, §8, with respect to exclusion from income and resources of certain funds.

See Vol. II, P.L. 99–146, §6(b), with respect to exclusion from income and resources of certain funds.

See Vol. II, P.L. 99–264, §16, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 99–346, §6(b), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 99–377, §4(b), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 100–139, §4(h)(6), with respect to exclusion of benefits as basis for denial of eligibility.

See Vol. II, P.L. 100–383, §§105(f)(2) and 206(d)(2), with respect to exclusion from income and resources of certain payments to certain individuals. See Vol. II, 31 U.S.C. 3803(c)(2)(C), with respect to benefits not affected by P.L. 100–383.

See Vol. II, P.L. 100–407, §105(g), with respect to the effect of financial assistance under that Act.

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(1) the home (including the land that appertains thereto);

(2)(A) household goods, personal effects, and an automobile, to the extent that their total value does not exceed such amount as the Commissioner of Social Security determines to be reasonable; and

(B) the value of any burial space or agreement (including any interest accumulated thereon) representing the purchase of a burial space (subject to such limits as to size or value as the Commissioner of Social Security may by regulation prescribe) held for the purpose of providing a place for the burial of the individual, his spouse, or any other member of his immediate family;

(3) other property which is so essential to the means of self-support of such individual (and such spouse) as to warrant its exclusion, as determined in accordance with and subject to limitations prescribed by the Commissioner of Social Security, except that the Commissioner of Social Security shall not establish a limitation on property (including the tools of a tradesperson and the machinery and livestock of a farmer) that is used in a trade or business or by such individual as an employee;

(4) such resources of an individual who is blind or disabled and who has a plan for achieving self-support approved by the Commissioner of Social Security, as may be necessary for the fulfillment of such plan;

(5) in the case of Natives of Alaska, shares of stock held in a Regional or a Village Corporation, during the period of twenty years in which such stock is inalienable, as provided in section 7(h) and section 8(c) of the Alaska Native Claims Settlement Act[39] ;

(6) assistance referred to in section 1612(b)(11) for the 9-month period beginning on the date such funds are received (or for such longer period as the Commissioner of Social Security shall by regulations prescribe in cases where good cause is shown by the individual concerned for extending such period); and, for purposes of this paragraph, the term "assistance" includes interest thereon which is excluded from income under section 1612(b)(12);

(7) any amount received from the United States which is attributable to underpayments of benefits due for one or more prior months, under this title or title II, to such individual (or spouse) or to any other person whose income is deemed to be included in such individual's (or spouse's) income for purposes of this title; but the application of this paragraph in the case

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See Vol. II, P.L. 100–409, §5, with respect to the effect of this Act on P.L. 92–203 or P.L. 96–487.

See Vol. II, P.L. 100–411, §2(d)(3)(B), with respect to the effect of per capita payments.

See Vol. II, P.L. 100–581, §§501, 502(b)(1), and 503, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 101–41, §10(b)-(d), with respect to eligibility for Federal programs and treatment of funds, assets, and income.

See Vol. II, P.L. 101–42, §3, with respect to the restoration of Federal recognition, rights, and privileges.

See Vol. II, P.L. 101–201, §1, with respect to Agent Orange settlement payments.

See Vol. II, P.L. 101–239, §10405, with respect to Agent Orange settlement payments excluded from countable income and resources under Federal means-tested programs.

See Vol. II, P.L. 101–277, §8(b), with respect to exclusion, from income or resources, of funds held in trust or distributed to Seminole Indians.

[39] See Vol. II, P.L. 92–203.

of any such individual (and eligible spouse if any), with respect to any amount so received from the United States, shall be limited to the first 9[40] months following the month in which such amount is received[41], and written notice of this limitation shall be given to the recipient concurrently with the payment of such amount;[42]

(8) the value of assistance referred to in section 1612(b)(14), paid with respect to the dwelling unit occupied by such individual (or such individual and spouse);

(9) for the 9-month period beginning after the month in which received, any amount received by such individual (or such spouse) from a fund established by a State to aid victims of crime, to the extent that such individual (or such spouse) demonstrates that such amount was paid as compensation for expenses incurred or losses suffered as a result of a crime;

(10) for the 9-month period beginning after the month in which received, relocation assistance provided by a State or local government to such individual (or such spouse), comparable to assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970 which is subject to the treatment required by section 216 of such Act[43];

(11)[44] for the 9-month period beginning after the month in which received--

(A) notwithstanding section 203 of the Economic Growth and Tax Relief Reconciliation Act of 2001, any refund of Federal income taxes made to such individual (or such spouse) under section 24 of the Internal Revenue Code of 1986 (relating to child tax credit) by reason of subsection (d) thereof; and

(B) any refund of Federal income taxes made to such individual (or such spouse) by reason of section 32 of the Internal Revenue Code of 1986 (relating to earned income tax credit), and any payment made to such individual (or such spouse) by an employer under section 3507 of such Code (relating to advance payment of earned income credit);

(12) any account, including accrued interest or other earnings thereon, established and maintained in accordance with section 1631(a)(2)(F);[45]

(13) any gift to, or for the benefit of, an individual who has not attained 18 years of age and who has a life–threatening condition, from an organization described in section 501(c)(3) of

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[40] P.L. 108–203, §431(a)(1), struck out "6" and substituted "9", effective March 2, 2004, applicable to amounts described in paragraph (7) of section 1613(a) and refunds of Federal income taxes described in paragraph (11), that are received by an eligible individual or eligible spouse on or after March 2, 2004.

[41] P.L. 108–203, §431(a)(2), struck out "(or to the first 9 months following such months with respect to any amount so received during the period beginning October 1, 1987, and ending September 30, 1989)", effective March 2, 2004.

[42] See Vol. II, P.L. 101–508, §5041(1), with respect to notification of certain individuals eligible to receive retroactive benefits.

[43] See Vol. II, P.L. 91–646, §216.

[44] P.L. 108-203, §431(b) amended paragraph (11) in its entirety, effective March 2, 2004, applicable to amounts in paragraph (7) of section 1613(a) and refunds of Federal income taxes described in paragraph (11), that are received by an eligible individual or eligible spouse on or after March 2, 2004. For paragraph (11) as it formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L. 108-203.

See Vol. II, P.L. 83-591 and P.L. 83-591, §3507 (this volume).

[45] P.L. 108-203, §101(c)(2)(A), struck out "and".

the Internal Revenue Code of 1986 which is exempt from taxation under section 501(a) of such Code—

(A) in the case of an in–kind gift, if the gift is not converted to cash; or

(B) in the case of a cash gift, only to the extent that the total amount excluded from the resources of the individual pursuant to this paragraph in the calendar year in which the gift is made does not exceed $2,000. ;[46]

(14)[47] for the 9-month period beginning after the month in which received, any amount received by such individual (or spouse) or any other person whose income is deemed to be included in such individual's (or spouse's) income for purposes of this title as restitution for benefits under this title, title II, or title VIII that a representative payee of such individual (or spouse) or such other person under section 205(j), 807, or 1631(a)(2) has misused; and[48]

(15)[49] for the 9-month period beginning after the month in which received, any grant, scholarship, fellowship, or gift (or portion of a gift) used to pay the cost of tuition and fees at any educational (including technical or vocational education) institution.

In determining the resources of an individual (or eligible spouse) an insurance policy shall be taken into account only to the extent of its cash surrender value; except that if the total face value of all life insurance policies on any person is $1,500 or less, no part of the value of any such policy shall be taken into account.

Disposition of Resources

(b)(1) The Commissioner of Social Security shall prescribe the period or periods of time within which, and the manner in which, various kinds of property must be disposed of in order not to be included in determining an individual's eligibility for benefits. Any portion of the individual's benefits paid for any such period shall be conditioned upon such disposal; and any benefits so paid shall (at the time of the disposal) be considered overpayments to the extent they would not have been paid had the disposal occurred at the beginning of the period for which such benefits were paid.

(2) Notwithstanding the provisions of paragraph (1), the Commissioner of Social Security shall not require the disposition of any real property for so long as it cannot be sold because (A) it is jointly owned (and its sale would cause undue hardship, due to loss of housing, for the other owner or owners), (B) its sale is barred by a legal impediment, or (C) as determined under regulations issued by the Commissioner of Social Security, the owner's reasonable efforts to sell it have been unsuccessful.

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[46] P.L. 108-203, §101(c)(2)(B), struck out the period and substituted "; and"; §435(b)(1), struck out "and".

[47] P.L. 108-203, §101(c)(2)(C), added paragraph (14), applicable to any case of benefit misuse by a representative payee with respect to which the Commissioner of Social Security makes the determination of misuse on or after January 1, 1995.

[48] P.L. 108-203, §435(b)(2), struck out the period and substituted "; and".

[49] P.L. 108-203, §435(b)(3), added paragraph (15), applicable to benefits payable for months that begin more than 90 days after March 2, 2004.

Disposal of Resources for Less Than Fair Market Value

(c)(1)(A)(i) If an individual or the spouse of an individual disposes of resources for less than fair market value on or after the look–back date described in clause (ii)(I), the individual is ineligible for benefits under this title for months during the period beginning on the date described in clause (iii) and equal to the number of months calculated as provided in clause (iv).

(ii)(I) The look-back date described in this subclause is a date that is 36 months before the date described in subclause (II).

(II) The date described in this subclause is the date on which the individual applies for benefits under this title or, if later, the date on which the individual (or the spouse of the individual) disposes of resources for less than fair market value.

(iii) The date described in this clause is the first day of the first month in or after which resources were disposed of for less than fair market value and which does not occur in any other period of ineligibility under this paragraph.

(iv) The number of months calculated under this clause shall be equal to—

(I) the total, cumulative uncompensated value of all resources so disposed of by the individual (or the spouse of the individual) on or after the look-back date described in clause (ii)(I); divided by

(II) the amount of the maximum monthly benefit payable under section 1611(b), plus the amount (if any) of the maximum State supplementary payment corresponding to the State's payment level applicable to the individual's living arrangement and eligibility category that would otherwise be payable to the individual by the Commissioner pursuant to an agreement under section 1616(a) of this Act or section 212(b) of Public Law 93–66, for the month in which occurs the date described in clause (ii)(II),

rounded, in the case of any fraction, to the nearest whole number, but shall not in any case exceed 36 months.

(B)(i) Notwithstanding subparagraph (A), this subsection shall not apply to a transfer of a resource to a trust if the portion of the trust attributable to the resource is considered a resource available to the individual pursuant to subsection (e)(3) (or would be so considered but for the application of subsection (e)(4)).

(ii) In the case of a trust established by an individual or an individual's spouse (within the meaning of subsection (e)), if from such portion of the trust, if any, that is considered a resource available to the individual pursuant to subsection (e)(3) (or would be so considered but for the application of subsection (e)(4)) or the residue of the portion on the termination of the trust—

(I) there is made a payment other than to or for the benefit of the individual; or

(II) no payment could under any circumstance be made to the individual,

then, for purposes of this subsection, the payment described in clause (I) or the foreclosure of payment described in clause (II) shall be considered a transfer of resources by the individual or the individual's spouse as of the date of the payment or foreclosure, as the case may be.

(C) An individual shall not be ineligible for benefits under this title by reason of the application of this paragraph to a disposal of resources by the individual or the spouse of the individual, to the extent that—

(i) the resources are a home and title to the home was transferred to—

(I) the spouse of the transferor;

(II) a child of the transferor who has not attained 21 years of age, or is blind or disabled;

(III) a sibling of the transferor who has an equity interest in such home and who was residing in the transferor's home for a period of at least 1 year immediately before the date the transferor becomes an institutionalized individual; or

(IV) a son or daughter of the transferor (other than a child described in subclause (II)) who was residing in the transferor's home for a period of at least 2 years immediately before the date the transferor becomes an institutionalized individual, and who provided care to the transferor which permitted the transferor to reside at home rather than in such an institution or facility;

(ii) the resources—

(I) were transferred to the transferor's spouse or to another for the sole benefit of the transferor's spouse;

(II) were transferred from the transferor's spouse to another for the sole benefit of the transferor's spouse;

(III) were transferred to, or to a trust (including a trust described in section 1917(d)(4)) established solely for the benefit of, the transferor's child who is blind or disabled; or

(IV) were transferred to a trust (including a trust described in section 1917(d)(4)) established solely for the benefit of an individual who has not attained 65 years of age and who is disabled;

(iii) a satisfactory showing is made to the Commissioner of Social Security (in accordance with regulations promulgated by the Commissioner) that—

(I) the individual who disposed of the resources intended to dispose of the resources either at fair market value, or for other valuable consideration;

(II) the resources were transferred exclusively for a purpose other than to qualify for benefits under this title; or

(III) all resources transferred for less than fair market value have been returned to the transferor; or

(iv) the Commissioner determines, under procedures established by the Commissioner, that the denial of eligibility would work an undue hardship as determined on the basis of criteria established by the Commissioner.

(D) For purposes of this subsection, in the case of a resource held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the resource (or the affected portion of such resource) shall be considered to be disposed of by the individual when any action is taken, either by the individual or by any other person, that reduces or eliminates the individual's ownership or control of such resource.

(E) In the case of a transfer by the spouse of an individual that results in a period of ineligibility for the individual under this subsection, the Commissioner shall apportion the period (or any portion of the period) among the individual and the individual's spouse if the spouse becomes eligible for benefits under this title.

(F) For purposes of this paragraph—

(i) the term "benefits under this title" includes payments of the type described in section 1616(a) of this Act and of the type described in section 212(b) of Public Law 93-66;

(ii) the term "institutionalized individual" has the meaning given such term in section 1917(e)(3); and

(iii) the term "trust" has the meaning given such term in subsection (e)(6)(A) of this section.

(2)(A) At the time an individual (and the individual's eligible spouse, if any) applies for benefits under this title, and at the time the eligibility of an individual (and such spouse, if any) for such benefits is redetermined, the Commissioner of Social Security shall—

(i) inform such individual of the provisions of paragraph (1) section 1917(c) providing for a period of ineligibility for benefits under this title and title XIX, respectively, for individuals who make certain dispositions of resources for less than fair market value, and inform such individual that information obtained pursuant to clause (ii) will be made available to the State agency administering a State plan under title XIX (as provided in subparagraph (B)); and

(ii) obtain from such individual information which may be used in determining whether or not a period of ineligibility for such benefits would be required by reason of paragraph (1) or section 1917(c).

(B) The Commissioner of Social Security shall make the information obtained under subparagraph (1)(A)(ii) available, on request, to any State agency administering a State plan approved under title XIX.

Funds Set Aside for Burial Expenses

(d)(1) In determining the resources of an individual, there shall be excluded an amount, not in excess of $1,500 each with respect to such individual and his spouse (if any), that is separately identifiable and has been set aside to meet the burial and related expenses of such individual or spouse.

(2) The amount of $1,500, referred to in paragraph (1), with respect to an individual shall be reduced by an amount equal to (A) the total face value of all insurance policies on his life which are owned by him or his spouse and the cash surrender value of which has been excluded in determining the resources of such individual or of such individual and his spouse, and (B) the total of any amounts in an irrevocable trust (or other irrevocable arrangement) available to meet the burial and related expenses of such individual or his spouse.

(3) If the Commissioner of Social Security finds that any part of the amount excluded under paragraph (1) was used for purposes other than those for which it was set aside in cases where the inclusion of any portion of the amount would cause the resources of such individual, or of such individual and spouse, to exceed the limits specified in paragraph (1) or (2) (whichever may be applicable) of section 1611(a), the Commissioner shall reduce any future benefits payable to the eligible individual (or to such individual and his spouse) by an amount equal to such part.

(4) The Commissioner of Social Security may provide by regulations that whenever an amount set aside to meet burial and related expenses is excluded under paragraph (1) in determining the resources of an individual, any interest earned or accrued on such amount (and left to accumulate), and any appreciation in the value of prepaid burial arrangements for which such amount was set aside, shall also be excluded (to such extent and subject to such conditions or limitations as such regulations may prescribe) in determining the resources (and the income) of such individual.

Trusts

(e)(1) In determining the resources of an individual, paragraph (3) shall apply to a trust (other than a trust described in paragraph (5)) established by the individual.

(2)(A) For purposes of this subsection, an individual shall be considered to have established a trust if any assets of the individual (or of the individual's spouse) are transferred to the trust other than by will.

(B) In the case of an irrevocable trust to which are transferred the assets of an individual (or of the individual's spouse) and the assets of any other person, this subsection shall apply to the portion of the trust attributable to the assets of the individual (or of the individual's spouse).

(C) This subsection shall apply to a trust without regard to—

(i) the purposes for which the trust is established;

(ii) whether the trustees have or exercise any discretion under the trust;

(iii) any restrictions on when or whether distributions may be made from the trust; or

(iv) any restrictions on the use of distributions from the trust.

(3)(A) In the case of a revocable trust established by an individual, the corpus of the trust shall be considered a resource available to the individual.

(B) In the case of an irrevocable trust established by an individual, if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual (or of the individual's spouse), the portion of the corpus from which payment to or for the benefit of the individual (or of the individual's spouse) could be made shall be considered a resource available to the individual.

(4) The Commissioner of Social Security may waive the application of this subsection with respect to an individual if the Commissioner determines that such application would work an undue hardship (as determined on the basis of criteria established by the Commissioner) on the individual.

(5) This subsection shall not apply to a trust described in subparagraph (A) or (C) of section 1917(d)(4).

(6) For purposes of this subsection—

(A) the term "trust" includes any legal instrument or device that is similar to a trust;

(B) the term "corpus" means, with respect to a trust, all property and other interests held by the trust, including accumulated earnings and any other addition to the trust after its establishment (except that such term does not include any such earnings or addition in the month in which the earnings or addition is credited or otherwise transferred to the trust); and

(C) the term "asset" includes any income or resource of the individual (or of the individual's spouse), including—

(i) any income excluded by section 1612(b);

(ii) any resource otherwise excluded by this section; and

(iii) any other payment or property to which the individual (or of the individual's spouse) is entitled but does not receive or have access to because of action by—

(I) the individual or spouse;

(II) a person or entity (including a court) with legal authority to act in place of, or on behalf of, the individual or spouse; or

(III) a person or entity (including a court) acting at the direction of, or on the request of, the individual or spouse.

MEANING OF TERMS

Aged, Blind, or Disabled Individual

SEC. 1614. [42 U.S.C. 1382c] (a)(1) For purposes of this title, the term "aged, blind, or disabled individual" means an individual who—

(A) is 65 years of age or older, is blind (as determined under paragraph (2)), or is disabled (as determined under paragraph (3)), and

(B)(i) is a resident of the United States, and is either (I) a citizen or (II) an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law (including any alien who is lawfully present in the United States as a result of the application of the provisions of section 212(d)(5) of the Immigration and Nationality Act[50]), or

(ii) is a child who is a citizen of the United States, and[51] who is living with a parent of the child who is a member of the Armed Forces of the United States assigned to permanent duty ashore outside the United States.[52]

(2) An individual shall be considered to be blind for purposes of this title if he has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered for purposes of the first sentence of this subsection as having a central visual acuity of 20/200 or less. An individual shall also be considered to be blind for purposes of this title if he is blind as defined under a State plan approved under title X or XVI as in effect for October 1972 and received aid under such plan (on the basis of blindness) for December 1973, so long as he is continuously blind as so defined.

(3)(A) Except as provided in subparagraph (C), an individual shall be considered to be disabled for purposes of this title if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months.

(B) For purposes of subparagraph (A), an individual shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. For purposes of the preceding sentence (with respect to any individual), "work which exists in the national economy" means work which exists in significant numbers either in the region where such individual lives or in several regions of the country.

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[50] See Vol. II, P.L. 82–414.

[51] P.L. 108-203, §434(a)(1), inserted "and".

[52] P.L. 108-203, §434(a)(2), struck out ", and who, for the month before the parent reported for such assignment, received a benefit under this title." and substituted a period, effective with respect to benefits payable for months beginning after March 2, 2004, but only on the basis of an application filed March 2, 2004.

(C)(i) An individual under the age of 18 shall be considered disabled for the purposes of this title if that individual has a medically determinable physical or mental impairment, which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

(ii) Notwithstanding clause (i), no individual under the age of 18 who engages in substantial gainful activity (determined in accordance with regulations prescribed pursuant to subparagraph (E)) may be considered to be disabled.

(D) For purposes of this paragraph, a physical or mental impairment is an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.

(E) The Commissioner of Social Security shall by regulations prescribe the criteria for determining when services performed or earnings derived from services demonstrate an individual's ability to engage in substantial gainful activity. In determining whether an individual is able to engage in substantial gainful activity by reason of his earnings, where his disability is sufficiently severe to result in a functional limitation requiring assistance in order for him to work, there shall be excluded from such earnings an amount equal to the cost (to such individual) of any attendant care services, medical devices, equipment, prostheses, and similar items and services (not including routine drugs or routine medical services unless such drugs or services are necessary for the control of the disabling condition) which are necessary (as determined by the Commissioner of Social Security in regulations) for that purpose, whether or not such assistance is also needed to enable him to carry out his normal daily functions; except that the amounts to be excluded shall be subject to such reasonable limits as the Commissioner of Social Security may prescribe. Notwithstanding the provisions of subparagraph (B), an individual whose services or earnings meet such criteria shall be found not to be disabled. The Commissioner of Social Security shall make determinations under this title with respect to substantial gainful activity, without regard to the legality of the activity.

(F) Notwithstanding the provisions of subparagraphs (A) through (D), an individual shall also be considered to be disabled for purposes of this title if he is permanently and totally disabled as defined under a State plan approved under title XIV or XVI as in effect for October 1972 and received aid under such plan (on the basis of disability) for December 1973 (and for at least one month prior to July 1973), so long as he is continuously disabled as so defined.

(G) In determining whether an individual's physical or mental impairment or impairments are of a sufficient medical severity that such impairment or impairments could be the basis of eligibility under this section, the Commissioner of Social Security shall consider the combined effect

of all of the individual's impairments without regard to whether any such impairment, if considered separately, would be of such severity. If the Commissioner of Social Security does find a medically severe combination of impairments, the combined impact of the impairments shall be considered throughout the disability determination process.

(H)(i) In making determinations with respect to disability under this title, the provisions of sections 221(h), 221(k), and 223(d)(5) shall apply in the same manner as they apply to determinations of disability under title II.

(ii)(I) Not less frequently than once every 3 years, the Commissioner shall review in accordance with paragraph (4) the continued eligibility for benefits under this title of each individual who has not attained 18 years of age and is eligible for such benefits by reason of an impairment (or combination of impairments) which is likely to improve (or, at the option of the Commissioner, which is unlikely to improve).

(II) A representative payee of a recipient whose case is reviewed under this clause shall present, at the time of review, evidence demonstrating that the recipient is, and has been, receiving treatment, to the extent considered medically necessary and available, of the condition which was the basis for providing benefits under this title.

(III) If the representative payee refuses to comply without good cause with the requirements of subclause (II), the Commissioner of Social Security shall, if the Commissioner determines it is in the best interest of the individual, promptly suspend payment of benefits to the representative payee, and provide for payment of benefits to an alternative representative payee of the individual or, of the interest of the individual under this title would be served thereby, to the individual.

(IV) Subclause (II) shall not apply to the representative payee of any individual with respect to whom the Commissioner determines such application would be inappropriate or unnecessary. In making such determination, the Commissioner shall take into consideration the nature of the individual's impairment (or combination of impairments). Section 1631(c) shall not apply to a finding by the Commissioner that the requirements of subclause (II) should not apply to an individual's representative payee.

(iii) If an individual is eligible for benefits under this title by reason of disability for the month preceding the month in which the individual attains the age of 18 years, the Commissioner shall redetermine such eligibility—

(I) by applying the criteria used in determining initial eligibility for individuals who are age 18 or older; and

(II) either during the 1–year period beginning on the individual's 18th birthday or, in lieu of a continuing disability review, whenever the Commissioner determines that an individual's case is subject to a redetermination under this clause.

With respect to any redetermination under this clause, paragraph (4) shall not apply.

(iv)(I) Except as provided in subclause (VI), not later than 12 months after the birth of an individual, the Commissioner shall review in accordance with paragraph (4) the continuing eligibility for benefits under this title by reason of disability of such individual whose low birth weight is a contributing factor material to the Commissioner's determination that the individual is disabled.

(II) A review under subclause (I) shall be considered a substitute for a review otherwise required under any other provision of the subparagraph during that 12–month period.

(III) A representative payee of a recipient whose case is reviewed under this clause shall present, at the time of review, evidence demonstrating that the recipient is, and has been, receiving treatment, to the extent considered medically necessary and available, of the condition which was the basis for providing benefits under this title.

(IV) If the representative payee refuses to comply without good cause with the requirements of subclause (III), the Commissioner of Social Security shall, if the Commissioner determines it is in the best interest of the individual, promptly suspend payment of benefits to the representative payee, and provide for payment of benefits to an alternative representative payee of the individual or, if the interest of the individual under this title would be served thereby, to the individual.

(V) Subclause (III) shall not apply to the representative payee of any individual with respect to whom the Commissioner determines such application would be inappropriate or unnecessary. In making such determination, the Commissioner shall take into consideration the nature of the individual's impairment (or combination of impairments). Section 1631(c) shall not apply to a finding by the Commissioner that the requirements of subclause (III) should not apply to an individual's representative payee.

(VI) Subclause (I) shall not apply in the case of an individual described in that subclause who, at the time of the individual's initial disability determination, the Commissioner determines has an impairment that is not expected to improve within 12 months after the birth of that individual, and who the Commissioner schedules

for a continuing disability review at a date that is after the individual attains 1 year of age.

(I) In making any determination under this title with respect to the disability of an individual who has not attained the age of 18 years and to whom section 221(h) does not apply, the Commissioner of Social Security shall make reasonable efforts to ensure that a qualified pediatrician or other individual who specializes in a field of medicine appropriate to the disability of the individual (as determined by the Commissioner of Social Security) evaluates the case of such individual.

(J) Notwithstanding subparagraph (A), an individual shall not be considered to be disabled for purposes of this title if alcoholism or drug addiction would (but for this subparagraph) be a contributing factor material to the Commissioner's determination that the individual is disabled.

(4) A recipient of benefits based on disability under this title may be determined not to be entitled to such benefits on the basis of a finding that the physical or mental impairment on the basis of which such benefits are provided has ceased, does not exist, or is not disabling only if such finding is supported by—

(A) in the case of an individual who is age 18 or older—

(i) substantial evidence which demonstrates that—

(I) there has been any medical improvement in the individual's impairment or combination of impairments (other than medical improvement which is not related to the individual's ability to work), and

(II) the individual is now able to engage in substantial gainful activity; or

(ii) substantial evidence (except in the case of an individual eligible to receive benefits under section 1619) which—

(I) consists of new medical evidence and a new assessment of the individual's residual functional capacity, and demonstrates that—

(aa) although the individual has not improved medically, he or she is nonetheless a beneficiary of advances in medical or vocational therapy or technology (related to the individual's ability to work), and

(bb) the individual is now able to engage in substantial gainful activity, or

(II) demonstrates that—

(aa) although the individual has not improved medically, he or she has undergone vocational therapy (related to the individual's ability to work), and

(bb) the individual is now able to engage in substantial gainful activity; or

(iii) substantial evidence which demonstrates that, as determined on the basis of new or improved diagnostic techniques or evaluations, the individual's impairment or combination of impairments is not as dis-

abling as it was considered to be at the time of the most recent prior decision that he or she was under a disability or continued to be under a disability, and that therefore the individual is able to engage in substantial gainful activity; or

(B) In the case of an individual who is under the age of 18—

(i) substantial evidence which demonstrates that there has been medical improvement in the individual's impairment or combination of impairments, and that such impairment or combination of impairments no longer results in marked and severe functional limitations; or

(ii) substantial evidence which demonstrates that, as determined on the basis of new or improved diagnostic techniques or evaluations, the individual's impairment or combination of impairments, is not as disabling as it was considered to be at the time of the most recent prior decision that the individual was under a disability or continued to be under a disability, and such impairment or combination of impairments does not result in marked and severe functional limitations; or

(C) in the case of any individual, substantial evidence (which may be evidence on the record at the time any prior determination of the entitlement to benefits based on disability was made, or newly obtained evidence which relates to that determination) which demonstrates that a prior determination was in error.

Nothing in this paragraph shall be construed to require a determination that an individual receiving benefits based on disability under this title is entitled to such benefits if the prior determination was fraudulently obtained or if the individual is engaged in substantial gainful activity, cannot be located, or fails, without good cause, to cooperate in a review of his or her entitlement or to follow prescribed treatment which would be expected (i) to restore his or her ability to engage in substantial gainful activity, or (ii) in the case of an individual under the age of 18, to eliminate or improve the individal's impairment or combination of impairments so that it no longer results in marked and severe functional limitations. Any determination under this paragraph shall be made on the basis of all the evidence available in the individual's case file, including new evidence concerning the individual's prior or current condition which is presented by the individual or secured by the Commissioner of Social Security. Any determination made under this paragraph shall be made on the basis of the weight of the evidence and on a neutral basis with regard to the individual's condition, without any initial inference as to the presence or absence of disability being drawn from the fact that the individual has previously been determined to be disabled.

Eligible Spouse

(b) For purposes of this title, the term "eligible spouse" means an aged, blind, or disabled individual who is the husband or wife of another aged, blind, or disabled individual, and who, in a month,

is living with such aged, blind, or disabled individual on the first day of the month or, in any case in which either spouse files an application for benefits, on the first day of the month following the date the application is filed, or, in any case in which either spouse requests restoration of eligibility under this title during the month, at the time the request is filed. If two aged, blind, or disabled individuals are husband and wife as described in the preceding sentence, only one of them may be an "eligible individual" within the meaning of section 1611(a).

Definition of Child

(c) For purposes of this title, the term "child" means an individual who is neither married nor (as determined by the Commissioner of Social Security) the head of a household, and who is (1) under the age of eighteen, or (2) under the age of twenty-two and (as determined by the Commissioner of Social Security) a student regularly attending a school, college, or university, or a course of vocational or technical training designed to prepare him for gainful employment.

Determination of Marital Relationships

(d) In determining whether two individuals are husband and wife for purposes of this title, appropriate State law shall be applied; except that—

(1) if a man and woman have been determined to be husband and wife under section 216(h)(1) for purposes of title II they shall be considered (from and after the date of such determination or the date of their application for benefits under this title, whichever is later) to be husband and wife for purposes of this title, or

(2) if a man and woman are found to be holding themselves out to the community in which they reside as husband and wife, they shall be so considered for purposes of this title notwithstanding any other provision of this section.

United States

(e) For purposes of this title, the term "United States", when used in a geographical sense, means the 50 States and the District of Columbia.

Income and Resources of Individuals Other Than Eligible Individuals and Eligible Spouses

(f)(1) For purposes of determining eligibility for and the amount of benefits for any individual who is married and whose spouse is living with him in the same household but is not an eligible spouse, such individual's income and resources shall be deemed to include any income and resources of such spouse, whether or not available to such individual, except to the extent determined by the Commissioner of Social Security to be inequitable under the circumstances.

(2)(A) For purposes of determining eligibility for and the amount of benefits for any individual who is a child under age 18, such individual's income and resources shall be deemed to include any income and resources of a parent of such individual (or the spouse of such a parent) who is living in the same

household as such individual, whether or not available to such individual, except to the extent determined by the Commissioner of Social Security to be inequitable under the circumstances.

(B) Subparagraph (A) shall not apply in the case of any child who has not attained the age of 18 years who—

(i) is disabled;

(ii) received benefits under this title, pursuant to section 1611(e)(1)(B), while in an institution described in section 1611(e)(1)(B);

(iii) is eligible for medical assistance under a State home care plan approved by the Secretary under the provisions of section 1915(c) relating to waivers, or authorized under section 1902(e)(3); and

(iv) but for this subparagraph, would not be eligible for benefits under this title.

(3) For purposes of determining eligibility for and the amount of benefits for any individual who is an alien, such individual's income and resources shall be deemed to include the income and resources of his sponsor and such sponsor's spouse (if such alien has a sponsor) as provided in section 1621. Any such income deemed to be income of such individual shall be treated as unearned income of such individual.

(4) For purposes of paragraphs (1) and (2), a spouse or parent (or spouse of such a parent) who is absent from the household in which the individual lives due solely to a duty assignment as a member of the Armed Forces on active duty shall, in the absence of evidence to the contrary, be deemed to be living in the same household as the individual.

REHABILITATION SERVICES FOR BLIND AND DISABLED INDIVIDUALS

SEC. 1615. [42 U.S.C. 1382d] (a) In the case of any blind or disabled individual who—

(1) has not attained age 16; and

(2) with respect to whom benefits are paid under this title, the Commissioner of Social Security shall make provision for referral of such individual to the appropriate State agency administering the State program under title V.

(b) [Repealed.[53]]

(c) [Repealed.[54]]

(d) The Commissioner of Social Security is authorized to reimburse the State agency administering or supervising the administration of a State plan for vocational rehabilitation services approved under title I of the Rehabilitation Act of 1973 for the costs incurred under such plan in the provision of rehabilitation services to individuals who are referred for such services pursuant to subsection (a) (1), in cases where the furnishing of such services results in the performance by such individuals of substantial gainful activity for a continuous period of nine months, (2) in cases where such individuals receive benefits as a result of section 1631(a)(6) (except that no reimbursement under this subsection shall be made for services furnished to any individual receiving such benefits for any period after the close of such individual's ninth consecutive

[53] P.L. 97–35, §2193(c)(8)(B); 95 Stat. 828.
[54] P.L. 106-170, §101(b)(2)(B); 113 Stat. 1874.

month of substantial gainful activity or the close of the month with which his or her entitlement to such benefits ceases, whichever first occurs), and (3) in cases where such individuals, without good cause, refuse to continue to accept vocational rehabilitation services or fail to cooperate in such a manner as to preclude their successful rehabilitation. The determination that the vocational rehabilitation services contributed to the successful return of an individual to substantial gainful activity, the determination that an individual, without good cause, refused to continue to accept vocational rehabilitation services or failed to cooperate in such a manner as to preclude successful rehabilitation, and the determination of the amount of costs to be reimbursed under this subsection shall be made by the Commissioner of Social Security in accordance with criteria determined by the Commissioner in the same manner as under section 222(d)(1).

(e) The Commissioner of Social Security may reimburse the State agency described in subsection (d) for the costs described therein incurred in the provision of rehabilitation services—

(1) for any month for which an individual received—

(A) benefits under section 1611 or 1619(a);

(B) assistance under section 1619(b); or

(C) a federally administered State supplementary payment under section 1616 of this Act or section 212(b) of Public Law 93–66[55] ; and

(2) for any month before the 13th consecutive month for which an individual, for a reason other than cessation of disability or blindness, was ineligible for—

(A) benefits under section 1611 or 1619(a);

(B) assistance under section 1619(b); or

(C) a federally administered State supplementary payment under section 1616 of this Act or section 212(b) of Public Law 93–66.

OPTIONAL STATE SUPPLEMENTATION

SEC. 1616. [42 U.S.C. 1382e] (a) Any cash payments which are made by a State (or political subdivision thereof) on a regular basis to individuals who are receiving benefits under this title or who would but for their income be eligible to receive benefits under this title, as assistance based on need in supplementation of such benefits (as determined by the Commissioner of Social Security), shall be excluded under section 1612(b)(6) in determining the income of such individuals for purposes of this title and the Commissioner of Social Security and such State may enter into an agreement which satisfies subsection (b) under which the Commissioner of Social Security will, on behalf of such State (or subdivision) make such supplementary payments to all such individuals.

(b) Any agreement between the Commissioner of Social Security and a State entered into under subsection (a) shall provide—

(1) that such payments will be made (subject to subsection (c)) to all individuals residing in such State (or subdivision) who are receiving benefits under this title, and

(2) such other rules with respect to eligibility for or amount of the supplementary payments, and such procedural or other general administrative provisions, as the Commissioner of So-

[55] See Vol. II, P.L. 93–66.

cial Security finds necessary (subject to subsection (c)) to achieve efficient and effective administration of both the program which the Commissioner conducts under this title and the optional State supplementation.

At the option of the State (but subject to paragraph (2) of this subsection), the agreement between the Commissioner of Social Security and such State entered into under subsection (a) shall be modified to provide that the Commissioner of Social Security will make supplementary payments, on and after an effective date to be specified in the agreement as so modified, to individuals receiving benefits determined under section 1611(e)(1)(B).

(c)(1) Any State (or political subdivision) making supplementary payments described in subsection (a) may at its option impose as a condition of eligibility for such payments, and include in the State's agreement with the Commissioner of Social Security under such subsection, a residence requirement which excludes individuals who have resided in the State (or political subdivision) for less than a minimum period prior to application for such payments.

(2) Any State (or political subdivision), in determining the eligibility of any individual for supplementary payments described in subsection (a), may disregard amounts of earned and unearned income in addition to other amounts which it is required or permitted to disregard under this section in determining such eligibility, and shall include a provision specifying the amount of any such income that will be disregarded, if any.

(3) Any State (or political subdivision) making supplementary payments described in subsection (a) shall have the option of making such payments to individuals who receive benefits under this title under the provisions of section 1619, or who would be eligible to receive such benefits but for their income.[56]

(d)(1) Any State which has entered into an agreement with the Commissioner of Social Security under this section which provides that the Commissioner of Social Security will, on behalf of the State (or political subdivision), make the supplementary payments to individuals who are receiving benefits under this title (or who would but for their income be eligible to receive such benefits), shall, in accordance with paragraph (5)[57], pay to the Commissioner of Social Security an amount equal to the expenditures made by the Commissioner of Social Security as such supplementary payments, plus an administration fee assessed in accordance with paragraph (2) and any additional services fee charged in accordance with paragraph (3).

(2)(A) The Commissioner of Social Security shall assess each State an administration fee in an amount equal to—

(i) the number of supplementary payments made by the Commissioner of Social Security on behalf of the State under this section for any month in a fiscal year; multiplied by

(ii) the applicable rate for the fiscal year.

(B) As used in subparagraph (A), the term "applicable rate" means—

(i) for fiscal year 1994, $1.67;

[56] See Vol. II, P.L. 96–265, §201(e), with respect to the maintenance of separate accounts.
[57] See Vol. II, P.L. 92–603, §401(d), with respect to phaseout of the hold harmless provision.

(ii) for fiscal year 1995, $3.33;
(iii) for fiscal year 1996, $5.00;
(iv) for fiscal year 1997, $5.00;
(v) for fiscal year 1998, $6.20;
(vi) for fiscal year 1999, $7.60;
(vii) for fiscal year 2000, $7.80;
(viii) for fiscal year 2001, $8.10;
(ix) for fiscal year 2002, $8.50; and
(x) for fiscal year 2003 and each succeeding fiscal year—

(I) the applicable rate in the preceding fiscal year, increased by the percentage, if any, by which the Consumer Price Index for the month of June of the calendar year of the increase exceeds the Consumer Price Index for the month of June of the calendar year preceding the calendar year of the increase, and rounded to the nearest whole cent; or

(II) such different rate as the Commissioner determines is appropriate for the State.

(C) Upon making a determination under subparagraph (B)(x)(II), the Commissioner of Social Security shall promulgate the determination in regulations, which may take into account the complexity of administering the State's supplementary payment program.

(D) All fees assessed pursuant to this paragraph shall be transferred to the Commissioner of Social Security at the same time that amounts for such supplementary payments are required to be so tranferred.

(3)(A) The Commissioner of Social Security may charge a State an additional services fee if, at the request of the State, the Commissioner of Social Security provides additional services beyond the level customarily provided, in the administration of State supplementary payments pursuant to this section.

(B) The additional services fee shall be in an amount that the Commissioner of Social Security determines is necessary to cover all costs (including indirect costs) incurred by the Federal Government in furnishing the additional services referred to in subparagraph (A).

(4)(A) The first $5 of each administration fee assessed pursuant to paragraph (2), upon collection, shall be deposited in the general fund of the Treasury of the United States as miscellaneous receipts.

(B) That portion of each administration fee in excess of $5, and 100 percent of each additional services fee charged pursuant to paragraph (3), upon collection for fiscal year 1998 and each subsequent fiscal year, shall be credited to a special fund established in the Treasury of the United States for State supplementary payment fees. The amounts so credited, to the extent and in the amounts provided in advance in appropriations Acts, shall be available to defray expenses incurred in carrying out this title and related laws.[58]

[58] See Vol. II, P.L. 105–33, §5102(b)(2), with respect to limitations on authorization of appropriations.

(5)(A)(i) Any State which has entered into an agreement with the Commissioner of Social Security under this section shall remit the payments and fees required under this subsection with respect to monthly benefits paid to individuals under this title no later than—

(I) the business day preceding the date that the Commissioner pays such monthly benefits; or

(II) with respect to such monthly benefits paid for the month that is the last month of the State's fiscal year, the fifth business day following such date.

(ii) The Commissioner may charge States a penalty in an amount equal to 5 percent of the payment and the fees due if the remittance is received after the date required by clause (i).

(B) The Cash Management Improvement Act of 1990 shall not apply to any payments or fees required under this subsection that are paid by a State before the date required by subparagraph (A)(i).

(C) Notwithstanding subparagraph (A)(i), the Commissioner may make supplementary payments on behalf of a State with funds appropriated for payment of benefits under this title, and subsequently to be reimbursed for such payments by the State at such times as the Commissioner and State may agree. Such authority may be exercised only if extraordinary circumstances affecting a State's ability to make payment when required by subparagraph (A)(i) are determined by the Commissioner to exist.

(e)(1) Each State shall establish or designate one or more State or local authorities which shall establish, maintain, and insure the enforcement of standards for any category of institutions, foster homes, or group living arrangements in which (as determined by the State) a significant number of recipients of supplemental security income benefits is residing or is likely to reside. Such standards shall be appropriate to the needs of such recipients and the character of the facilities involved, and shall govern such matters as admission policies, safety, sanitation, and protection of civil rights.

(2) Each State shall annually make available for public review a summary of the standards established pursuant to paragraph (1), and shall make available to any interested individual a copy of such standards, along with the procedures available in the State to insure the enforcement of such standards and a list of any waivers of such standards and any violations of such standards which have come to the attention of the authority responsible for their enforcement.

(3) Each State shall certify annually to the Commissioner of Social Security that it is in compliance with the requirements of this subsection.

(4) Payments made under this title with respect to an individual shall be reduced by an amount equal to the amount of any supplementary payment (as described in subsection (a)) or

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See Vol. II, P.L. 105–78, §516(b)(2), with respect to limitations on authorization of appropriations.

other payment made by a State (or political subdivision thereof) which is made for or on account of any medical or any other type of remedial care provided by an institution of the type described in paragraph (1) to such individual as a resident or an inpatient of such institution if such institution is not approved as meeting the standards described in such paragraph by the appropriate State or local authorities.

COST–OF–LIVING ADJUSTMENTS IN BENEFITS [59]

SEC. 1617. [42 U.S.C. 1382f] (a) Whenever benefit amounts under title II are increased by any percentage effective with any month as a result of a determination made under section 215(i)—

(1) each of the dollar amounts in effect for such month under subsections (a)(1)(A), (a)(2)(A), (b)(1), and (b)(2) of section 1611, and subsection (a)(1)(A) of section 211 of Public Law 93–66 [60], as specified in such subsections or as previously increased under this section, shall be increased by the amount (if any) by which—

(A) the amount which would have been in effect for such month under such subsection but for the rounding of such amount pursuant to paragraph (2), exceeds

(B) the amount in effect for such month under such subsection; and

(2) the amount obtained under paragraph (1) with respect to each subsection shall be further increased by the same percentage by which benefit amounts under title II are increased for such month, or, if greater (in any case where the increase under title II was determined on the basis of the wage increase percentage rather than the CPI increase percentage), the percentage by which benefit amounts under title II would be increased for such month if the increase had been determined on the basis of the CPI increase percentage, (and rounded, when not a multiple of $12, to the next lower multiple of $12), effective with respect to benefits for months after such month.

(b) The new dollar amounts to be in effect under section 1611 of this title and under section 211 of Public Law 93–66 by reason of subsection (a) of this section shall be published in the Federal Register together with, and at the same time as, the material required by section 215(i)(2)(D) to be published therein by reason of the determination involved.

(c) Effective July 1, 1983—

(1) each of the dollar amounts in effect under subsections (a)(1)(A) and (b)(1) of section 1611, as previously increased under this section, shall be increased by $240 (and the dollar amount in effect under subsection (a)(1)(A) of section 211 of Public Law 93–66, as previously so increased, shall be increased by $120); and

(2) each of the dollar amounts in effect under subsections (a)(2)(A) and (b)(2) of section 1611, as previously increased under this section, shall be increased by $360.

[59] See Vol. II, Appendixes A and B, for Cost-of-Living Increase information.
[60] See Vol. II, P.L. 93–66.

OPERATION OF STATE SUPPLEMENTATION PROGRAMS

SEC. 1618. [42 U.S.C. 1382g] (a) In order for any State which makes supplementary payments of the type described in section 1616(a) (including payments pursuant to an agreement entered into under section 212(a) of Public Law 93–66)[61], on or after June 30, 1977, to be eligible for payments pursuant to title XIX with respect to expenditures for any calendar quarter which begins—

(1) after June 30, 1977, or, if later,

(2) after the calendar quarter in which it first makes such supplementary payments,

such State must have in effect an agreement with the Commissioner of Social Security whereby the State will—

(3) continue to make such supplementary payments, and

(4) maintain such supplementary payments at levels which are not lower than the levels of such payments in effect in December 1976, or, if no such payments were made in that month, the levels for the first subsequent month in which such payments were made.

(b)(1) The Commissioner of Social Security shall not find that a State has failed to meet the requirements imposed by paragraph (4) of subsection (a) with respect to the levels of its supplementary payments for a particular month or months if the State's expenditures for such payments in the twelve-month period (within which such month or months fall) beginning on the effective date of any increase in the level of supplemental security income benefits pursuant to section 1617 are not less than its expenditures for such payments in the preceding twelve-month period.

(2) For purposes of determining under paragraph (1) whether a State's expenditures for supplementary payments in the 12-month period beginning on the effective date of any increase in the level of supplemental security income benefits are not less than the State's expenditures for such payments in the preceding 12-month period, the Commissioner of Social Security, in computing the State's expenditures, shall disregard, pursuant to a 1-time election of the State, all expenditures by the State for retroactive supplementary payments that are required to be made in connection with the retroactive supplemental security income benefits referred to in section 5041 of the Omnibus Budget Reconcilation Act of 1990.

(c) Any State which satisfies the requirements of this section solely by reason of subsection (b) for a particular month or months in any 12-month period (described in such subsection) ending on or after June 30, 1982, may elect, with respect to any month in any subsequent 12-month period (so described), to apply subsection (a)(4) as though the reference to December 1976 in such subsection were a reference to the month of December which occurred in the 12-month period immediately preceding such subsequent period.

(d) The Commissioner of Social Security shall not find that a State has failed to meet the requirements imposed by paragraph (4) of subsection (a) with respect to the levels of its supplementary payments for any portion of the period July 1, 1980, through June 30, 1981, if the State's expenditures for such payments in that twelve-month period were not less than its expenditures for such payments for the period July 1, 1976, through June 30, 1977 (or,

[61] See Vol. II, P.L. 93–66.

if the State made no supplementary payments in the period July 1, 1976, through June 30, 1977, the expenditures for the first twelve-month period extending from July 1 through June 30 in which the State made such payments).

(e)(1) For any particular month after March 1983, a State which is not treated as meeting the requirements imposed by paragraph (4) of subsection (a) by reason of subsection (b) shall be treated as meeting such requirements if and only if—

(A) the combined level of its supplementary payments (to recipients of the type involved) and the amounts payable (to or on behalf of such recipients) under section 1611(b) of this Act and section 211(a)(1)(A) of Public Law 93–66, for that particular month,

is not less than—

(B) the combined level of its supplementary payments (to recipients of the type involved) and the amounts payable (to or on behalf of such recipients) under section 1611(b) of this Act and section 211(a)(1)(A) of Public Law 93–66, for March 1983, increased by the amount of all cost-of-living adjustments under section 1617 (and any other benefit increases under this title) which have occurred after March 1983 and before that particular month.

(2) In determining the amount of any increase in the combined level involved under paragraph (1)(B) of this subsection, any portion of such amount which would otherwise be attributable to the increase under section 1617(c) shall be deemed instead to be equal to the amount of the cost-of-living adjustment which would have occurred in July 1983 (without regard to the 3-percent limitation contained in section 215(i)(1)(B)) if section 111 of the Social Security Amendments of 1983[62] had not been enacted.

(f) The Commissioner of Social Security shall not find that a State has failed to meet the requirements imposed by subsection (a) with respect to the levels of its supplementary payments for the period January 1, 1984, through December 31, 1985, if in the period January 1, 1986, through December 31, 1986, its supplementary payment levels (other than to recipients of benefits determined under section 1611(e)(1)(B)) are not less than those in effect in December 1976, increased by a percentage equal to the percentage by which payments under section 1611(b) of this Act and section 211(a)(1)(A) of Public Law 93–66 have been increased as a result of all adjustments under section 1617(a) and (c) which have occurred after December 1976 and before February 1986.

(g) In order for any State which makes supplementary payments of the type described in section 1616(a) (including payments pursuant to an agreement entered into under section 212(a) of Public Law 93–66) to recipients of benefits determined under section 1611(e)(1)(B), on or after October 1, 1987, to be eligible for payments pursuant to title XIX with respect to any calendar quarter which begins—

(1) after October 1, 1987, or, if later

(2) after the calendar quarter in which it first makes such supplementary payments to recipients of benefits so determined,

[62] P.L. 98–21.

such State must have in effect an agreement with the Commissioner of Social Security whereby the State will—

(3) continue to make such supplementary payments to recipients of benefits so determined, and

(4) maintain such supplementary payments to recipients of benefits so determined at levels which assure (with respect to any particular month beginning with the month in which this subsection is first effective) that—

(A) the combined level of such supplementary payments and the amounts payable to or on behalf of such recipients under section 1611(e)(1)(B) for that particular month,

is not less than—

(B) the combined level of such supplementary payments and the amounts payable to or on behalf of such recipients under section 1611(e)(1)(B) for October 1987 (or, if no such supplementary payments were made for that month, the combined level for the first subsequent month for which such payments were made), increased—

(i) in a case to which clause (i) of such section 1611(e)(1)(B) applies or (with respect to the individual or spouse who is in the hospital, home, or facility involved) to which clause (ii) of such section applies, by $5, and

(ii) in a case to which clause (iii) of such section 1611(e)(1)(B) applies, by $10.

BENEFITS FOR INDIVIDUALS WHO PERFORM SUBSTANTIAL GAINFUL ACTIVITY DESPITE SEVERE MEDICAL IMPAIRMENT[63]

SEC. 1619. [42 U.S.C. 1382h] (a)(1) Except as provided in section 1631(j), any individual who was determined to be an eligible individual (or eligible spouse) by reason of being under a disability and was eligible to receive benefits under section 1611 (or a federally administered State supplementary payment) for a month and whose earnings in a subsequent month exceed the amount designated by the Commissioner of Social Security ordinarily to represent substantial gainful activity shall qualify for a monthly benefit under this subsection for such subsequent month (which shall be in lieu of any benefit under section 1611) equal to an amount determined under section 1611(b)(1) (or, in the case of an individual who has an eligible spouse, under section 1611(b)(2)), and for purposes of title XIX shall be considered to be receiving supplemental security income benefits under this title, for so long as—

(A) such individual continues to have the disabling physical or mental impairment on the basis of which such individual was found to be under a disability; and

(B) the income of such individual, other than income excluded pursuant to section 1612(b), is not equal to or in excess of the amount which would cause him to be ineligible for payments under section 1611 and such individual meets all other non-disability-related requirements for eligibility for benefits under this title.

(2) The Commissioner of Social Security shall make a determination under paragraph (1)(A) with respect to an individual

[63] See Vol. II, P.L. 96–265, §201(e), with respect to the maintenance of separate accounts.

not later than 12 months after the first month for which the individual qualifies for a benefit under this subsection.

(b)(1) Except as provided in section 1631(j), for purposes of title XIX, any individual who was determined to be a blind or disabled individual eligible to receive a benefit under section 1611 or any federally administered State supplementary payment for a month and who in a subsequent month is ineligible for benefits under this title (and for any federally administered State supplementary payments) because of his or her income shall, nevertheless, be considered to be receiving supplemental security income benefits for such subsequent month provided that the Commissioner of Social Security determines under regulations that—

(A) such individual continues to be blind or continues to have the disabling physical or mental impairment on the basis of which he was found to be under a disability and, except for his earnings, meets all non-disability-related requirements for eligibility for benefits under this title;

(B) the income of such individual would not, except for his earnings and increases pursuant to section 215(i) in the level of monthly insurance benefits to which the individual is entitled under title II that occur while such individual is considered to be receiving supplemental security income benefits by reason of this subsection, be equal to or in excess of the amount which would cause him to be ineligible for payments under section 1611(b) (if he were otherwise eligible for such payments);

(C) the termination of eligibility for benefits under title XIX would seriously inhibit his ability to continue his employment; and

(D) such individual's earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the benefits under this title (including any federally administered State supplementary payments), benefits under title XIX, and publicly funded attendant care services (including personal care assistance), which would be available to him in the absence of such earnings.

(2)(A) Determinations made under paragraph (1)(D) shall be based on information and data updated no less frequently than annually.

(B) In determining an individual's earnings for purposes of paragraph (1)(D), there shall be excluded from such earnings an amount equal to the sum of any amounts which are or would be excluded under clauses (ii) and (iv) of section 1612(b)(4)(B) (or under clauses (ii) and (iii) of section 1612(b)(4)(A)) in determining his or her income.

(3) In the case of a State that exercises the option under section 1902(f), any individual who—

(A)(i) qualifies for a benefit under subsection (a), or

(ii) meets the requirements of paragraph (1); and

(B) was eligible for medical assistance under the State plan approved under title XIX in the month immediately preceding the first month in which the individual qualified for a benefit under such subsection or met such requirements,

shall remain eligible for medical assistance under such plan for so long as the individual qualifies for a benefit under such subsection or meets such requirements.

(c) Subsection (a)(2) and section 1631(j)(2)(A) shall not be construed, singly or jointly, to require more than 1 determination during any 12-month period with respect to the continuing disability or blindness of an individual.

(d) The Commissioner of Social Security and the Secretary of Education shall jointly develop and disseminate information, and establish training programs for staff personnel, with respect to the potential availability of benefits and services for disabled individuals under the provisions of this section. The Commissioner of Social Security shall provide such information to individuals who are applicants for and recipients of benefits based on disability under this title and shall conduct such programs for the staffs of the district offices of the Social Security Administration. The Secretary of Education shall conduct such programs for the staffs of the State Vocational Rehabilitation agencies, and in cooperation with such agencies shall also provide such information to other appropriate individuals and to public and private organizations and agencies which are concerned with rehabilitation and social services or which represent the disabled.

MEDICAL AND SOCIAL SERVICES FOR CERTAIN HANDICAPPED PERSONS

SEC. 1620. [42 U.S.C. 1382i] (a) There are authorized to be appropriated such sums as may be necessary to establish and carry out a 3-year Federal-State pilot program to provide medical and social services for certain handicapped individuals in accordance with this section.

(b)(1) The total sum of $18,000,000 shall be allotted to the States for such program by the Commissioner of Social Security, during the period beginning September 1, 1981, and ending September 30, 1984, as follows:

(A) The total sum of $6,000,000 shall be allotted to the States for the fiscal year ending September 30, 1982 (which for purposes of this section shall include the month of September 1981).

(B) The total sum of $6,000,000, plus any amount remaining available (after the application of paragraph (4)) from the allotment made under subparagraph (A), shall be allotted to the States for the fiscal year ending September 30, 1983.

(C) The total sum of $6,000,000, plus any amount remaining available (after the application of paragraph (4)) from the allotments made under subparagraphs (A) and (B), shall be allotted to the States for the fiscal year ending September 30, 1984.

(2) The allotment to each State from the total sum allotted under paragraph (1) for any fiscal year shall bear the same ratio to such total sum as the number of individuals in such State who are over age 17 and under age 65 and are receiving supplemental security income benefits as disabled individuals in such year (as determined by the Commissioner of Social Security on the basis of the most recent data available) bears to the total number of such individuals in all the States. For pur-

poses of the preceding sentence, the term "supplemental security income benefits" includes payments made pursuant to an agreement under section 1616(a) of this Act or under section 212(b) of Public Law 93–66[64].

(3) At the beginning of each fiscal year in which the pilot program under this section is in effect, each State that does not intend to use the allotment to which it is entitled for such year (or any allotment which was made to it for a prior fiscal year), or that does not intend to use the full amount of any such allotment, shall certify to the Commissioner of Social Security the amount of such allotment which it does not intend to use, and the State's allotment for the fiscal year (or years) involved shall thereupon be reduced by the amount so certified.

(4) The portion of the total amount available for allotment for any particular fiscal year under paragraph (1) which is not allotted to States for that year by reason of paragraph (3) (plus the amount of any reductions made at the beginning of such year in the allotments of States for prior fiscal years under paragraph (3)) shall be reallocated in such manner as the Commissioner of Social Security may determine to be appropriate to States which need, and will use, additional assistance in providing services to severely handicapped individuals in that particular year under their approved plans. Any amount reallocated to a State under this paragraph for use in a particular fiscal year shall be treated for purposes of this section as increasing such State's allotment for that year by an equivalent amount.

(c) In order to participate in the pilot program and be eligible to receive payments for any period under subsection (d), a State (during such period) must have a plan, approved by the Commissioner of Social Security as meeting the requirements of this section, which provides medical and social services for severely handicapped individuals whose earnings are above the level which ordinarily demonstrates an ability to engage in substantial gainful activity and who are not receiving benefits under section 1611 or 1619 or assistance under a State plan approved under section 1902, and which—

(1) declares the intent of the State to participate in the pilot program;

(2) designates an appropriate State agency to administer or supervise the administration of the program in the State;

(3) describes the criteria to be applied by the State in determining the eligibility of any individual for assistance under the plan and in any event requires a determination by the State agency to the effect that (A) such individual's ability to continue his employment would be significantly inhibited without such assistance and (B) such individual's earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the cash and other benefits that would be available to him under this title and titles XIX and XX in the absence of those earnings;

(4) describes the process by which the eligibility of individuals for such assistance is to be determined (and such process may not involve the performance of functions by any State

[64] See Vol. II, P.L. 93–66.

agency or entity which is engaged in making determinations of disability for purposes of disability insurance or supplemental security income benefits except when the use of a different agency or entity to perform those functions would not be feasible);

(5) describes the medical and social services to be provided under the plan;

(6) describes the manner in which the medical and social services involved are to be provided and, if they are not to be provided through the State's medical assistance and social services programs under titles XIX and XX (with the Federal payments being made under subsection (d) of this section rather than under those titles), specifies the particular mechanisms and procedures to be used in providing such services; and

(7) contains such other provisions as the Commissioner of Social Security may find to be necessary or appropriate to meet the requirements of this section or otherwise carry out its purpose.

(d)(1) From its allotment under subsection (b) for any fiscal year (and any amounts remaining available from allotments made to it for prior fiscal years), the Commissioner of Social Security shall from time to time pay to each State which has a plan approved under subsection (c) an amount equal to 75 per centum of the total sum expended under such plan (including the cost of administration of such plan) in providing medical and social services to severely handicapped individuals who are eligible for such services under the plan.

(2) The method of computing and making payments under this section shall be as follows:

(A) The Commissioner of Social Security shall, prior to each period for which a payment is to be made to a State, estimate the amount to be paid to the State for such period under the provisions of this section.

(B) From the allotment available therefor, the Commissioner of Social Security shall pay the amount so estimated, reduced or increased, as the case may be, by any sum (not previously adjusted under this subsection) by which the Commissioner finds that the Commissioner's estimate of the amount to be paid the State for any prior period under this section was greater or less than the amount which should have been paid to the State for such period under this section.

(e) Within nine months after the date of the enactment of this section[65], the Commissioner of Social Security shall prescribe and publish such regulations as may be necessary or appropriate to carry out the pilot program and otherwise implement this section.

(f) Each State participating in the pilot program under his section shall from time to time report to the Commissioner of Social Security on the operation and results of such program in that State, with particular emphasis upon the work incentive effects of the program. On or before October 1, 1983, the Commissioner of Social Security shall submit to the Congress a report on the program, incorporating the information contained in the State reports along with the Commissioner's findings and recommendations.

[65] This section was enacted June 9, 1980 (P.L. 96–265; 94 Stat. 446, 448).

ATTRIBUTION OF SPONSOR'S INCOME AND RESOURCES TO ALIENS

SEC. 1621. [42 U.S.C. 1382j] (a) For purposes of determining eligibility for and the amount of benefits under this title for an individual who is an alien, the income and resources of any person who (as a sponsor of such individual's entry into the United States) executed an affidavit of support or similar agreement with respect to such individual, and the income and resources of the sponsor's spouse, shall be deemed to be the income and resources of such individual (in accordance with subsections (b) and (c)) for a period of 3 years after the individual's entry into the United States. Any such income deemed to be income of such individual shall be treated as unearned income of such individual.

(b)(1) The amount of income of a sponsor (and his spouse) which shall be deemed to be the unearned income of an alien for any year shall be determined as follows:

(A) The total yearly rate of earned and unearned income (as determined under section 1612(a)) of such sponsor and such sponsor's spouse (if such spouse is living with the sponsor) shall be determined for such year.

(B) The amount determined under subparagraph (A) shall be reduced by an amount equal to (i) the maximum amount of the Federal benefit under this title for such year which would be payable to an eligible individual who has no other income and who does not have an eligible spouse (as determined under section 1611(b)(1)), plus (ii) one-half of the amount determined under clause (i) multiplied by the number of individuals who are dependents of such sponsor (or such sponsor's spouse if such spouse is living with the sponsor), other than such alien and such alien's spouse.

(C) The amount of income which shall be deemed to be unearned income of such alien shall be at a yearly rate equal to the amount determined under subparagraph (B). The period for determination of such amount shall be the same as the period for determination of benefits under section 1611(c).

(2) The amount of resources of a sponsor (and his spouse) which shall be deemed to be the resources of an alien for any year shall be determined as follows:

(A) The total amount of the resources (as determined under section 1613) of such sponsor and such sponsor's spouse (if such spouse is living with the sponsor) shall be determined.

(B) The amount determined under subparagraph (A) shall be reduced by an amount equal to (i) the applicable amount determined under section 1611(a)(3)(B) in the case of a sponsor who has no spouse with whom he is living, or (ii) the applicable amount determined under section 1611(a)(3)(A) in the case of a sponsor who has a spouse with whom he is living.

(C) The resources of such sponsor (and spouse) as determined under subparagraphs (A) and (B) shall be deemed to be resources of such alien in addition to any resources of such alien.

(c) In determining the amount of income of an alien during the period of 3 years after such alien's entry into the United States, the

reduction in dollar amounts otherwise required under section 1612(a)(2)(A)(i) shall not be applicable if such alien is living in the household of a person who is a sponsor (or such sponsor's spouse) of such alien, and is receiving support and maintenance in kind from such sponsor (or spouse), nor shall support or maintenance furnished in cash or kind to an alien by such alien's sponsor (to the extent that it reflects income or resources which were taken into account in determining the amount of income and resources to be deemed to the alien under subsection (a) or (b)) be considered to be income of such alien under section 1612(a)(2)(A).

(d)(1) Any individual who is an alien shall, during the period of 3 years after entry into the United States, in order to be an eligible individual or eligible spouse for purposes of this title, be required to provide to the Commissioner of Social Security such information and documentation with respect to his sponsor as may be necessary in order for the Commissioner of Social Security to make any determination required under this section, and to obtain any cooperation from such sponsor necessary for any such determination. Such alien shall also be required to provide to the Commissioner of Social Security such information and documentation as the Commissioner of Social Security may request and which such alien or his sponsor provided in support of such alien's immigration application.

(2) The Commissioner of Social Security shall enter into agreements with the Secretary of State and the Attorney General whereby any information available to such persons and required in order to make any determination under this section will be provided by such persons to the Commissioner of Social Security, and whereby such persons shall inform any sponsor of an alien, at the time such sponsor executes an affidavit of support or similar agreement, of the requirements imposed by this section.

(e) Any sponsor of an alien, and such alien, shall be jointly and severally liable for an amount equal to any overpayment made to such alien during the period of 3 years after such alien's entry into the United States, on account of such sponsor's failure to provide correct information under the provisions of this section, except where such sponsor was without fault, or where good cause for such failure existed. Any such overpayment which is not repaid to the Commissioner of Social Security or recovered in accordance with section 1631(b) shall be withheld from any subsequent payment to which such alien or such sponsor is entitled under any provision of this Act.

(f)(1) The provisions of this section shall not apply with respect to any individual who is an "aged, blind, or disabled individual" for purposes of this title by reason of blindness (as determined under section 1614(a)(2)) or disability (as determined under section 1614(a)(3)), from and after the onset of the impairment, if such blindness or disability commenced after the date of such individual's admission into the United States for permanent residence.

(2) The provisions of this section shall not apply with respect to any alien who is—

(A) admitted to the United States as a result of the application, prior to April 1, 1980, of the provisions of section 203(a)(7) of the Immigration and Nationality Act[66];

(B) admitted to the United States as a result of the application, after March 31, 1980, of the provisions of section 207(c)(1) of such Act;

(C) paroled into the United States as a refugee under section 212(d)(5) of such Act; or

(D) granted political asylum by the Attorney General.

Part B—Procedural and General Provisions

PAYMENTS AND PROCEDURES[67]

Payment of Benefits[68]

SEC. 1631. [42 U.S.C. 1383] (a)(1) Benefits under this title shall be paid at such time or times and (subject to paragraph (10)) in such installments as will best effectuate the purposes of this title, as determined under regulations (and may in any case be paid less frequently than monthly where the amount of the monthly benefit would not exceed $10).

(2)(A)(i) Payments of the benefit of any individual may be made to any such individual or to the eligible spouse (if any) of such individual or partly to each.

(ii)(I) Upon a determination by the Commissioner of Social Security that the interest of such individual would be served thereby, such payments shall be made, regardless of the legal competency or incompetency of the individual or eligible spouse, to another individual, or an organization, with respect to whom the requirements of subparagraph (B) have been met (in this paragraph referred to as such individual's "representative payee") for the use and benefit of the individual or eligible spouse.

(II) In the case of an individual eligible for benefits under this title by reason of disability, the payment of such benefits shall be made to a representative payee if the Commissioner of Social Security determines that such payment would serve the interest of the individual because the individual also has an alcoholism or drug addiction condition (as determined by the Commissioner) and the individual is incapable of managing such benefits.

(iii) If the Commissioner of Social Security or a court of competent jurisdiction determines that the representative payee of an individual or eligible spouse has misused any benefits which have been paid to the representative payee pursuant to clause (ii) or section 205(j)(1) or 807, the Commissioner of Social Security

[66] See Vol. II, P.L. 82–414.

[67] See Vol. II, P.L. 90–321, §913(2), with respect to electronic fund transfers.

[68] See Vol. II, P.L. 101–508, §4008(i)(1), with respect to extension of rural hospital demonstration.

See Vol. II, P.L. 103–296, §201(a)(1)(E), with respect to a study regarding representative payees for all disability beneficiaries suffering from alcoholism or drug addiction.

shall promptly terminate payment of benefits to the representative payee pursuant to this subparagraph, and provide for payment of benefits to an alternative representative payee of the individual or eligible spouse or, if the interest of the individual under this title would be served thereby, to the individual or eligible spouse.

(iv)[69] For purposes of this paragraph, misuse of benefits by a representative payee occurs in any case in which the representative payee receives payment under this title for the use and benefit of another person and converts such payment, or any part thereof, to a use other than for the use and benefit of such other person. The Commissioner of Social Security may prescribe by regulation the meaning of the term "use and benefit" for purposes of this clause.

(B)(i) Any determination made under subparagraph (A) for payment of benefits to the representative payee of an individual or eligible spouse shall be made on the basis of—

(I) an investigation by the Commissioner of Social Security of the person to serve as representative payee, which shall be conducted in advance of such payment, and shall, to the extent practicable, include a face-to-face interview with such person; and

(II) adequate evidence that such payment is in the interest of the individual or eligible spouse (as determined by the Commissioner of Social Security in regulations).

(ii) As part of the investigation referred to in clause (i)(I), the Commissioner of Social Security shall—

(I) require the person being investigated to submit documented proof of the identity of such person, unless information establishing such identity was submitted with an application for benefits under title II, title VIII, or this title;

(II) verify the social security account number (or employer identification number) of such person;

(III) determine whether such person has been convicted of a violation of section 208, 811, or 1632; and

(IV) determine whether payment of benefits to such person has been terminated pursuant to subparagraph (A)(iii), whether the designation of such person as a representative payee has been revoked pursuant to section 807(a), and whether certification of payment of benefits to such person has been revoked pursuant to section 205(j), by reason of misuse of funds paid as benefits under title II, title VIII, or this title.

(iii) Benefits of an individual may not be paid to any other person pursuant to subparagraph (A)(ii) if—

[69] P.L. 108–203, §101(c)(3), added clause (iv), applicable to any case of benefit misuse by a representative payee with respect to which the Commissioner of Social Security makes the determination of misuse on or after January 1, 1995.

(I) such person has previously been convicted as described in clause (ii)(III);

(II) except as provided in clause (iv), payment of benefits to such person pursuant to subparagraph (A)(ii) has previously been terminated as described in clause (ii)(IV), the designation of such person as a representative payee has been revoked pursuant to section 807(a), or certification of payment of benefits to such person under section 205(j) has previously been revoked as described in section 205(j)(2)(B)(i)(IV); or

(III) except as provided in clause (v), such person is a creditor of such individual who provides such individual with goods or services for consideration.

(iv) The Commissioner of Social Security shall prescribe regulations under which the Commissioner of Social Security may grant an exemption from clause (iii)(II) to any person on a case-by-case basis if such exemption would be in the best interest of the individual or eligible spouse whose benefits under this title would be paid to such person pursuant to subparagraph (A)(ii).

(v) Clause (iii)(III) shall not apply with respect to any person who is a creditor referred to therein if such creditor is—

(I) a relative of such individual if such relative resides in the same household as such individual;

(II) a legal guardian or legal representative of such individual;

(III) a facility that is licensed or certified as a care facility under the law of a State or a political subdivision of a State;

(IV) a person who is an administrator, owner, or employee of a facility referred to in subclause (III) if such individual resides in such facility, and the payment of benefits under this title to such facility or such person is made only after good faith efforts have been made by the local servicing office of the Social Security Administration to locate an alternative representative payee to whom the payment of such benefits would serve the best interests of such individual; or

(V) an individual who is determined by the Commissioner of Social Security, on the basis of written findings and under procedures which the Commissioner of Social Security shall prescribe by regulation, to be acceptable to serve as a representative payee.

(vi) The procedures referred to in clause (v)(V) shall require the individual who will serve as representative payee to establish, to the satisfaction of the Commissioner of Social Security, that—

(I) such individual poses no risk to the beneficiary;

(II) the financial relationship of such individual to the beneficiary poses no substantial conflict of interest; and

(III) no other more suitable representative payee can be found.

(vii) In the case of an individual described in subparagraph (A)(ii)(II), when selecting such individual's representative payee, preference shall be given to—

(I) a community-based nonprofit social service agency licensed or bonded by the State;

(II) a Federal, State, or local government agency whose mission is to carry out income maintenance, social service, or health care-related activities;

(III) a State or local government agency with fiduciary responsibilities; or

(IV) a designee of an agency (other than of a Federal agency) referred to in the preceding subclauses of this clause, if the Commissioner of Social Security deems it appropriate,

unless the Commissioner of Social Security determines that selection of a family member would be appropriate.

(viii) Subject to clause (ix), if the Commissioner of Social Security makes a determination described in subparagraph (A)(ii) with respect to any individual's benefit and determines that direct payment of the benefit to the individual would cause substantial harm to the individual, the Commissioner of Social Security may defer (in the case of initial entitlement) or suspend (in the case of existing entitlement) direct payment of such benefit to the individual, until such time as the selection of a representative payee is made pursuant to this subparagraph.

(ix) (I) Except as provided in subclause (II), any deferral or suspension of direct payment of a benefit pursuant to clause (viii) shall be for a period of not more than 1 month.

(II) Subclause (I) shall not apply in any case in which the individual or eligible spouse is, as of the date of the Commissioner's determination, legally incompetent, under the age of 15 years, or described in subparagraph (A)(ii)(II).

(x) Payment pursuant to this subparagraph of any benefits which are deferred or suspended pending the selection of a representative payee shall be made to the individual, or to the representative payee upon such selection, as a single sum or over such period of time as the Commissioner of Social Security determines is in the best interests of the individual entitled to such benefits.

(xi) Any individual who is dissatisfied with a determination by the Commissioner of Social Security to pay such individual's benefits to a representative payee under this title, or with the designation of a particular person to serve as representative payee, shall be entitled to a hearing by the Commissioner of

Social Security, and to judicial review of the Commissioner's final decision, to the same extent as is provided in subsection (c).

(xii) In advance of the first payment of an individual's benefit to a representative payee under subparagraph (A)(ii), the Commissioner of Social Security shall provide written notice of the Commissioner's initial determination to make any such payment. Such notice shall be provided to such individual, except that, if such individual—

(I) is under the age of 15,

(II) is an unemancipated minor under the age of 18, or

(III) is legally incompetent,

then such notice shall be provided solely to the legal guardian or legal representative of such individual.

(xiii) Any notice described in clause (xii) shall be clearly written in language that is easily understandable to the reader, shall identify the person to be designated as such individual's representative payee, and shall explain to the reader the right under clause (xi) of such individual or of such individual's legal guardian or legal representative—

(I) to appeal a determination that a representative payee is necessary for such individual,

(II) to appeal the designation of a particular person to serve as the representative payee of such individual, and

(III) to review the evidence upon which such designation is based and submit additional evidence.

(C)(i) In any case where payment is made under this title to a representative payee of an individual or spouse, the Commissioner of Social Security shall establish a system of accountability monitoring whereby such person shall report not less often than annually with respect to the use of such payments. The Commissioner of Social Security shall establish and implement statistically valid procedures for reviewing such reports in order to identify instances in which such persons are not properly using such payments.

(ii) Clause (i) shall not apply in any case where the representative payee is a State institution. In such cases, the Commissioner of Social Security shall establish a system of accountability monitoring for institutions in each State.

(iii) Clause (i) shall not apply in any case where the individual entitled to such payment is a resident of a Federal institution and the representative payee is the institution.

(iv) Notwithstanding clauses (i), (ii), and (iii), the Commissioner of Social Security may require a report at any time from any representative payee, if the Commissioner of Social Security has reason to believe

that the representative payee is misusing such payments.

(v)[70] In any case in which the person described in clause (i) or (iv) receiving payments on behalf of another fails to submit a report required by the Commissioner of Social Security under clause (i) or (iv), the Commissioner may, after furnishing notice to the person and the individual entitled to the payment, require that such person appear in person at a field office of the Social Security Administration serving the area in which the individual resides in order to receive such payments.

(D)(i) Except as provided in the next sentence, a[71] qualified organization may collect from an individual a monthly fee for expenses (including overhead) incurred by such organization in providing services performed as such individual's representative payee pursuant to subparagraph (A)(ii) if the fee does not exceed the lesser of—

(I) 10 percent of the monthly benefit involved, or

(II) $25.00 per month ($50.00 per month in any case in which an individual is described in subparagraph (A)(ii)(II).

A qualified organization may not collect a fee from an individual for any month with respect to which the Commissioner of Social Security or a court of competent jurisdiction has determined that the organization misused all or part of the individual's benefit, and any amount so collected by the qualified organization for such month shall be treated as a misused part of the individual's benefit for purposes of subparagraphs (E) and (F). The Commissioner[72] of Social Security shall adjust annually (after 1995) each dollar amount set forth in subclause (II) of this clause under procedures providing for adjustments in the same manner and to the same extent as adjustments are provided for under the procedures used to adjust benefit amounts under section 215(i)(2)(A), except that any amount so adjusted that is not a multiple of $1.00 shall be rounded to the nearest multiple of $1.00. Any agreement providing for a fee in excess of the amount permitted under this clause shall be void and shall be treated as misuse by the organization of such individual's benefits.

(ii) For purposes of this subparagraph, the term "qualified organization" means any State or local government agency whose mission is to carry out income maintenance, social service, or health care-related activities, any State or local government agency with fiduciary responsibilities, or any community-based nonprofit social service agency, which—

(I) is bonded or licensed in each State in which the agency serves as a representative payee; and

[70] P.L. 108–203, §106(c), added clause (v), effective September 2004.

[71] P.L. 108–203, §104(b)(1), struck out "A" and substituted "Except as provided in the next sentence, a".

[72] P.L. 108–203, §104(b)(2), struck out "The Commissioner" and substituted a sentence beginning "A qualified organization ... subparagraphs (E) and (F). The Commissioner", applicable to any month involving benefit misuse by a representative payee in any case with respect to which the Commissioner of Social Security or a court of competent jurisdiction makes the determination of misuse after September 2004.

(II) in accordance with any applicable regulations of the Commissioner of Social Security—

(aa) regularly provides services as a representative payee pursuant to subparagraph (A)(ii) or section 205(j)(4) or 807 concurrently to 5 or more individuals; and

(bb) demonstrates to the satisfaction of the Commissioner of Social Security that such agency is not otherwise a creditor of any such individual.

The Commissioner of Social Security shall prescribe regulations under which the Commissioner of Social Security may grant an exception from subclause (II)(bb) for any individual on a case-by-case basis if such exception is in the best interests of such individual.

(iii) Any qualified organization which knowingly charges or collects, directly or indirectly, any fee in excess of the maximum fee prescribed under clause (i) or makes any agreement, directly or indirectly, to charge or collect any fee in excess of such maximum fee, shall be fined in accordance with title 18, United States Code, or imprisoned not more than 6 months, or both.

(iv) In the case of an individual who is no longer eligible for benefits under this title but to whom any amount of past-due benefits under this title has not been paid, for purposes of clause (i), any amount of such past-due benefits payable in any month shall be treated as a monthly benefit referred to in clause (i)(I).

(E) RESTITUTION.—In cases where the negligent failure of the Commissioner of Social Security to investigate or monitor a representative payee results in misuse of benefits by the representative payee, the Commissioner of Social Security shall make payment to the beneficiary or the beneficiary's representative payee of an amount equal to such misused benefits. In any case in which a representative payee that—

(i) is not an individual (regardless of whether it is a "qualified organization" within the meaning of subparagraph (D)(ii)); or

(ii) is an individual who, for any month during a period when misuse occurs, serves 15 or more individuals who are beneficiaries under this title, title II, title VIII, or any combination of such titles;

misuses all or part of an individual's benefit paid to such representative payee, the Commissioner of Social Security shall pay to the beneficiary or the beneficiary's alternative representative payee an amount equal to the amount of such benefit so misused. The provisions of this subparagraph are subject to the limitations of subparagraph (H)(ii).[73] The Commissioner of Social Security shall make a good faith effort to obtain restitution from the terminated representative payee.

(F)(i)(I) Each representative payee of an eligible individual under the age of 18 who is eligible for the payment of

[73] P.L. 108–203, §101(c)(1), added this sentence, applicable to any case of benefit misuse by a representative payee with respect to which the Commissioner of Social Security makes the determination of misuse on or after January 1, 1995.

benefits described in subclause (II) shall establish on behalf of such individual an account in a financial institution into which such benefits shall be paid, and shall thereafter maintain such account for use in accordance with clause (ii).

(II) Benefits described in this subclause are past–due monthly benefits under this title (which, for purposes of this subclause, include State supplementary payments made by the Commissioner pursuant to an agreement under section 1616 or section 212(b) of Public Law 93–66) in an amount (after any withholding by the Commissioner for reimbursement to a State for interim assistance under subsection (g) and payment of attorney fees under subsection (d)(2)(B)[74]) that exceeds the product of—

(aa) 6, and

(bb) the maximum monthly benefit payable under this title to an eligible individual.

(ii)(I) A representative payee shall use funds in the account established under clause (i) to pay for allowable expenses described in subclause (II).

(II) An allowable expense described in this subclause is an expense for—

(aa) education or job skills training;

(bb) personal needs assistance;

(cc) special equipment

(dd) housing modification

(ee) medical treatment;

(ff) therapy or rehabilitation; or

(gg) any other item or service that the Commissioner determines to be appropriate;

provided that such expense benefits such individual and, in the case of an expense described in item (bb), (cc), (dd), (ff), or (gg), is related to the impairment (or combination of impairments) of such individual.

(III) The use of funds from an account established under clause (i) in any manner not authorized by this clause—

(aa) by a representative payee shall be considered a misapplication of benefits for all purposes of this paragraph, and any representative payee who knowingly misapplies benefits from such an account shall be liable to the Commissioner in an amount equal to the total amount of such benefits; and

(bb) by an eligible individual who is his or her own payee shall be considered a misapplication of benefits for all purposes of this paragraph and in any case in which the individual knowingly misapplies benefits from such an account, the Commissioner shall reduce future benefits payable to such individ-

[74] P.L. 108–203, §302(b)(1), inserted, "and payment of attorney fees under subsection (d)(2)(B)".

ual (or to such individual and his spouse) by an amount equal to the total amount of such benefits so misapplied.

(IV) This clause shall continue to apply to funds in the account after the child has reached age 18, regardless of whether benefits are paid directly to the beneficiary or through a representative payee.

(iii) The representative payee may deposit into the account established under clause (i) any other funds representing past due benefits under this title to the eligible individual, provided that the amount of such past due benefits is equal to or exceeds the maximum monthly benefit payable under this title to an eligible individual (including State supplementary payments made by the Commissioner pursuant to an agreement under section 1616 or section 212(b) of Public Law 93–66[75]).

(iv) The Commissioner of Social security shall establish a system for accountability monitoring whereby such representative payee shall report, at such time and in such manner as the Commissioner shall require, on activity respecting funds in the account established pursuant to clause (i).

(G)(i)[76] In addition to such other reviews of representative payees as the Commissioner of Social Security may otherwise conduct, the Commissioner shall provide for the periodic onsite review of any person or agency that receives the benefits payable under this title (alone or in combination with benefits payable under title II or title VIII) to another individual pursuant to the appointment of the person or agency as a representative payee under this paragraph, section 205(j), or section 807 in any case in which—

(I) the representative payee is the person who serves in the capacity with respect to 15 or more such individuals;

(II) the representative payee is a certified community-based nonprofit social service agency (as defined in subparagraph (I) of this paragraph or section 205(j)(10)[77]); or

(III) the representative payee is an agency (other than an agency described in subclause (II)) that serves in that capacity with respect to 50 or more such individuals.

(ii) Within 120 days after the end of each fiscal year, the Commissioner shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report on the results of periodic onsite reviews conducted during the fiscal year pursuant to clause (i) and of any other reviews of representative payees conducted during

[75] See Vol. II, P.L. 93–66, §212(b).

[76] P.L. 108-203, §102(b)(3), amended subparagraph (G) in its entirety, effective March 2, 2004. For subparagraph (G) as it formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L. 108-203.

[77] P.L. 108–203, §105(c)(1), struck out, "section 205(j)(9)" and substituted "section 205(j)(10)".

such fiscal year in connection with benefits under this title. Each such report shall describe in detail all problems identified in the reviews and any corrective action taken or planned to be taken to correct the problems, and shall include-

(I) the number of the reviews;

(II) the results of such reviews;

(III) the number of cases in which the representative payee was changed and why;

(IV) the number of cases involving the exercise of expedited, targeted oversight of the representative payee by the Commissioner conducted upon receipt of an allegation of misuse of funds, failure to pay a vendor, or a similar irregularity;

(V) the number of cases discovered in which there was a misuse of funds;

(VI) how any such cases of misuse of funds were dealt with by the Commissioner;

(VII) the final disposition of such cases of misuse of funds, including any criminal penalties imposed; and

(VIII) such other information as the Commissioner deems appropriate.

(H)[78](i) If the Commissioner of Social Security or a court of competent jurisdiction determines that a representative payee that is not a Federal, State, or local government agency has misused all or part of an individual's benefit that was paid to the representative payee under this paragraph, the representative payee shall be liable for the amount misused, and the amount (to the extent not repaid by the representative payee) shall be treated as an overpayment of benefits under this title to the representative payee for all purposes of this Act and related laws pertaining to the recovery of the overpayments. Subject to clause (ii), upon recovering all or any part of the amount, the Commissioner shall make payment of an amount equal to the recovered amount to such individual or such individual's alternative representative payee.

(ii) The total of the amount paid to such individual or such individual's alternative representative payee under clause (i) and the amount paid under subparagraph (E) may not exceed the total benefit amount misused by the representative payee with respect to such individual.

(3) The Commissioner of Social Security may by regulations establish ranges of incomes within which a single amount of benefits under this title shall apply.

(4) The Commissioner of Social Security—

(A) may make to any individual initially applying for benefits under this title who is presumptively eligible for

[78] P.L. 108–203, §105(c)(2), amended subparagraph (H) in its entirety, applicable to benefit misuse by a representative payee in any case with respect to which the Commissioner of Social Security or a court of competent jurisdiction makes the determination of misuse after September 2004. For subparagraph (H) as it formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L. 108-203.

such benefits for the month following the date the application is filed and who is faced with financial emergency a cash advance against such benefits, including any federally-administered State supplementary payments, in an amount not exceeding the monthly amount that would be payable to an eligible individual with no other income for the first month of such presumptive eligibility, which shall be repaid through proportionate reductions in such benefits over a period of not more than 6 months; and

(B) may pay benefits under this title to an individual applying for such benefits on the basis of disability or blindness for a period not exceeding 6 months prior to the determination of such individual's disability or blindness, if such individual is presumptively disabled or blind and is determined to be otherwise eligible for such benefits, and any benefits so paid prior to such determination shall in no event be considered overpayments for purposes of subsection (b) solely because such individual is determined not to be disabled or blind.

(5) Payment of the benefit of any individual who is an aged, blind, or disabled individual solely by reason of blindness (as determined under section 1614(a)(2)) or disability (as determined under section 1614(a)(3)), and who ceases to be blind or to be under such disability, shall continue (so long as such individual is otherwise eligible) through the second month following the month in which such blindness or disability ceases.

(6) Notwithstanding any other provision of this title, payment of the benefit of any individual who is an aged, blind, or disabled individual solely by reason of blindness (as determined under section 1614(a)(2)) or disability (as determined under section 1614(a)(3)) shall not be terminated or suspended because the blindness or other physical or mental impairment, on which the individual's eligibility for such benefit is based, has or may have ceased, if—

(A) such individual is participating in a program consisting of the Ticket to Work and Self–Sufficiency Program under section 1148 or another program of vocational rehabilitation services, employment services, or other support services approved by the Commissioner of Social Security, and,

(B) the Commissioner of Social Security determines that the completion of such program, or its continuation for a specified period of time, will increase the likelihood that such individual may (following his participation in such program) be permanently removed from the blindness and disability benefit rolls.

(7)(A) In any case where—

(i) an individual is a recipient of benefits based on disability or blindness under this title,

(ii) the physical or mental impairment on the basis of which such benefits are payable is found to have ceased, not to have existed, or to no longer be disabling, and as a consequence such individual is determined not to be entitled to such benefits, and

(iii) a timely request for review or for a hearing is pending with respect to the determination that he is not so entitled,

such individual may elect (in such manner and form and within such time as the Commissioner of Social Security shall by regulations prescribe) to have the payment of such benefits continued for an additional period beginning with the first month beginning after the date of the enactment of this paragraph for which (under such determination) such benefits are no longer otherwise payable, and ending with the earlier of (I) the month preceding the month in which a decision is made after such a hearing, or (II) the month preceding the month in which no such request for review or a hearing is pending.

(B)(i) If an individual elects to have the payment of his benefits continued for an additional period under subparagraph (A), and the final decision of the Commissioner of Social Security affirms the determination that he is not entitled to such benefits, any benefits paid under this title pursuant to such election (for months in such additional period) shall be considered overpayments for all purposes of this title, except as otherwise provided in clause (ii).

(ii) If the Commissioner of Social Security determines that the individual's appeal of his termination of benefits was made in good faith, all of the benefits paid pursuant to such individual's election under subparagraph (A) shall be subject to waiver consideration under the provisions of subsection (b)(1).

(C) The provisions of subparagraphs (A) and (B) shall apply with respect to determinations (that individuals are not entitled to benefits) which are made on or after the date of the enactment of this paragraph [79], or prior to such date but only on the basis of a timely request for review or for a hearing.

(8)(A) In any case in which an administrative law judge has determined after a hearing as provided in subsection (c) that an individual is entitled to benefits based on disability or blindness under this title and the Commissioner of Social Security has not issued the Commissioner's final decision in such case within 110 days after the date of the administrative law judge's determination, such benefits shall be currently paid for the months during the period beginning with the month in which such 110-day period expires and ending with the month in which such final decision is issued.

(B) For purposes of subparagraph (A), in determining whether the 110-day period referred to in subparagraph (A) has elapsed, any period of time for which the action or inaction of such individual or such individual's representative without good cause results in the delay in the issuance of the Commissioner's final decision shall not be taken into account to the extent that such period of time exceeds 20 calendar days.

(C) Any benefits currently paid under this title pursuant to this paragraph (for the months described in subparagraph (A)) shall not be considered overpayments for any

[79] This paragraph was enacted October 9, 1984. [P.L. 98–460, §7(b); 98 Stat. 1083]

purposes of this title, unless payment of such benefits was fraudulently obtained.

(9) Benefits under this title shall not be denied to any individual solely by reason of the refusal of the individual to accept an amount offered as compensation for a crime of which the individual was a victim.

(10)(A) If an individual is eligible for past–due monthly benefits under this title in an amount that (after any withholding for reimbursement to a State for interim assistance under subsection (g) and payment of attorney fees under subsection (d)(2)(B)[80]) equals or exceeds the product of—

(i) 12, and

(ii) the maximum monthly benefit payable under this title to an eligible individual (or, if appropriate, to an eligible individual and eligible spouse),

then the payment of such past–due benefits (after any such reimbursement to a State and payment of attorney fees under subsection (d)(2)(B)[81]) shall be made in installments as provided in subparagraph (B).

(B)(i) The payment of past–due benefits subject to this subparagraph shall be made in not to exceed 3 installments that are made at 6–month intervals.

(ii) Except as provided in clause (iii), the amount of each of the first and second installments may not exceed an amount equal to the product of clauses (i) and (ii) of subparagraph (A).

(iii) In the case of an individual who has—

(I) outstanding debt attributable to—

(aa) food,

(bb) clothing,

(cc) shelter, or

(dd) medically necessary services, supplies or equipment, or medicine; or

(II) current expenses or expenses anticipated in the near term attributable to—

(aa) medically necessary services, supplies or equipment, or medicine, or

(bb) the purchase of a home, and

such debt or expenses are not subject to reimbursement by a public assistance program, the Secretary under title XVIII, a State plan approved under title XIX, or any private entity legally liable to provide payment pursuant to an insurance policy, pre–paid plan, or other arrangement, the limitation specified in clause (ii) may be exceeded by an amount equal to the total of such debt and expenses.

(C) This paragraph shall not apply to any individual who, at the time of the Commissioner's determination that such individual is eligible for the payment of past–due monthly benefits under this title—

(i) is afflicted with a medically determinable impairment that is expected to result in death within 12 months; or

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[80] P.L. 108–203, §302(b)(2)(A), inserted, "and payment of attorney fees under subsection (d)(2)(B)".

[81] P.L. 108–203, §302(b)(2)(B), inserted, "and payment of attorney fees under subsection (d)(2)(B)".

(ii) is ineligible for benefits under this title and the Commissioner determines that such individual is likely to remain ineligible for the next 12 months.

(D) For purposes of this paragraph, the term "benefits under this title" includes supplementary payments pursuant to an agreement for Federal administration under section 1616(a), and payments pursuant to an agreement entered into under section 212(b) of Public Law 93–66.

Overpayments and Underpayments

(b)(1)(A) Whenever the Commissioner of Social Security finds that more or less than the correct amount of benefits has been paid with respect to any individual, proper adjustment or recovery shall, subject to the succeeding provisions of this subsection, be made by appropriate adjustments in future payments to such individual or by recovery from such individual or his eligible spouse (or from the estate of either) or by payment to such individual or his eligible spouse, or, if such individual is deceased, by payment—

(i) to any surviving spouse of such individual, whether or not the individual's eligible spouse, if (within the meaning of the first sentence of section 202(i)) such surviving husband or wife was living in the same household with the individual at the time of his death or within the 6 months immediately preceding the month of such death, or

(ii) if such individual was a disabled or blind child who was living with his parent or parents at the time of his death or within the 6 months immediately preceding the month of such death, to such parent or parents.

(B) The Commissioner of Social Security (i) shall make such provision as the Commissioner finds appropriate in the case of payment of more than the correct amount of benefits with respect to an individual with a view to avoiding penalizing such individual or his eligible spouse who was without fault in connection with the overpayment, if adjustment or recovery on account of such overpayment in such case would defeat the purposes of this title, or be against equity and good conscience, or (because of the small amount involved) impede efficient or effective administration of this title, and (ii) shall in any event make the adjustment or recovery (in the case of payment of more than the correct amount of benefits), in the case of an individual or eligible spouse receiving monthly benefit payments under this title (including supplementary payments of the type described in section 1616(a) and payments pursuant to an agreement entered into under section 212(a) of Public Law 93–66[82]), in amounts which in the aggregate do not exceed (for any month) the lesser of (I) the amount of his or their benefit under this title for that month or (II) an amount equal to 10 percent of his or their income for that month (including such benefit but excluding payments under title II when recovery is made from title II pay-

[82] See Vol. II, P.L. 93–66.

ments pursuant to section 1147 and excluding[83] income excluded pursuant to section 1612(b)), and in the case of an individual or eligible spouse to whom a lump sum is payable under this title (including under section 1616(a) of this Act or under an agreement entered into under section 212(a) of Public Law 93–66) shall, as at least one means of recovering such overpayment, make the adjustment or recovery from the lump sum payment in an amount equal to not less than the lesser of the amount of the overpayment or[84] the lump sum payment, unless fraud, willful misrepresentation, or concealment of material information was involved on the part of the individual or spouse in connection with the overpayment, or unless the individual requests that such adjustment or recovery be made at a higher or lower rate and the Commissioner of Social Security determines that adjustment or recovery at such rate is justified and appropriate. The availability (in the case of an individual who has been paid more than the correct amount of benefits) of procedures for adjustment or recovery at a limited rate under clause (ii) of the preceding sentence shall not, in and of itself, prevent or restrict the provision (in such case) of more substantial relief under clause (i) of such sentence.

(2) Notwithstanding any other provision of this section, when any payment of more than the correct amount is made to or on behalf of an individual who has died, and such payment—

(A) is made by direct deposit to a financial institution;

(B) is credited by the financial institution to a joint account of the deceased individual and another person; and

(C) such other person is the surviving spouse of the deceased individual, and was eligible for a payment under this title (including any State supplementation payment paid by the Commissioner of Social Security) as an eligible spouse (or as either member of an eligible couple) for the month in which the deceased individual died,

the amount of such payment in excess of the correct amount shall be treated as a payment of more than the correct amount to such other person. If any payment of more than the correct amount is made to a representative payee on behalf of an individual after the individual's death, the representative payee shall be liable for the repayment of the overpayment, and the Commissioner of Social Security shall establish an overpayment control record under the social security account number of the representative payee.

(3) If any overpayment with respect to an individual (or an individual and his or her spouse) is attributable solely to the ownership or possession by such individual (and spouse if any) of resources having a value which exceeds the applicable dollar figure specified in paragraph (1)(B) or (2)(B) of section 1611(a) by $50 or less, such individual (and spouse if any) shall be deemed for purposes of the second sentence of paragraph (1) to

[83] P.L. 108-203, §210(b)(4)(i), struck out "excluding any other" and substituted "excluding payments under title II when recovery is made from title II payments pursuant to section 1147 and excluding", effective March 2, 2004 with respect to overpayments under titles II, VIII, and XVI of the Social Security Act that are outstanding on March 2, 2004.

[84] P.L. 108-203, §210(b)(4)(A)(ii), struck out "50 percent of", effective March 2, 2004 with respect to overpayments under titles II, VIII, and XVI of the Social Security Act that are outstanding on March 2, 2004.

have been without fault in connection with the overpayment, and no adjustment or recovery shall be made under the first sentence of such paragraph, unless the Commissioner of Social Security finds that the failure of such individual (and spouse if any) to report such value correctly and in a timely manner was knowing and willful.

(4)(A) With respect to any delinquent amount, the Commissioner of Social Security may use the collection practices described in sections 3711(f), 3716, 3717, and 3718 of title 31, United States Code, and in section 5514 of title 5, United States Code[85], all as in effect immediately after the enactment of the Debt Collection Improvement Act of 1996.

(B) For purposes of subparagraph (A), the term "delinquent amount" means an amount—

(i) in excess of the correct amount of payment under this title;

(ii) paid to a person after such person has attained 18 years of age; and

(iii) determined by the Commissioner of Social Security, under regulations, to be otherwise unrecoverable under this section after such person ceases to be a beneficiary under this title.

(5) For payments for which adjustments are made by reason of a retroactive payment of benefits under title II, see section 1127.

(6)[86] For provisions relating to the cross-program recovery of overpayments made under programs administered by the Commissioner of Social Security, see section 1147.

Hearings and Review

(c)(1)(A) The Commissioner of Social Security is directed to make findings of fact, and decisions as to the rights of any individual applying for payment under this title. Any such decision by the Commissioner of Social Security which involves a determination of disability and which is in whole or in part unfavorable to such individual shall contain a statement of the case, in understandable language, setting forth a discussion of the evidence, and stating the Commissioner's determination and the reason or reasons upon which it is based. The Commissioner of Social Security shall provide reasonable notice and opportunity for a hearing to any individual who is or claims to be an eligible individual or eligible spouse and is in disagreement with any determination under this title with respect to eligibility of such individual for benefits, or the amount of such individual's benefits, if such individual requests a hearing on the matter in disagreement within sixty days after notice of such determination is received, and, if a hearing is held, shall, on the basis of evidence adduced at the hearing affirm, modify, or reverse the Commissioner's findings of fact and such decision. The Commissioner of Social Security is further authorized, on the Commissioner's own motion, to hold such hearings and to con-

[85] See Vol. II, Titles 31 and 5.
The date of enactment for the Debt Collection Improvement Act of 1996, §31001 of P.L. 104-134 was April 26, 1996.

[86] P.L. 108-203, §210(b)(4)(B), amended paragraph (6) in its entirety, effective March 2, 2004 with respect to overpayments under title II, VII, and XVI of the Social Security Act that are outstanding on or after March 2, 2004.

duct such investigations and other proceedings as the Commissioner may deem necessary or proper for the administration of this title. In the course of any hearing, investigation, or other proceeding, the Commissioner may administer oaths and affirmations, examine witnesses, and receive evidence. Evidence may be received at any hearing before the Commissioner of Social Security even though inadmissible under the rules of evidence applicable to court procedure. The Commissioner of Social Security shall specifically take into account any physical, mental, educational, or linguistic limitation of such individual (including any lack of facility with the English language) in determining, with respect to the eligibility of such individual for benefits under this title, whether such individual acted in good faith or was at fault, and in determining fraud, deception, or intent.

(B)(i) A failure to timely request review of an initial adverse determination with respect to an application for any payment under this title or an adverse determination on reconsideration of such an initial determination shall not serve as a basis for denial of a subsequent application for any payment under this title if the applicant demonstrates that the applicant, or any other individual referred to in subparagraph (A), failed to so request such a review acting in good faith reliance upon incorrect, incomplete, or misleading information, relating to the consequences of reapplying for payments in lieu of seeking review of an adverse determination, provided by any officer or employee of the Social Security Administration or any State agency acting under section 221.

(ii) In any notice of an adverse determination with respect to which a review may be requested under subparagraph (A), the Commissioner of Social Security shall describe in clear and specific language the effect on possible eligibility to receive payments under this title of choosing to reapply in lieu of requesting review of the determination.

(2) Determination on the basis of such hearing, except to the extent that the matter in disagreement involves a disability (within the meaning of section 1614(a)(3)), shall be made within ninety days after the individual requests the hearing as provided in paragraph (1).

(3) The final determination of the Commissioner of Social Security after a hearing under paragraph (1) shall be subject to judicial review as provided in section 205(g) to the same extent as the Commissioner's final determinations under section 205.

Procedures; Prohibitions of Assignments; Representation of Claimants

(d)(1) The provisions of section 207 and subsections (a), (d), and (e) of section 205 shall apply with respect to this part to the same extent as they apply in the case of title II.

(2)[87](A) The provisions of section 206[88] (other than subsections (a)(4) and (d) thereof)[89] shall apply to this part to the same extent as they apply in the case of title II, except that such section[90] shall be applied—

(i) by substituting in subparagraphs (A)(ii)(I) and (D)(i) of subsection (a)(2)[91], the phrase "(as determined before any applicable reduction under section 1631(g), and reduced by the amount of any reduction in benefits under this title or title II made pursuant to section 1127(a))" for the parenthetical phrase contained therein;[92]

(ii)[93] by substituting, in subsections (a)(2)(B) and (b)(1)(B)(i), the phrase "paragraph (7)(A) or (8)(A) of section 1631(a) or the requirements of due process of law" for the phrase "subsection (g) or (h) of section 223";

(iii) by substituting, in subsection (a)(2)(C)(i), the phrase "under title II" for the phrase "under title XVI";

(iv) by substituting, in subsection (b)(1)(A), the phrase "pay the amount of such fee" for the phrase "certify the amount of such fee for payment" and by striking, in subsection (b)(1)(A), the phrase "or certified for payment"; and

(v) by substituting, in subsection (b)(1)(B)(ii), the phrase "deemed to be such amounts as determined before any applicable reduction under section 1631(g), and reduced by the amount of any reduction in benefits under this title or title II made pursuant to section 1127(a)" for the phrase "determined before any applicable reduction under section 1127(a))".

(B)[94] Subject to subparagraph (C), if the claimant is determined to be entitled to past-due benefits under this title and the person representing the claimant is an attorney, the Commissioner of Social Security shall pay out of such past-due benefits to such attorney an amount equal to the lesser of—

(i) so much of the maximum fee as does not exceed 25 percent of such past-due benefits (as determined before any applicable reduction under section 1631(g) and reduced by the amount of any reduction in benefits under this title or title II pursuant to section 1127(a)), or

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[87] See Vol. II, P.L. 108-203, §302, with respect to the temporary extension of attorney fee payment system to Title XVI claims; §303, with respect to a nationwide demonstration project providing for extension of fee withholding procedures to non-attorney representatives; and §304, with respect to a GAO study regarding the fee payment process for claimant representatives..

[88] P.L. 108-203, §302(a)(1)(A), struck out "section 206(a)" and substituted "section 206".

[89] P.L. 108-203, §302(a)(1)(B), struck out "(other than paragraph (4) thereof)" and substituted "(other than subsections (a)(4) and (d) thereof)".

[90] P.L. 108-203, §302(a)(1)(C), struck out "paragraph (2) thereof" and substituted "such section".

[91] P.L. 108-203, §302(a)(2)(A), struck out "in subparagraphs (A)(ii)(I) and (C)(i)," and substituted "in subparagraphs (A)(ii)(I) and (D)(i) of subsection (a)(2)".

[92] P.L. 108-203, §302(a)(2)(B), struck out "and".

[93] P.L. 108-203, §302(a)(3), struck out clause (ii) and added a new clause (ii) and clauses (iii), (iv) and (v). For the effective date, see Vol. II, P.L. 108-203, §302(c). For clause (ii) as it formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L. 108-203.

[94] P.L. 108-203, §302(a)(4), added a new subparagraph (B) and a subparagraph (C). For the effective date, see Vol. II, P.L. 108-203, §302(c).

(ii) the amount of past-due benefits available after any applicable reductions under sections 1631(g) and 1127(a).

(C)(i) Whenever a fee for services is required to be paid to an attorney from a claimant's past-due benefits pursuant to subparagraph (B), the Commissioner shall impose on the attorney an assessment calculated in accordance with clause (ii).

(ii)(I) The amount of an assessment under clause (i) shall be equal to the product obtained by multiplying the amount of the representative's fee that would be required to be paid by subparagraph (B) before the application of this subparagraph, by the percentage specified in subclause (II), except that the maximum amount of the assessment may not exceed $75. In the case of any calendar year beginning after the amendments made by section 302 of the Social Security Protection Act of 2003 take effect, the dollar amount specified in the preceding sentence (including a previously adjusted amount) shall be adjusted annually under the procedures used to adjust benefit amounts under section 215(i)(2)(A)(ii), except such adjustment shall be based on the higher of $75 or the previously adjusted amount that would have been in effect for December of the preceding year, but for the rounding of such amount pursuant to the following sentence. Any amount so adjusted that is not a multiple of $1 shall be rounded to the next lowest multiple of $1, but in no case less than $75.

(II) The percentage specified in this subclause is such percentage rate as the Commissioner determines is necessary in order to achieve full recovery of the costs of determining and approving fees to attorneys from the past-due benefits of claimants, but not in excess of 6.3 percent.

(iii) The Commissioner may collect the assessment imposed on an attorney under clause (i) by offset from the amount of the fee otherwise required by subparagraph (B) to be paid to the attorney from a claimant's past-due benefits.

(iv) An attorney subject to an assessment under clause (i) may not, directly or indirectly, request or otherwise obtain reimbursement for such assessment from the claimant whose claim gave rise to the assessment.

(v) Assessments on attorneys collected under this subparagraph shall be deposited as miscellaneous receipts in the general fund of the Treasury.

(vi) The assessments authorized under this subparagraph shall be collected and available for obligation only to the extent and in the amount provided in advance in appropriations Acts. Amounts so appropriated are authorized to remain available until expended, for administrative expenses in carrying out this title and related laws.

(D)[95] The Commissioner of Social Security shall notify each claimant in writing, together with the notice to such claimant of an adverse determination, of the options for obtaining attorneys to represent individuals in presenting their cases before the Commissioner of Social Security. Such notification shall also advise the claimant of the availability to qualifying claimants of legal services organizations which provide legal services free of charge.

Applications and Furnishing of Information[96]

(e)(1)(A) The Commissioner of Social Security shall, subject to subparagraph (B) and subsection (j), prescribe such requirements with respect to the filing of applications, the suspension or termination of assistance, the furnishing of other data and material, and the reporting of events and changes in circumstances, as may be necessary for the effective and efficient administration of this title.

(B)(i) The requirements prescribed by the Commissioner of Social Security pursuant to subparagraph (A) shall require that eligibility for benefits under this title will not be determined solely on the basis of declarations by the applicant concerning eligibility factors or other relevant facts, and that relevant information will be verified from independent or collateral sources and additional information obtained as necessary in order to assure that such benefits are only provided to eligible individuals (or eligible spouses) and that the amounts of such benefits are correct. For this purpose and for purposes of federally administered supplementary payments of the type described in section 1616(a) of this Act (including payments pursuant to an agreement entered into under section 212(a) of Public Law 93–66[97]), the Commissioner of Social Security shall, as may be necessary, request and utilize information available pursuant to section 6103(l)(7) of the Internal Revenue Code of 1954[98], and any information which may be available from State systems under section 1137 of this Act, and shall comply with the requirements applicable to States (with respect to information available pursuant to section 6103(l)(7)(B) of such Code) under subsections (a)(6) and (c) of such section 1137.

(ii)(I) The Commissioner of Social Security may require each applicant for, or recipient of, benefits under this title to provide authorization by the applicant or recipient (or by any other person whose income or resources are material to the determination of the eligibility of the applicant or recipient for such benefits) for the Commissioner to obtain (subject to the cost reimbursement requirements of section 1115(a) of the Right to Financial Privacy Act) from any financial institution (within the meaning of section 1101(1) of such Act) any financial record (within the meaning of

[95] P.L. 108-203, §302(a)(4), redesignated the former subparagraph (B) as subparagraph (D).
[96] See Vol. II, P.L. 88–525, §11(i), with respect to inquiry into the need for food stamps.
See Vol. II, P.L. 95–630, §§1101–1121, with respect to an individual's right to financial privacy.
[97] See Vol. II, P.L. 93–66.
[98] See Vol. II, P.L. 83–591.

section 1101(2) of such Act) held by the institution with respect to the applicant or recipient (or any such other person) whenever the Commissioner determines the record is needed in connection with a determination with respect to such eligibility or the amount of such benefits.

(II) Notwithstanding section 1104(a)(1) of the Right to Financial Privacy Act, an authorization provided by an applicant or recipient (or any other person whose income or resources are material to the determination of the eligibility of the applicant or recipient) pursuant to subclause (I) of this clause shall remain effective until the earliest of—

(aa) the rendering of a final adverse decision on the applicant's application for eligibility for benefits under this title;

(bb) the cessation of the recipient's eligibility for benefits under this title; or

(cc) the express revocation by the applicant or recipient (or such other person referred to in subclause (I)) of the authorization, in a written notification to the Commissioner.

(III)(aa) An authorization obtained by the Commissioner of Social Security pursuant to this clause shall be considered to meet the requirements of the Right to Financial Privacy Act for purposes of section 1103(a) of such Act, and need not be furnished to the financial institution, notwithstanding section 1104(a) of such Act.

(bb) The certification requirements of section 1103(b) of the Right to Financial Privacy Act shall not apply to requests by the Commissioner of Social Security pursuant to an authorization provided under this clause.

(cc) A request by the Commissioner pursuant to an authorization provided under this clause is deemed to meet the requirements of section 1104(a)(3) of the Right to Financial Privacy Act and the flush language of section 1102 of such Act.

(IV) The Commissioner shall inform any person who provides authorization pursuant to this clause of the duration and scope of the authorization.

(V) If an applicant for, or recipient of, benefits under this title (or any such other person referred to in subclause (I)) refuses to provide, or revokes, any authorization made by the applicant or recipient for the Commissioner of Social Security to obtain from any financial institution any financial record, the Commissioner may, on that basis, determine that the applicant or recipient is ineligible for benefits under this title.

(C) For purposes of making determinations under section 1611(e), the requirements prescribed by the Commissioner

of Social Security pursuant to subparagraph (A) of this paragraph shall require each administrator of a nursing home, extended care facility, or intermediate care facililty, within 2 weeks after the admission of any eligible individual or eligible spouse receiving benefits under this title, to transmit to the Commissioner a report of the admission.

(2) In case of the failure by any individual to submit a report of events and changes in circumstances relevant to eligibility for or amount of benefits under this title as required by the Commissioner of Social Security under paragraph (1), or delay by any individual in submitting a report as so required, the Commissioner of Social Security (in addition to taking any other action the Commissioner may consider appropriate under paragraph (1)) shall reduce any benefits which may subsequently become payable to such individual under this title by—

(A) $25 in the case of the first such failure or delay,

(B) $50 in the case of the second such failure or delay, and

(C) $100 in the case of the third or a subsequent such failure or delay,

except where the individual was without fault or good cause for such failure or delay existed.

(3) The Commissioner of Social Security shall provide a method of making payments under this title to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

(4) A translation into English by a third party of a statement made in a foreign language by an applicant for or recipient of benefits under this title shall not be regarded as reliable for any purpose under this title unless the third party, under penalty of perjury—

(A) certifies that the translation is accurate; and

(B) discloses the nature and scope of the relationship between the third party and the applicant or recipient, as the case may be.

(5) In any case in which it is determined to the satisfaction of the Commissioner of Social Security that an individual failed as of any date to apply for benefits under this title by reason of misinformation provided to such individual by any officer or employee of the Social Security Administration relating to such individual's eligibility for benefits under this title, such individual shall be deemed to have applied for such benefits on the later of—

(A) the date on which such misinformation was provided to such individual, or

(B) the date on which such individual met all requirements for entitlement to such benefits (other than application therefor).

(6) In any case in which an individual visits a field office of the Social Security Administration and represents during the visit to an officer or employee of the Social Security Administration in the office that the individual's visit is occasioned by—

(A) the receipt of a notice from the Social Security Administration indicating a time limit for response by the individual, or

(B) the theft, loss, or nonreceipt of a benefit payment under this title,

the Commissioner of Social Security shall ensure that the individual is granted a face-to-face interview at the office with an officer or employee of the Social Security Administration before the close of business on the day of the visit.

(7)(A)(i) The Commissioner of Social Security shall immediately redetermine the eligibility of an individual for benefits under this title if there is reason to believe that fraud or similar fault was involved in the application of the individual for such benefits, unless a United States attorney, or equivalent State prosecutor, with jurisdiction over potential or actual related criminal cases, certifies, in writing, that there is a substantial risk that such action by the Commissioner of Social Security with regard to recipients in a particular investigation would jeopardize the criminal prosecution of a person involved in a suspected fraud.

(ii) When redetermining the eligibility, or making an initial determination of eligibility, of an individual for benefits under this title, the Commissioner of Social Security shall disregard any evidence if there is reason to believe that fraud or similar fault was involved in the providing of such evidence.

(B) For purposes of subparagraph (A), similar fault is involved with respect to a determination if—

(i) an incorrect or incomplete statement that is material to the determination is knowingly made; or

(ii) information that is material to the determination is knowingly concealed.

(C) If, after redetermining the eligibility of an individual for benefits under this title, the Commissioner of Social Security determines that there is insufficient evidence to support such eligibility, the Commissioner of Social Security may terminate such eligibility and may treat benefits paid on the basis of such insufficient evidence as overpayments.

(8)(A) The Commissioner of Social Security shall request the Immigration and Naturalization Service or the Centers for Disease Control to provide the Commissioner of Social Security with whatever medical information, identification information, and employment history either such entity has with respect to any alien who has applied for benefits under title XVI to the extent that the information is relevant to any determination relating to eligibility for such benefits under title XVI.

(B) Subparagraph (A) shall not be construed to prevent the Commissioner of Social Security from adjudicating the case before receiving such information.

(9) Notwithstanding any other provision of law, the Commissioner shall, at least 4 times annually and upon request of the Immigration and Naturalization Service (hereafter in this paragraph referred to as the "Service"), furnish the Service with the name and address of, and other identifying information on, any individual who the Commissioner knows is not lawfully present in the United States, and shall ensure that each agreement entered into under section 1616(a) with a State provides that the State shall furnish such information at

such times with respect to any individual who the State knows is not lawfully present in the United States.

Furnishing of Information by Other Agencies [99]

(f) The head of any Federal agency shall provide such information as the Commissioner of Social Security needs for purposes of determining eligibility for or amount of benefits, or verifying other information with respect thereto.

Reimbursement to States for Interim Assistance Payments

(g)(1) Notwithstanding subsection (d)(1) and subsection (b) as it relates to the payment of less than the correct amount of benefits, the Commissioner of Social Security may, upon written authorization by an individual, withhold benefits due with respect to that individual and may pay to a State (or a political subdivision thereof if agreed to by the Commissioner of Social Security and the State) from the benefits withheld an amount sufficient to reimburse the State (or political subdivision) for interim assistance furnished on behalf of the individual by the State (or political subdivision).

(2) For purposes of this subsection, the term "benefits" with respect to any individual means supplemental security income benefits under this title, and any State supplementary payments under section 1616 or under section 212 of Public Law 93–66 which the Commissioner of Social Security makes on behalf of a State (or political subdivision thereof), that the Commissioner of Social Security has determined to be due with respect to the individual at the time the Commissioner of Social Security makes the first payment of benefits with respect to the period described in clause (A) or (B) of paragraph (3). A cash advance made pursuant to subsection (a)(4)(A) shall not be considered as the first payment of benefits for purposes of the preceding sentence.

(3) For purposes of this subsection, the term "interim assistance" with respect to any individual means assistance financed from State or local funds and furnished for meeting basic needs (A) during the period, beginning with the month following the month in which the individual filed an application for benefits (as defined in paragraph (2)), for which he was eligible for such benefits, or (B) during the period beginning with the first month for which the individual's benefits (as defined in paragraph (2)) have been terminated or suspended if the individual was subsequently found to have been eligible for such benefits.

(4) In order for a State to receive reimbursement under the provisions of paragraph (1), the State shall have in effect an agreement with the Commissioner of Social Security which shall provide—

(A) that if the Commissioner of Social Security makes payment to the State (or a political subdivision of the State as provided for under the agreement) in reimbursement for interim assistance (as defined in paragraph (3)) for any individual in an amount greater than the reimbursable amount authorized by paragraph (1), the State

[99] See Vol. II, P.L. 95–630, §§1101–1121, with respect to an individual's right to financial privacy.

(or political subdivision) shall pay to the individual the balance of such payment in excess of the reimbursable amount as expeditiously as possible, but in any event within ten working days or a shorter period specified in the agreement; and

(B) that the State will comply with such other rules as the Commissioner of Social Security finds necessary to achieve efficient and effective administration of this subsection and to carry out the purposes of the program established by this title, including protection of hearing rights for any individual aggrieved by action taken by the State (or political subdivision) pursuant to this subsection.

(5) The provisions of subsection (c) shall not be applicable to any disagreement concerning payment by the Commissioner of Social Security to a State pursuant to the preceding provisions of this subsection nor the amount retained by the State (or political subdivision).

Payment of Certain Travel Expenses [100]

(h) The Commissioner of Social Security shall pay travel expenses, either on an actual cost or commuted basis, to individuals for travel incident to medical examinations requested by the Commissioner of Social Security in connection with disability determinations under this title, and to parties, their representatives, and all reasonably necessary witnesses for travel within the United States (as defined in section 1614(e)) to attend reconsideration interviews and proceedings before administrative law judges with respect to any determination under this title. The amount available under the preceding sentence for payment for air travel by any person shall not exceed the coach fare for air travel between the points involved unless the use of first-class accommodations is required (as determined under regulations of the Commissioner of Social Security) because of such person's health condition or the unavailability of alternative accommodations; and the amount available for payment for other travel by any person shall not exceed the cost of travel (between the points involved) by the most economical and expeditious means of transportation appropriate to such person's health condition, as specified in such regulations. The amount available for payment under this subsection for travel by a representative to attend an administrative proceeding before an administrative law judge or other adjudicator shall not exceed the maximum amount allowable under this subsection for such travel originating within the geographic area of the office having jurisdiction over such proceeding.

Payment to States With Respect to Certain Unnegotiated Checks

(i)(1) The Secretary of the Treasury shall, on a monthly basis, notify the Commissioner of Social Security of all benefit checks issued under this title which include amounts representing State supplementary payments as described in paragraph (2) and which have not been presented for payment within one hundred and eighty days after the day on which they were issued.

[100] See Vol. II, P.L. 102–394; 106 Stat. 1807, with respect to limitation on administrative expenses.

(2) The Commissioner of Social Security shall from time to time determine the amount representing the total of the State supplementary payments made pursuant to agreements under section 1616(a) of this Act and under section 212(b) of Public Law 93–66 which is included in all such benefit checks not presented for payment within one hundred and eighty days after the day on which they were issued, and shall pay each State (or credit each State with) an amount equal to that State's share of all such amount. Amounts not paid to the States shall be returned to the appropriation from which they were originally paid.

(3) The Commissioner of Social Security, upon notice from the Secretary of the Treasury under paragraph (1), shall notify any State having an agreement described in paragraph (2) of all such benefit checks issued under that State's agreement which were not presented for payment within one hundred and eighty days after the day on which they were issued.

(4) The Commissioner of Social Security shall, to the maximum extent feasible, investigate the whereabouts and eligibility of the individuals whose benefit checks were not presented for payment within one hundred and eighty days after the day on which they were issued.

Application and Review Requirements for Certain Individuals

(j)(1) Notwithstanding any provision of section 1611 or 1619, any individual who—

(A) was an eligible individual (or eligible spouse) under section 1611 or was eligible for benefits under or pursuant to section 1619, and

(B) who, after such eligibility, is ineligible for benefits under or pursuant to both such sections for a period of 12 consecutive months,

may not thereafter become eligible for benefits under or pursuant to either such section until the individual has reapplied for benefits under section 1611 and been determined to be eligible for benefits under such section, or has filed a request for reinstatement of eligibility under subsection (p)(2) and been determined to be eligible for reinstatement.

(2)(A) Notwithstanding any provision of section 1611 or section 1619 (other than subsection (c) thereof), any individual who was eligible for benefits pursuant to section 1619(b), and who—

(i)(I) on the basis of the same impairment on which his or her eligibility under such section 1619(b) was based becomes eligible (other than pursuant to a request for reinstatement under subsection (p)) for benefits under section 1611 or 1619(a) for a month that follows a period during which the individual was ineligible for benefits under sections 1611 and 1619(a), and

(II) has earned income (other than income excluded pursuant to section 1612(b)) for any month in the 12-month period preceding such month that is equal to or in excess of the amount that would cause him or her to be ineligible for payments under section 1611(b) for that month (if

he or she were otherwise eligible for such payments); or

(ii)(I) on the basis of the same impairment on which his or her eligibility under such section 1619(b) was based becomes eligible under section 1619(b) for a month that follows a period during which the individual was ineligible under section 1611 and section 1619, and

(II) has earned income (other than income excluded pursuant to section 1612(b)) for such month or for any month in the 12-month period preceding such month that is equal to or in excess of the amount that would cause him or her to be ineligible for payments under section 1611(b) for that month (if he or she were otherwise eligible for such payments);

shall, upon becoming eligible (as described in clause (i)(I) or (ii)(I)), be subject to a prompt review of the type described in section 1614(a)(4).

(B) If the Commissioner of Social Security determines pursuant to a review required by subparagraph (A) that the impairment upon which the eligibility of an individual is based has ceased, does not exist, or is not disabling, such individual may not thereafter become eligible for a benefit under or pursuant to section 1611 or section 1619 until the individual has reapplied for benefits under section 1611 and been determined to be eligible for benefits under such section.

Notifications to Applicants and Recipients

(k) The Commissioner of Social Security shall notify an individual receiving benefits under section 1611 on the basis of disability or blindness of his or her potential eligibility for benefits under or pursuant to section 1619—

(1) at the time of the initial award of benefits to the individual under section 1611 (if the individual has attained the age of 18 at the time of such initial award), and

(2) at the earliest time after an initial award of benefits to an individual under section 1611 that the individual's earned income for a month (other than income excluded pursuant to section 1612(b)) is $200 or more, and periodically thereafter so long as such individual has earned income (other than income so excluded) of $200 or more per month.

Special Notice to Blind Individuals with Respect to Hearings and Other Official Actions

(l)(1) In any case where an individual who is applying for or receiving benefits under this title on the basis of blindness is entitled (under subsection (c) or otherwise) to receive notice from the Commissioner of Social Security of any decision or determination made or other action taken or proposed to be taken with respect to his or her rights under this title, such individual shall at his or her election be entitled either (A) to receive a supplementary notice of such decision, determination, or action, by telephone, within 5 working days after the initial notice is mailed, (B) to receive the

initial notice in the form of a certified letter, or (C) to receive notification by some alternative procedure established by the Commissioner of Social Security and agreed to by the individual.

(2) The election under paragraph (1) may be made at any time; but an opportunity to make such an election shall in any event be given (A) to every individual who is an applicant for benefits under this title on the basis of blindness, at the time of his or her application, and (B) to every individual who is a recipient of such benefits on the basis of blindness, at the time of each redetermination of his or her eligibility. Such an election, once made by an individual, shall apply with respect to all notices of decisions, determinations, and actions which such individual may thereafter be entitled to receive under this title until such time as it is revoked or changed.

Pre-release Procedures for Institutionalized Persons

(m) The Commissioner of Social Security shall develop a system under which an individual can apply for supplemental security income benefits under this title prior to the discharge or release of the individual from a public institution.

Concurrent SSI and Food Stamp Applications by Institutionalized Individuals

(n) The Commissioner of Social Security and the Secretary of Agriculture shall develop a procedure under which an individual who applies for supplemental security income benefits under this section shall also be permitted to apply at the same time for participation in the food stamp program authorized under the Food Stamp Act of 1977 [101] (7 U.S.C. 2011 et seq.).

Notice Requirements

(o) The Commissioner of Social Security shall take such actions as are necessary to ensure that any notice to one or more individuals issued pursuant to this title by the Commissioner of Social Security or by a State agency—

(1) is written in simple and clear language, and

(2) includes the address and telephone number of the local office of the Social Security Administration which serves the recipient.

In the case of any such notice which is not generated by a local servicing office, the requirements of paragraph (2) shall be treated as satisfied if such notice includes the address of the local office of the Social Security Administration which services the recipient of the notice and a telephone number through which such office can be reached.

(p)(1)(A) Eligibility for benefits under this title shall be reinstated in any case where the Commissioner determines that an individual described in subparagraph (B) has filed a request for reinstatement meeting the requirements of paragraph (2)(A) during the period prescribed in subparagraph (C). Reinstatement of eligibility shall be in accordance with the terms of this subsection.

(B) An individual is described in this subparagraph if—

[101] P.L. 88–525.

(i) prior to the month in which the individual files a request for reinstatement—

(I) the individual was eligible for benefits under this title on the basis of blindness or disability pursuant to an application filed therefor; and

(II) the individual thereafter was ineligible for such benefits due to earned income (or earned and unearned income) for a period of 12 or more consecutive months;

(ii) the individual is blind or disabled and the physical or mental impairment that is the basis for the finding of blindness or disability is the same as (or related to) the physical or mental impairment that was the basis for the finding of blindness or disability that gave rise to the eligibility described in clause (i);

(iii) the individual's blindness or disability renders the individual unable to perform substantial gainful activity; and

(iv) the individual satisfies the nonmedical requirements for eligibility for benefits under this title.

(C)(i) Except as provided in clause (ii), the period prescribed in this subparagraph with respect to an individual is 60 consecutive months beginning with the month following the most recent month for which the individual was eligible for a benefit under this title (including section 1619) prior to the period of ineligibility described in subparagraph (B)(i)(II).

(ii) In the case of an individual who fails to file a reinstatement request within the period prescribed in clause (i), the Commissioner may extend the period if the Commissioner determines that the individual had good cause for the failure to so file.

(2)(A)(i) A request for reinstatement shall be filed in such form, and containing such information, as the Commissioner may prescribe.

(ii) A request for reinstatement shall include express declarations by the individual that the individual meets the requirements specified in clauses (ii) through (iv) of paragraph (1)(B).

(B) A request for reinstatement filed in accordance with subparagraph (A) may constitute an application for benefits in the case of any individual who the Commissioner determines is not eligible for reinstated benefits under this subsection.

(3) In determining whether an individual meets the requirements of paragraph (1)(B)(ii), the provisions of section 1614(a)(4) shall apply.

(4)(A) Eligibility for benefits reinstated under this subsection shall commence with the benefit payable for the month following the month in which a request for reinstatement is filed.

(B)(i) Subject to clause (ii), the amount of the benefit payable for any month pursuant to the reinstatement of eligibility under this subsection shall be determined in accordance with the provisions of this title.

(ii) The benefit under this title payable for any month pursuant to a request for reinstatement filed in

accordance with paragraph (2) shall be reduced by the amount of any provisional benefit paid to such individual for such month under paragraph (7).

(C) Except as otherwise provided in this subsection, eligibility for benefits under this title reinstated pursuant to a request filed under paragraph (2) shall be subject to the same terms and conditions as eligibility established pursuant to an application filed therefor.

(5) Whenever an individual's eligibility for benefits under this title is reinstated under this subsection, eligibility for such benefits shall be reinstated with respect to the individual's spouse if such spouse was previously an eligible spouse of the individual under this title and the Commissioner determines that such spouse satisfies all the requirements for eligibility for such benefits except requirements related to the filing of an application. The provisions of paragraph (4) shall apply to the reinstated eligibility of the spouse to the same extent that they apply to the reinstated eligibility of such individual.

(6) An individual to whom benefits are payable under this title pursuant to a reinstatement of eligibility under this subsection for twenty–four months (whether or not consecutive) shall, with respect to benefits so payable after such twenty-fourth month, be deemed for purposes of paragraph (1)(B)(i)(I) to be eligible for such benefits on the basis of an application filed therefor.

(7)(A) An individual described in paragraph (1)(B) who files a request for reinstatement in accordance with the provisions of paragraph (2)(A) shall be eligible for provisional benefits payable in accordance with this paragraph, unless the Commissioner determines that the individual does not meet the requirements of paragraph (1)(B)(i) or that the individual's declaration under paragraph (2)(A)(ii) is false. Any such determination by the Commissioner shall be final and not subject to review under paragraph (1) or (3) of subsection (c).

(B)(i) Except as otherwise provided in clause (ii), the amount of a provisional benefit for a month shall equal the amount of the monthly benefit that would be payable to an eligible individual under this title with the same kind and amount of income.

(ii) If the individual has a spouse who was previously an eligible spouse of the individual under this title and the Commissioner determines that such spouse satisfies all the requirements of section 1614(b) except requirements related to the filing of an application, the amount of a provisional benefit for a month shall equal the amount of the monthly benefit that would be payable to an eligible individual and eligible spouse under this title with the same kind and amount of income.

(C)(i) Provisional benefits shall begin with the month following the month in which a request for reinstatement is filed in accordance with paragraph (2)(A).

(ii) Provisional benefits shall end with the earliest of—

(I) the month in which the Commissioner makes a determination regarding the individual's eligibility for reinstated benefits;

(II) the fifth month following the month for which provisional benefits are first payable under clause (i); or

(III) the month in which the Commissioner determines that the individual does not meet the requirements of paragraph (1)(B)(i) or that the individual's declaration made in accordance with paragraph (2)(A)(ii) is false.

(D) In any case in which the Commissioner determines that an individual is not eligible for reinstated benefits, any provisional benefits paid to the individual under this paragraph shall not be subject to recovery as an overpayment unless the Commissioner determines that the individual knew or should have known that the individual did not meet the requirements of paragraph (1)(B).

(8) For purposes of this subsection other than paragraph (7), the term "benefits under this title" includes State supplementary payments made pursuant to an agreement under section 1616(a) of this Act or section 212(b) of Public Law 93–66.

PENALTIES FOR FRAUD [102]

SEC. 1632. [42 U.S.C. 1383a] (a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to any such benefit,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit, or (B) the initial or continued right to any such benefit of any other individual in whose behalf he has applied for or is receiving such benefit, conceals or fails to disclose such event with an intent fraudulently to secure such benefit either in a greater amount or quantity than is due or when no such benefit is authorized, or

(4) having made application to receive any such benefit for the use and benefit of another and having received it, knowingly and willfully converts such benefit or any part thereof to a use other than for the use and benefit of such other person,

shall be fined under title 18, United States Code, imprisoned not more than 5 years, or both

(b) [103] (1) Any Federal court, when sentencing a defendant convicted of an offense under subsection (a), may order, in addition to or in lieu of any other penalty authorized by law, that the defendant make restitution to the Commissioner of Social Security, in any case in which such offense results in--

[102] See Vol. II, 18 U.S.C. 1028 and 1738, with respect to penalties relating to use of identification documents.

[103] P.L. 108-203, §209(c)(2), added this subsection (b), applicable with respect to violations occurring on or after March 2, 2004.

(A) the Commissioner of Social Security making a benefit payment that should not have been made, or

(B) an individual suffering a financial loss due to the defendant's violation of subsection (a) in his or her capacity as the individual's representative payee appointed pursuant to section 1631(a)(2).

(2) Sections 3612, 3663, and 3664 of title 18, United States Code [104], shall apply with respect to the issuance and enforcement of orders of restitution under this subsection. In so applying such sections, the Commissioner of Social Security shall be considered the victim.

(3) If the court does not order restitution, or orders only partial restitution, under this subsection, the court shall state on he record the reasons therefor.

(4)(A) Except as provided in subparagraph (B), funds paid to the Commissioner of Social Security as restitution pursuant to a court order shall be deposited as miscellaneous receipts in the general fund of the Treasury.

(B) In the case of funds paid to the Commissioner of Social Security pursuant to paragraph (1)(B), the Commissioner of Social Security shall certify for payment to the individual described in such paragraph an amount equal to the lesser of the amount of the funds so paid or the individual's outstanding financial loss as described in such paragraph, except that such amount may be reduced by any overpayment of benefits owed under this title, title II, or title VIII by the individual.

(c) [105] Any person or entity convicted of a violation of subsection (a) of this section or section 208 may not be certified as a representative payee under section 1631(a)(2).

ADMINISTRATION

SEC. 1633. [42 U.S.C. 1383b] (a) Subject to subsection (b), the Commissioner of Social Security may make such administrative and other arrangements (including arrangements for the determination of blindness and disability under section 1614(a)(2) and (3) in the same manner and subject to the same conditions as provided with respect to disability determinations under section 221) as may be necessary or appropriate to carry out the Commissioner's functions under this title.

(b) In determining, for purposes of this title, whether an individual is blind, there shall be an examination of such individual by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select.

(c)(1) In any case in which the Commissioner of Social Security initiates a review under this title, similar to the continuing disability reviews authorized for purposes of title II under section 221(i), the Commissioner of Social Security shall notify the individual whose case is to be reviewed in the same manner as required under section 221(i)(4).

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[104] See Vol. II, Title 18 U.S.C. 3612, 3663 and 3664.

[105] P.L. 108-203, §209(c)(1), redesignated the former subsection (b) as subsection (c).

P.L. 108-203, §209(c)(3), struck out paragraph (1) and struck out "(2)", applicable with respect to violations occurring on or after March 2, 2004.

(2) For suspension of continuing disability reviews and other reviews under this title similar to reviews under section 221 in the case of an individual using a ticket to work and self–sufficiency, see section 1148(i).

(d) The Commissioner of Social Security shall establish by regulation criteria for time limits and other criteria related to individuals' plans for achieving self-support, that take into account—

(1) the length of time that the individual will need to achieve the individual's employment goal (within such reasonable period as the Commissioner of Social Security may establish); and

(2) other factors determined by the Commissioner of Social Security to be appropriate.

DETERMINATIONS OF MEDICAID ELIGIBILITY [106]

SEC. 1634. [42 U.S.C. 1383c] (a) The Commissioner of Social Security may enter into an agreement with any State which wishes to do so under which the Commissioner will determine eligibility for medical assistance in the case of aged, blind, or disabled individuals under such State's plan approved under title XIX. Any such agreement shall provide for payments by the State, for use by the Commissioner of Social Security in carrying out the agreement, of an amount equal to one-half of the cost of carrying out the agreement, but in computing such cost with respect to individuals eligible for benefits under this title, the Commissioner of Social Security shall include only those costs which are additional to the costs incurred in carrying out this title.

(b)(1) An eligible disabled widow or widower (described in paragraph (2)) who is entitled to a widow's or widower's insurance benefit based on a disability for any month under section 202(e) or (f) but is not eligible for benefits under this title in that month, and who applies for the protection of this subsection under paragraph (3), shall be deemed for purposes of title XIX to be an individual with respect to whom benefits under this title are paid in that month if he or she—

(A) has been continuously entitled to such widow's or widower's insurance benefits from the first month for which the increase described in paragraph (2)(C) was reflected in such benefits through the month involved, and

(B) would be eligible for benefits under this title in the month involved if the amount of the increase described in paragraph (2)(C) in his or her widow's or widower's insurance benefits, and any subsequent cost-of-living adjustments in such benefits under section 215(i), were disregarded.

(2) For purposes of paragraph (1), the term "eligible disabled widow or widower" means an individual who—

(A) was entitled to a monthly insurance benefit under title II for December 1983,

(B) was entitled to a widow's or widower's insurance benefit based on a disability under section 202(e) or (f) for January 1984 and with respect to whom a benefit under this title was paid in that month, and

[106] See Vol. II, P.L. 94–566, §503, with respect to preservation of medicaid eligibility.

(C) because of the increase in the amount of his or her widow's or widower's insurance benefits which resulted from the amendments made by section 134 of the Social Security Amendments of 1983 (Public Law 98–21) (eliminating the additional reduction factor for disabled widows and widowers under age 60), was ineligible for benefits under this title in the first month in which such increase was paid to him or her (and in which a retroactive payment of such increase for prior months was not made).

(3) This subsection shall only apply to an individual who files a written application for protection under this subsection, in such manner and form as the Commissioner of Social Security may prescribe, no later than July 1, 1988.

(4) For purposes of this subsection, the term "benefits under this title" includes payments of the type described in section 1616(a) or of the type described in section 212(a) of Public Law 93–66. [107]

(c) If any individual who has attained the age of 18 and is receiving benefits under this title on the basis of blindness or a disability which began before he or she attained the age of 22—

(1) becomes entitled, on or after the effective date of this subsection, to child's insurance benefits which are payable under section 202(d) on the basis of such disability or to an increase in the amount of the child's insurance benefits which are so payable, and

(2) ceases to be eligible for benefits under this title because of such child's insurance benefits or because of the increase in such child's insurance benefits,

such individual shall be treated for purposes of title XIX as receiving benefits under this title so long as he or she would be eligible for benefits under this title in the absence of such child's insurance benefits or such increase. [108]

(d)(1) This subsection applies with respect to any person who—

(A) applies for and obtains benefits under subsection (e) or (f) of section 202 (or under any other subsection of section 202 if such person is also eligible for benefits under such subsection (e) or (f)) being then not entitled to hospital insurance benefits under part A of title XVIII, and

(B) is determined to be ineligible (by reason of the receipt of such benefits under section 202) for supplemental security income benefits under this title or for State supplementary payments of the type described in section 1616(a) (or payments of the type described in section 212(a) of Public Law 93–66).

(2) For purposes of title XIX, each person with respect to whom this subsection applies—

(A) shall be deemed to be a recipient of supplemental security income benefits under this title if such person received such a benefit for the month before the month in which such person began to receive a benefit described in paragraph (1)(A), and

(B) shall be deemed to be a recipient of State supplementary payments of the type referred to in section

[107] See Vol. II, P.L. 93–66.
[108] See Vol. II, P.L. 99–643, §6(b), with respect to State determinations.

1616(a) of this Act (or payments of the type described in section 212(a) of Public Law 93–66) if such person received such a payment for the month before the month in which such person began to receive a benefit described in paragraph (1)(A),

for so long as such person (i) would be eligible for such supplemental security income benefits, or such State supplementary payments (or payments of the type described in section 212(a) of Public Law 93–66), in the absence of benefits described in paragraph (1)(A), and (ii) is not entitled to hospital insurance benefits under part A of title XVIII.

OUTREACH PROGRAM FOR CHILDREN

SEC. 1635. [42 U.S.C. 1383d] (a) Establishment.—The Commissioner of Social Security shall establish and conduct an ongoing program of outreach to children who are potentially eligible for benefits under this title by reason of disability or blindness.

(b) REQUIREMENTS.—Under this program, the Commissioner of Social Security shall—

(1) aim outreach efforts at populations for whom such efforts would be most effective; and

(2) work in cooperation with other Federal, State, and private agencies, and nonprofit organizations, which serve blind or disabled individuals and have knowledge of potential recipients of supplemental security income benefits, and with agencies and organizations (including school systems and public and private social service agencies) which focus on the needs of children.

TREATMENT REFERRALS FOR INDIVIDUALS WITH AN ALCOHOLISM OR DRUG ADDICTION CONDITION

SEC. 1636. [42 U.S.C. 1383e] In the case of any individual whose benefits under this title are paid to a representative payee pursuant to section 1631(a)(2)(A)(ii)(II), the Commissioner of Social Security shall refer such individual to the appropriate State agency administering the State plan for substance abuse treatment services approved under subpart II of part B of title XIX of the Public Health Service Act (42 U.S.C. 300x–21 et seq.).

ANNUAL REPORT ON PROGRAM

SEC. 1637. [42 U.S.C. 1383f] (a) Not later than May 30 of each year, the Commissioner of Social Security shall prepare and deliver a report annually to the President and the Congress regarding the program under this title, including—

(1) a comprehensive description of the program;

(2) historical and current data on allowances and denials, including number of applications and allowance rates for initial determinations, reconsideration determinations, administrative law judge hearings, appeals council reviews, and Federal court decisions;

(3) historical and current data on characteristics of recipients and program costs, by recipient group (aged, blind, disabled adults, and disabled children);

(4) historical and current data on prior enrollment by recipients in public benefit programs, including State programs funded under part A of title IV of the Social Security Act and State general assistance programs;

(5) projections of future number of recipients and program costs, through at least 25 years;

(6) number of redeterminations and continuing disability reviews, and the outcomes of such redeterminations and reviews;

(7) data on the utilization of work incentives;

(8) detailed information on administrative and other program operation costs;

(9) summaries of relevant research undertaken by the Social Security Administration, or by other researchers;

(10) State supplementation program operations;

(11) a historical summary of statutory changes to this title; and

(12) such other information as the Commissioner deems useful.

(b) Each member of the Social Security Advisory Board shall be permitted to provide an individual report, or a joint report if agreed, of views of the program under this title, to be included in the annual report required under this section.

TITLE XVII—GRANTS FOR PLANNING COMPREHENSIVE ACTION TO COMBAT MENTAL RETARDATION [1]

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AUTHORIZATION OF APPROPRIATIONS

SEC. 1701. [42 U.S.C. 1391] For the purpose of assisting the States (including the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa) to plan for and take other steps leading to comprehensive State and community action to combat mental retardation, there is authorized to be appropriated the sum of $2,200,000. There are also authorized to be appropriated, for assisting such States in initiating the implementation and carrying out of planning and other steps to combat mental retardation, $2,750,000 for the fiscal year ending June 30, 1966, and $2,750,000 for the fiscal year ending June 30, 1967.

GRANTS TO STATES

SEC. 1702. [42 U.S.C. 1392] The sums appropriated pursuant to the first sentence of section 1701 shall be available for grants to States by the Secretary during the fiscal year ending June 30, 1964, and the succeeding fiscal year; and the sums appropriated pursuant to the second sentence of such section for the fiscal year ending June 30, 1966, shall be available for such grants during such year and the next two fiscal years, and sums appropriated pursuant thereto for the fiscal year ending June 30, 1967, shall be available for such grants during such year and the succeeding fiscal year. Any such grant to a State, which shall not exceed 75 per centum of the cost of the planning and related activities involved, may be used by it to determine what action is needed to combat mental retardation in the State and the resources available for this

[1] Title XVII of the Social Security Act is administered by the Rehabilitation Services Administration, Office of Special Education and Rehabilitative Services, Department of Education.

Title XVII appears in the United States Code as §§1391–1394, subchapter XVII, chapter 7, Title 42.

No regulations have been promulgated for Title XVII.

Title XVII was added to the Social Security Act by P.L. 88–156, "Maternal and Child Health and Mental Retardation Planning Amendments of 1963", §5 (77 Stat. 273, 275), effective October 24, 1963; however, it now is inactive.

[2] This table of contents does not appear in the law.

purpose, to develop public awareness of the mental retardation problem and of the need for combating it, to coordinate State and local activities relating to the various aspects of mental retardation and its prevention, treatment, or amelioration, and to plan other activities leading to comprehensive State and community action to combat mental retardation.

APPLICATIONS

SEC. 1703. [42 U.S.C. 1393] In order to be eligible for a grant under section 1702, a State must submit an application therefor which—

(1) designates or establishes a single State agency, which may be an interdepartmental agency, as the sole agency for carrying out the purposes of this title;

(2) indicates the manner in which provision will be made to assure full consideration of all aspects of services essential to planning for comprehensive State and community action to combat mental retardation, including services in the fields of education, employment, rehabilitation, welfare, health, and the law, and services provided through community programs for and institutions for the mentally retarded;

(3) sets forth its plans for expenditure of such grant, which plans provide reasonable assurance of carrying out the purposes of this title;

(4) provides for submission of a final report of the activities of the State agency in carrying out the purposes of this title, and for submission of such other reports, in such form and containing such information, as the Secretary[3] may from time to time find necessary for carrying out the purposes of this title and for keeping such records and affording such access thereto as he may find necessary to assure the correctness and verification of such reports; and

(5) provides for such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement of and accounting for funds paid to the State under this title.

PAYMENTS

SEC. 1704. [42 U.S.C. 1394] Payment of grants under this title may be made (after necessary adjustment on account of previously made underpayments or overpayments) in advance or by way of reimbursement, and in such installments and on such conditions, as the Secretary may determine.

[3] P.L. 88–156, §6, provides that the term "Secretary" means the Secretary of Health, Education, and Welfare [now Secretary of Health and Human Services].

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED [1]

[1] Title XVIII of the Social Security Act is administered by the Centers for Medicare and Medicaid Services.

Title XVIII appears in the United States Code as §§1395–1395ccc, subchapter XVIII, chapter 7, Title 42.

Regulations of the Secretary of Health and Human Services relating to Title XVIII are contained in chapter IV, Title 42, and in subtitle A, Title 45, Code of Federal Regulations.

See Vol. II, P.L. 78–410, §353(i)(3) and (n), with respect to clinical laboratories.

See Vol. II, P.L. 88–352, §601, for prohibition against discrimination in Federally assisted programs.

See Vol. II, P.L. 89–73, §§203 and 422(c), with respect to consultation with respect to programs and services for the aged.

See Vol. II, P.L. 93–288, §312(d), with respect to exclusion from income and resources of certain Federal major disaster and emergency assistance.

See Vol. II, P.L. 95–250, §201(19), with respect to trust fund contributions, and §204(b)(4), with respect to Title XVIII ineligibility.

See Vol. II, P.L. 95–521, §102(i), with respect to reporting of benefits received under the Social Security Act.

See Vol. II, P.L. 97–248, §119, with respect to private sector review initiative and restriction against recovery from beneficiaries.

See Vol. II, P.L. 98–369, §2355, with respect to waivers for social health maintenance organizations.

See Vol. II, P.L. 99–177, §257(b)(3) and (c)(3), with respect to the calculation of the baseline.

See Vol. II, P.L. 99–272, §9220, with respect to extension, terms, conditions, and period of approval of the extension of On Lok waiver; and §9215, with respect to the extension of certain medicare health services demonstration projects.

See Vol. II, P.L. 99–319, §105, with respect to systems requirements.

See Vol. II, P.L. 99–509, §9339(d) with respect to State standards for directors of clinical laboratories; §9342 with respect to Alzheimer's disease demonstration projects; §9353(a)(4) with respect to a small-area analysis; and §9412 with respect to the waiver authority for chronically mentally ill and frail elderly.

See Vol. II, P.L. 99–660, Title IV, with respect to professional review activities.

See Vol. II, P.L. 100–203, §4008(d)(3), with respect to a report regarding hospital outlier payments.

See Vol. II, P.L. 100–204, §724(d), with respect to furnishing information to the United States Commission on Improving the Effectiveness of the United Nations; and §725(b), with respect to the detailing of Government personnel.

See Vol. II, P.L. 100–235, §§5–8, with respect to responsibilities of each Federal agency for computer systems security and privacy.

See Vol. II, P.L. 100–383, §§105(f)(2) and 206(d)(2), with respect to exclusions from income and resources of certain payments to certain individuals.

See Vol. II, P.L. 100–407, §105(g), with respect to the effect of financial assistance under that Act.

See Vol. II, P.L. 100–411, §2(d)(3)(B), with respect to the effect of per capita payments.

See Vol. II, P.L. 100–581, §§501, 502(b)(1), and 503, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 100–647, §8411, with respect to treatment of certain nursing education programs.

See Vol. II, P.L. 100–690, §5301(a)(1)(C) and (d)(1)(B), with respect to benefits of drug traffickers and possessors.

See Vol. II, P.L. 100–713, §712, with respect to the provision of services in Montana.

See Vol. II, P.L. 101–121, with respect to the amounts collected by the Secretary of Health and Human Services under the authority of title IV of the Indian Health Care Improvement Act.

See Vol. II, P.L. 101–239, §6025, with respect to a dentist's serving as hospital medical director; §6205(a)(1)(A) and (a)(2), with respect to recognition of costs of certain hospital-based nursing schools.

See Vol. II, P.L. 101–508, §4008(i)(1), with respect to Secretarial waiver authority; §4008(k), with respect to the prospective payment system for skilled nursing facility services; §4161(b)(3), with respect to productivity screens; §4207(b)(1), with respect to the prohibition of cost savings policies before the beginning of the fiscal year; §4207(b)(2), with respect to the prohibition of payment cycle changes; §4207(c), with respect to the development of a prospective payment system for home health services; §4359, with respect to health insurance advisory service for medi-

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See Vol. II, P.L. 103–432, §154, with respect to the qualified medicare beneficiary outreach.

See Vol. II, P.L. 104–134, §516(d), with respect to a study and report on deeming for nursing facilities and renal dialysis facilities.

See Vol. II, P.L. 105–13, §1, with respect to the extension of term of appointment of certain members of the Prospective Payment Assessment Commission and the Physician Payment Review Commission.

See Vol. II, P.L. 105–33, §4002(c), with respect to an enrollment transition rule; §4011, with respect to Medicare+Choice competitive pricing demonstration project; §4012, with respect to advisory committees; §4014(c), with respect to the report on integration and transition; §4016, with respect to Medicare Coordinated Care Demonstration Project; §4021, with respect to a National Bipartisan Commission on the future of Medicare; §4207, with the Informatics, Telemedicine, and Education Demonstration Project; §4611(e), with respect to a transition for the aggregate amount of expenditures transferred from part A to part B of title XVIII; §4018, with respect to the Medicare enrollment demonstration project; §4019, with respect to an extension of certain Medicare community nursing organization demonstration projects; §4022(c)(3), with respect to continuing responsibility for reports; §4031(e), with respect to transition provisions; §4105(c), with respect to the establishment of outcome measures for beneficiaries with diabetes; §4107, with respect to the vaccines outreach expansion; §4108, with respect to a study on preventive and enhanced benefits; §4206, with respect to Medicare reimbursement for Telehealth services; §4315(d), with respect to developing a fee schedule for particular services; §4432(c), with respect to a medical review process; §4506, with respect to dissemination of information on high per discharge relative values for in–hospital physicians' services; §4513(c), with respect to utilization guidelines; §4532, with respect to demonstration of coverage of ambulance services under Medicare through contracts with units of local government; §4551(b), with respect to payment freeze for parental and eternal nutrients, supplies, and equipment; §4552(c), with respect to service standards for persons seeking payment under part B of title XVIII; §4552(d), with respect to access to home oxygen equipment; §4553(c), with respect to a study and report on clinical laboratory tests; §4554, with respect to improvements in administration of laboratory tests benefit; §4558, with respect to renal dialysis–related services; §4602(e), with respect to the submission of data for case mix system; §4616, with respect to reports to Congress regarding home health cost containment; §4628, with respect to a demonstration project on use of consortia; §4629, with respect to recommendations on long–term policies regarding teaching hospitals and graduate medical education.

See Vol. II, P.L. 106–554, §1(a)(6) [121], with respect to a demonstration project for disease management for severely chronically ill Medicare beneficiaries; [122], with respect to cancer prevention and treatment demonstrations for ethnic and racial minorities; and [128] with respect to a lifestyle modification program demonstration.

See Vol. II, P.L. 108-203, §413, with respect to the reinstatement of certain reporting requirements.

[2] This table of contents does not appear in the law.

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PROHIBITION AGAINST ANY FEDERAL INTERFERENCE

SEC. 1801. [42 U.S.C. 1395] Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

FREE CHOICE BY PATIENT GUARANTEED

SEC. 1802. [42 U.S.C. 1395a] (a) BASIC FREEDOM OF CHOICE.—Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide him such services.

(b) USE OF PRIVATE CONTRACTS BY MEDICARE BENEFICIARIES.—

(1) IN GENERAL.—Subject to the provisions of this subsection, nothing in this title shall prohibit a physician or practitioner from entering into a private contract with a medicare beneficiary for any item or service—

(A) for which no claim for payment is to be submitted under this title, and

(B) for which the physician or practitioner receives—

(i) no reimbursement under this title directly or on a capitated basis, and

(ii) receives no amount for such item or service from an organization which receives reimbursement for such item or service under this title directly or on a capitated basis.

(2) BENEFICIARY PROTECTIONS.—

(A) IN GENERAL.—Paragraph (1) shall not apply to any contract unless—

(i) the contract is in writing and is signed by the medicare beneficiary before any item or service is provided pursuant to the contract;

(ii) the contract contains the items described in subparagraph (B); and

(iii) the contract is not entered into at a time when the medicare beneficiary is facing an emergency or urgent health care situation.

(B) ITEMS REQUIRED TO BE INCLUDED IN CONTRACT.—Any contract to provide items and services to which paragraph (1) applies shall clearly indicate to the medicare beneficiary that by signing such contract the beneficiary—

(i) agrees not to submit a claim (or to request that the physician or practitioner submit a claim) under this title for such items or services even if such items or services are otherwise covered by this title;

(ii) agrees to be responsible, whether through insurance or otherwise, for payment of such items or services and understands that no reimbursement will be provided under this title for such items or services;

(iii) acknowledges that no limits under this title (including the limits under section 1848(g)) apply to amounts that may be charged for such items or services;

(iv) acknowledges that Medigap plans under section 1882 do not, and other supplemental insurance plans may elect not to, make payments for such items and services because payment is not made under this title; and

(v) acknowledges that the medicare beneficiary has the right to have such items or services provided by other physicians or practitioners for whom payment would be made under this title.

Such contract shall also clearly indicate whether the physician or practitioner is excluded from participation under the medicare program under section 1128.

(3) PHYSICIAN OR PRACTITIONER REQUIREMENTS.—

(A) IN GENERAL.—Paragraph (1) shall not apply to any contract entered into by a physician or practitioner unless an affidavit described in subparagraph (B) is in effect during the period any item or service is to be provided pursuant to the contract.

(B) AFFIDAVIT.—An affidavit is described in this subparagraph if—

(i) the affidavit identifies the physician or practitioner and is in writing and is signed by the physician or practitioner;

(ii) the affidavit provides that the physician or practitioner will not submit any claim under this title for any item or service provided to any medicare beneficiary (and will not receive any reimbursement or amount described in paragraph (1)(B) for any such item or service) during the 2–year period beginning on the date the affidavit is signed; and

(iii) a copy of the affidavit is filed with the Secretary no later than 10 days after the first contract to which such affidavit applies is entered into.

(C) ENFORCEMENT.—If a physician or practitioner signing an affidavit under subparagraph (B) knowingly and willfully submits a claim under this title for any item or service provided during the 2–year period described in subparagraph (B)(ii) (or receives any reimbursement or amount described in paragraph (1)(B) for any such item or service) with respect to such affidavit—

(i) this subsection shall not apply with respect to any items and services provided by the physician or practitioner pursuant to any contract on and after the date of such submission and before the end of such period; and

(ii) no payment shall be made under this title for any item or service furnished by the physician or practitioner during the period described in clause (i) (and no reimbursement or payment of any amount described in paragraph (1)(B) shall be made for any such item or service).

(4) LIMITATION ON ACTUAL CHARGE AND CLAIM SUBMISSION REQUIREMENT NOT APPLICABLE.—Section 1848(g) shall not apply with respect to any item or service provided to a medicare beneficiary under a contract described in paragraph (1).

(5) DEFINITIONS.—In this subsection:

(A) MEDICARE BENEFICIARY.—The term "medicare beneficiary" means an individual who is entitled to benefits under part A or enrolled under part B.

(B) PHYSICIAN.—The term "physician" has the meaning given such term by paragraphs (1), (2), (3), and (4) of section 1861(r)[3].

(C) PRACTITIONER.—The term "practitioner" has the meaning given such term by section 1842(b)(18)(C).

OPTION TO INDIVIDUALS TO OBTAIN OTHER HEALTH INSURANCE PROTECTION

SEC. 1803. [42 U.S.C. 1395b] Nothing contained in this title shall be construed to preclude any State from providing, or any individual from purchasing or otherwise securing, protection against the cost of any health services.

[3] P.L. 108-173, §603, struck out "section 1861(r)(1)" and substituted "paragraphs (1), (2), (3), and (4) of section 1861(r)", effective December 8, 2003.

NOTICE OF MEDICARE BENEFITS: MEDICARE AND MEDIGAP INFORMATION[4]

SEC. 1804. [42 U.S.C. 1395b-2] (a) The Secretary shall prepare (in consultation with groups representing the elderly and with health insurers) and provide for distribution of a notice containing—

(1) a clear, simple explanation of the benefits available under this title and the major categories of health care for which benefits are not available under this title,

(2) the limitations on payment (including deductibles and coinsurance amounts) that are imposed under this title, and

(3) a description of the limited benefits for long-term care services available under this title and generally available under State plans approved under title XIX.

Such notice shall be mailed annually to individuals entitled to benefits under part A or part B of this title and when an individual applies for benefits under part A or enrolls under part B.

(b) The Secretary shall provide information via a toll-free telephone number on the programs under this title. The Secretary shall provide, through the toll-free telephone number 1-800-MEDICARE, for a means by which individuals seeking information about, or assistance with, such programs who phone such toll-free number are transferred (without charge) to appropriate entities for the provision of such information or assistance. Such toll-free number shall be the toll-free number listed for general information and assistance in the annual notice under subsection (a) instead of the listing of numbers of individual contractors.[5]

(c) The notice provided under subsection (a) shall include—

(1) a statement which indicates that because errors do occur and because medicare fraud, waste, and abuse is a significant problem, beneficiaries should carefully check any explanation of benefits or itemized statement furnished pursuant to section 1806 for accuracy and report any errors or questionable charges by calling the toll–free phone number described in paragraph (4);

(2) a statement of the beneficiary's right to request an itemized statement for medicare items and services (as provided in section 1806(b));

(3) a description of the program to collect information on medicare fraud and abuse established under section 203(b) of the Health Insurance Portability and Accountability Act of 1996; and

(4) a toll–free telephone number maintained by the Inspector General in the Department of Health and Human Services for the receipt of complaints and information about waste, fraud, and abuse in the provision or billing of services under this title.

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[4] See Vol. II, P.L. 101–239, §6011(b), with respect to determining the payment amount for services to hemophilia inpatients.

[5] P.L. 108–173, §923(d)(1), added these (second and third) sentences for subsection (b), effective December 8, 2003.

See Vol. II, P.L. 108–173, §923(d)(2), with respect to a study and report on the accuracy and consistency of information provided through the toll-free telephone number 1-800-MEDICARE.

MEDICARE PAYMENT ADVISORY COMMISSION

SEC. 1805. [42 U.S.C. 1395b–6] (a) ESTABLISHMENT.—There is hereby established the Medicare Payment Advisory Commission (in this section referred to as the "Commission").

(b) DUTIES.—

(1) REVIEW OF PAYMENT POLICIES AND ANNUAL REPORTS.—The Commission shall—

(A) review payment policies under this title, including the topics described in paragraph (2);

(B) make recommendations to Congress concerning such payment policies;

(C) by not later than March 1 of each year (beginning with 1998), submit a report to Congress containing the results of such reviews and its recommendations concerning such policies; and

(D) by not later than June 15 of each year, submit a report to Congress containing an examination of issues affecting the medicare program, including the implications of changes in health care delivery in the United States and in the market for health care services on the medicare program and including a review of the estimate of the conversion factor submitted under section 1848(d)(1)(E)(ii).

(2) SPECIFIC TOPICS TO BE REVIEWED.—

(A) MEDICARE+CHOICE PROGRAM.—Specifically, the Commission shall review, with respect to the Medicare+Choice program under part D, the following:

(i) The methodology for making payment to plans under such program, including the making of differential payments and the distribution of differential updates among different payment areas.

(ii) The mechanisms used to adjust payments for risk and the need to adjust such mechanisms to take into account health status of beneficiaries.

(iii) The implications of risk selection both among Medicare+Choice organizations and between the Medicare+Choice option and the original medicare fee–for–service option.

(iv) The development and implementation of mechanisms to assure the quality of care for those enrolled with Medicare+Choice organizations.

(v) The impact of the Medicare+Choice program on access to care for medicare beneficiaries.

(vi) Other major issues in implementation and further development of the Medicare+Choice program.

(B) ORIGINAL MEDICARE FEE–FOR–SERVICE SYSTEM.—Specifically, the Commission shall review payment policies under parts A and B, including—

(i) the factors affecting expenditures for the efficient provision of[6] services in different sectors, including the process for updating hospital, skilled nursing facility, physician, and other fees,

(ii) payment methodologies, and

(iii) their relationship to access and quality of care for medicare beneficiaries.

[6] P.L. 108–173, §735(b), added "the efficient provision of", effective December 8, 2003.

(C) INTERACTION OF MEDICARE PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—Specifically, the Commission shall review the effect of payment policies under this title on the delivery of health care services other than under this title and assess the implications of changes in health care delivery in the United States and in the general market for health care services on the medicare program.

(3) COMMENTS ON CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to payment policies under this title, the Secretary shall transmit a copy of the report to the Commission. The Commission shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress written comments on such report. Such comments may include such recommendations as the Commission deems appropriate.

(4) AGENDA AND ADDITIONAL REVIEWS.—The Commission shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding the Commission's agenda and progress towards achieving the agenda. The Commission may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title as may be requested by such chairmen and members and as the Commission deems appropriate.

(5) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

(6) APPROPRIATE COMMITTEES OF CONGRESS.—For purposes of this section, the term appropriate committees of Congress' means the Committees on Ways and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate.

(7) VOTING AND REPORTING REQUIREMENTS.—With respect to each recommendation contained in a report submitted under paragraph (1), each member of the Commission shall vote on the recommendation, and the Commission shall include, by member, the results of that vote in the report containing the recommendation.

(8)[7] EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, the Commission shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities.

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 17 members appointed by the Comptroller General.

(2) QUALIFICATIONS.—

(A) IN GENERAL.—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, actuarial

[7] P.L. 108–173, §735(a), added paragraph (8), effective December 8, 2003.

science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians, and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

(B) INCLUSION.—The membership of the Commission shall include (but not be limited to) physicians and other health professionals, experts in the area of pharmaco-economics or prescription drug benefit programs,[8] employers, third–party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include representatives of consumers and the elderly.

(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under this title shall not constitute a majority of the membership of the Commission.

(D) ETHICAL DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members. Members of the Commission shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95-521).[9]

(3) TERMS.—

(A) IN GENERAL.—The terms of members of the Commission shall be for 3 years except that the Comptroller General shall designate staggered terms for the members first appointed.

(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

(4) COMPENSATION.—While serving on the business of the Commission (including traveltime), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the Commission. Physicians serving

[8] P.L. 108–173, §735(e)(1), inserted "experts in the area of pharmaco-economics or prescription drug benefit programs," effective December 8, 2003; §735(e)(2) provided that "The Comptroller General of the United States shall ensure that the membership of the Commission complies with the amendment made by paragraph (1) with respect to appointments made on or after the date of the enactment of this Act". (December 8, 2003)

[9] P.L. 108–173, §735(c)(1), added this second sentence to subparagraph (D), effective January 1, 2004.

as personnel of the Commission may be provided a physician comparability allowance by the Commission in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code [10], and for such purpose subsection (i) of such section shall apply to the Commission in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

(5) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General shall designate a member of the Commission, at the time of appointment of the member as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General may designate another member for the remainder of that member's term.

(6) MEETINGS.—The Commission shall meet at the call of the Chairman.

(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General deems necessary to assure the efficient administration of the Commission, the Commission may—

(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5)) [11];

(4) make advance, progress, and other payments which relate to the work of the Commission;

(5) provide transportation and subsistence for persons serving without compensation; and

(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

(e) POWERS.—

(1) OBTAINING OFFICIAL DATA.—The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to the Commission on an agreed upon schedule.

(2) DATA COLLECTION.—In order to carry out its functions, the Commission shall—

[10] See Vol. II, Title 5, §5948.
[11] See Vol. II, Revised Statutes of the United States.

(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section,

(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate, and

(C) adopt procedures allowing any interested party to submit information for the Commission's use in making reports and recommendations.

(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data of the Commission, immediately upon request.

(4) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by the Comptroller General.

(f) AUTHORIZATION OF APPROPRIATIONS.—

(1) REQUEST FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section. Sixty percent of such appropriation shall be payable from the Federal Hospital Insurance Trust Fund, and 40 percent of such appropriation shall be payable from the Federal Supplementary Medical Insurance Trust Fund.

EXPLANATION OF MEDICARE BENEFITS [12]

SEC. 1806. [42 U.S.C. 1395b–7] (a) IN GENERAL.—The Secretary shall furnish to each individual for whom payment has been made under this title (or would be made without regard to any deductible) a statement which—

(1) lists the item or service for which payment has been made and the amount of such payment for each item or service; and

(2) includes a notice of the individual's right to request an itemized statement (as provided in subsection (b)).

(b) REQUEST FOR ITEMIZED STATEMENT FOR MEDICARE ITEMS AND SERVICES.—

(1) IN GENERAL.—An individual may submit a written request to any physician, provider, supplier, or any other person (including an organization, agency, or other entity) for an itemized statement for any item or service provided to such individual by such person with respect to which payment has been made under this title.

(2) 30–DAY PERIOD TO FURNISH STATEMENT.—

(A) IN GENERAL.—Not later than 30 days after the date on which a request under paragraph (1) has been made, a person described in such paragraph shall furnish an itemized statement describing each item or service provided to the individual requesting the itemized statement.

[12] See Vol. II, P.L. 108-173, §925, with respect to the inclusion of additional information in notices to beneficiaries about skilled nursing faciity benefits.

(B) PENALTY.—Whoever knowingly fails to furnish an itemized statement in accordance with subparagraph (A) shall be subject to a civil money penalty of not more than $100 for each such failure. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

(3) REVIEW OF ITEMIZED STATEMENT.—

(A) IN GENERAL.—Not later than 90 days after the receipt of an itemized statement furnished under paragraph (1), an individual may submit a written request for a review of the itemized statement to the Secretary.

(B) SPECIFIC ALLEGATIONS.—A request for a review of the itemized statement shall identify—

(i) specific items or services that the individual believes were not provided as claimed, or

(ii) any other billing irregularity (including duplicate billing).

(4) FINDINGS OF SECRETARY.—The Secretary shall, with respect to each written request submitted under paragraph (3), determine whether the itemized statement identifies specific items or services that were not provided as claimed or any other billing irregularity (including duplicate billing) that has resulted in unnecessary payments under this title.

(5) RECOVERY OF AMOUNTS.—The Secretary shall take all appropriate measures to recover amounts unnecessarily paid under this title with respect to a statement described in paragraph (4).

CHRONIC CARE IMPROVEMENT [13]

SEC. 1807. [42 U.S.C. 1395b–8] (a) IMPLEMENTATION OF CHRONIC CARE IMPROVEMENT PROGRAMS.—

(1) IN GENERAL.—The Secretary shall provide for the phased-in development, testing, evaluation, and implementation of chronic care improvement programs in accordance with this section. Each such program shall be designed to improve clinical quality and beneficiary satisfaction and achieve spending targets with respect to expenditures under this title for targeted beneficiaries with one or more threshold conditions.

(2) DEFINITIONS.—For purposes of this section:

(A) CHRONIC CARE IMPROVEMENT PROGRAM.—The term "chronic care improvement program" means a program described in paragraph (1) that is offered under an agreement under subsection (b) or (c).

(B) CHRONIC CARE IMPROVEMENT ORGANIZATION.—The term "chronic care improvement organization" means an entity that has entered into an agreement under subsection (b) or (c) to provide, directly or through contracts with subcontractors, a chronic care improvement program under this section. Such an entity may be a disease management organization, health insurer, integrated delivery

[13] P.L. 108-173, §721, added §1807, effective December 8, 2003.

See Vol. II, P.L. 108-173, §648, with respect to a demonstration project for consumer-directed chronic outpatient services; §721(b), with respect to reports on the operation of §1807; and §723, with respect to a chronically ill Medicare beneficiary research, data, demonstration strategy.

system, physician group practice, a consortium of such entities, or any other legal entity that the Secretary determines appropriate to carry out a chronic care improvement program under this section.

(C) CARE MANAGEMENT PLAN.—The term "care management plan" means a plan established under section (d) for a participant in a chronic care improvement program.

(D) THRESHOLD CONDITION.—The term "threshold condition" means a chronic condition, such as congestive heart failure, diabetes, chronic obstructive pulmonary disease (COPD), or other diseases or conditions, as selected by the Secretary as appropriate for the establishment of a chronic care improvement program.

(E) TARGETED BENEFICIARY.—The term "targeted beneficiary" means, with respect to a chronic care improvement program, an individual who—

(i) is entitled to benefits under part A and enrolled under part B, but not enrolled in a plan under part C;

(ii) has one or more threshold conditions covered under such program; and

(iii) has been identified under subsection (d)(1) as a potential participant in such program.

(3) CONSTRUCTION.—Nothing in this section shall be construed as—

(A) expanding the amount, duration, or scope of benefits under this title;

(B) providing an entitlement to participate in a chronic care improvement program under this section;

(C) providing for any hearing or appeal rights under section 1869, 1878, or otherwise, with respect to a chronic care improvement program under this section; or

(D) providing benefits under a chronic care improvement program for which a claim may be submitted to the Secretary by any provider of services or supplier (as defined in section 1861(d)).

(b) DEVELOPMENTAL PHASE (PHASE I).—

(1) IN GENERAL.—In carrying out this section, the Secretary shall enter into agreements consistent with subsection (f) with chronic care improvement organizations for the development, testing, and evaluation of chronic care improvement programs using randomized controlled trials. The first such agreement shall be entered into not later than 12 months after the date of the enactment of this section.

(2) AGREEMENT PERIOD.—The period of an agreement under this subsection shall be for 3 years.

(3) MINIMUM PARTICIPATION.—

(A) IN GENERAL.—The Secretary shall enter into agreements under this subsection in a manner so that chronic care improvement programs offered under this section are offered in geographic areas that, in the aggregate, consist of areas in which at least 10 percent of the aggregate number of medicare beneficiaries reside.

(B) MEDICARE BENEFICIARY DEFINED.—In this paragraph, the term "medicare beneficiary" means an individual who is entitled to benefits under part A, enrolled under part B, or both, and who resides in the United States.

(4) SITE SELECTION.—In selecting geographic areas in which agreements are entered into under this subsection, the Secretary shall ensure that each chronic care improvement program is conducted in a geographic area in which at least 10,000 targeted beneficiaries reside among other individuals entitled to benefits under part A, enrolled under part B, or both to serve as a control population.

(5) INDEPENDENT EVALUATIONS OF PHASE I PROGRAMS.—The Secretary shall contract for an independent evaluation of the programs conducted under this subsection. Such evaluation shall be done by a contractor with knowledge of chronic care management programs and demonstrated experience in the evaluation of such programs. Each evaluation shall include an assessment of the following factors of the programs:

(A) Quality improvement measures, such as adherence to evidence—based guidelines and rehospitalization rates.

(B) Beneficiary and provider satisfaction.

(C) Health outcomes.

(D) Financial outcomes, including any cost savings to the program under this title.

(c) EXPANDED IMPLEMENTATION PHASE (PHASE II).—

(1) IN GENERAL.—With respect to chronic care improvement programs conducted under subsection (b), if the Secretary finds that the results of the independent evaluation conducted under subsection (b)(6) indicate that the conditions specified in paragraph (2) have been met by a program (or components of such program), the Secretary shall enter into agreements consistent with subsection (f) to expand the implementation of the program (or components) to additional geographic areas not covered under the program as conducted under subsection (b), which may include the implementation of the program on a national basis. Such expansion shall begin not earlier than 2 years after the program is implemented under subsection (b) and not later than 6 months after the date of completion of such program.

(2) CONDITIONS FOR EXPANSION OF PROGRAMS.—The conditions specified in this paragraph are, with respect to a chronic care improvement program conducted under subsection (b) for a threshold condition, that the program is expected to—

(A) improve the clinical quality of care;

(B) improve beneficiary satisfaction; and

(C) achieve targets for savings to the program under this title specified by the Secretary in the agreement within a range determined to be appropriate by the Secretary, subject to the application of budget neutrality with respect to the program and not taking into account any payments by the organization under the agreement under the program for risk under subsection (f)(3)(B).

(3) INDEPENDENT EVALUATIONS OF PHASE II PROGRAMS.—The Secretary shall carry out evaluations of programs expanded under this subsection as the Secretary determines appropriate. Such evaluations shall be carried out in the similar manner as is provided under subsection (b)(5).

(d) IDENTIFICATION AND ENROLLMENT OF PROSPECTIVE PROGRAM PARTICIPANTS.—

(1) IDENTIFICATION OF PROSPECTIVE PROGRAM PARTICIPANTS.—The Secretary shall establish a method for identifying targeted beneficiaries who may benefit from participation in a chronic care improvement program.

(2) INITIAL CONTACT BY SECRETARY.—The Secretary shall communicate with each targeted beneficiary concerning participation in a chronic care improvement program. Such communication may be made by the Secretary and shall include information on the following:

(A) A description of the advantages to the beneficiary in participating in a program.

(B) Notification that the organization offering a program may contact the beneficiary directly concerning such participation.

(C) Notification that participation in a program is voluntary.

(D) A description of the method for the beneficiary to participate or for declining to participate and the method for obtaining additional information concerning such participation.

(3) VOLUNTARY PARTICIPATION.—A targeted beneficiary may participate in a chronic care improvement program on a voluntary basis and may terminate participation at any time.

(e) CHRONIC CARE IMPROVEMENT PROGRAMS.—

(1) IN GENERAL.—Each chronic care improvement program shall—

(A) have a process to screen each targeted beneficiary for conditions other than threshold conditions, such as impaired cognitive ability and co-morbidities, for the purposes of developing an individualized, goal oriented care management plan under paragraph (2);

(B) provide each targeted beneficiary participating in the program with such plan; and (C) carry out such plan and other chronic care improvement activities in accordance with paragraph (3).

(2) ELEMENTS OF CARE MANAGEMENT PLANS.—A care management plan for a targeted beneficiary shall be developed with the beneficiary and shall, to the extent appropriate, include the following:

(A) A designated point of contact responsible for communications with the beneficiary and for facilitating communications with other health care providers under the plan.

(B) Self—care education for the beneficiary (through approaches such as disease management or medical nutrition therapy) and education for primary caregivers and family members.

(C) Education for physicians and other providers and collaboration to enhance communication of relevant clinical information.

(D) The use of monitoring technologies that enable patient guidance through the exchange of pertinent clinical information, such as vital signs, symptomatic information, and health self-assessment.

(E) The provision of information about hospice care, pain and palliative care, and end-of-life care.

(3) CONDUCT OF PROGRAMS.—In carrying out paragraph (1)(C) with respect to a participant, the chronic care improvement organization shall—

(A) guide the participant in managing the participant's health (including all co-morbidities, relevant health care services, and pharmaceutical needs) and in performing activities as specified under the elements of the care management plan of the participant;

(B) use decision-support tools such as evidence-based practice guidelines or other criteria as determined by the Secretary; and

(C) develop a clinical information database to track and monitor each participant across settings and to evaluate outcomes.

(4) ADDITIONAL RESPONSIBILITIES.—

(A) OUTCOMES REPORT.—Each chronic care improvement organization offering a chronic care improvement program shall monitor and report to the Secretary, in a manner specified by the Secretary, on health care quality, cost, and outcomes.

(B) ADDITIONAL REQUIREMENTS.—Each such organization and program shall comply with such additional requirements as the Secretary may specify.

(5) ACCREDITATION.—The Secretary may provide that chronic care improvement programs and chronic care improvement organizations that are accredited by qualified organizations (as defined by the Secretary) may be deemed to meet such requirements under this section as the Secretary may specify.

(f) TERMS OF AGREEMENTS.—

(1) TERMS AND CONDITIONS.—

(A) IN GENERAL.—An agreement under this section with a chronic care improvement organization shall contain such terms and conditions as the Secretary may specify consistent with this section.

(B) CLINICAL, QUALITY IMPROVEMENT, AND FINANCIAL REQUIREMENTS.—The Secretary may not enter into an agreement with such an organization under this section for the operation of a chronic care improvement program unless—

(i) the program and organization meet the requirements of subsection (e) and such clinical, quality improvement, financial, and other requirements as the Secretary deems to be appropriate for the targeted beneficiaries to be served; and

(ii) the organization demonstrates to the satisfaction of the Secretary that the organization is able to assume financial risk for performance under the agreement (as applied under paragraph (3)(B)) with respect to payments made to the organization under such agreement through available reserves, reinsurance, withholds, or such other means as the Secretary determines appropriate.

(2) MANNER OF PAYMENT.—Subject to paragraph (3)(B), the payment under an agreement under—

(A) subsection (b) shall be computed on a permember per-month basis; or

(B) subsection (c) may be on a per-member permonth basis or such other basis as the Secretary and organization may agree.

(3) APPLICATION OF PERFORMANCE STANDARDS.—

(A) SPECIFICATION OF PERFORMANCE STANDARDS.—Each agreement under this section with a chronic care improvement organization shall specify performance standards for each of the factors specified in subsection (c)(2), including clinical quality and spending targets under this title, against which the performance of the chronic care improvement organization under the agreement is measured.

(B) ADJUSTMENT OF PAYMENT BASED ON PERFORMANCE.—

(i) IN GENERAL.—Each such agreement shall provide for adjustments in payment rates to an organization under the agreement insofar as the Secretary determines that the organization failed to meet the performance standards specified in the agreement under subparagraph (A).

(ii) FINANCIAL RISK FOR PERFORMANCE.—In the case of an agreement under subsection (b) or (c), the agreement shall provide for a full recovery for any amount by which the fees paid to the organization under the agreement exceed the estimated savings to the programs under this title attributable to implementation of such agreement.

(4) BUDGET NEUTRAL PAYMENT CONDITION.—Under this section, the Secretary shall ensure that the aggregate sum of medicare program benefit expenditures for beneficiaries participating in chronic care improvement programs and funds paid to chronic care improvement organizations under this section, shall not exceed the medicare program benefit expenditures that the Secretary estimates would have been made for such targeted beneficiaries in the absence of such programs.

(g) FUNDING.—

(1) Subject to paragraph (2), there are appropriated to the Secretary, in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, such sums as may be necessary to provide for agreements with chronic care improvement programs under this section.

(2) In no case shall the funding under this section exceed $100,000,000 in aggregate increased expenditures under this title (after taking into account any savings attributable to the operation of this section) over the 3-fiscal-year period beginning on October 1, 2003.

PROVISIONS RELATING TO ADMINISTRATION

SEC. 1808. [42 U.S.C. 1395b–9] (a)[14] COORDINATED ADMINISTRATION OF MEDICARE PRESCRIPTION DRUG AND MEDICARE ADVANTAGE PROGRAMS.—

(1) IN GENERAL.—There is within the Centers for Medicare and Medicaid Services a center to carry out the duties described in paragraph (3).

[14] P.L. 108-173, §900(a), added §1808(a), effective December 8, 2003.

(2) DIRECTOR.—Such center shall be headed by a director who shall report directly to the Administrator of the Centers for Medicare and Medicaid Services.

(3) DUTIES.—The duties described in this paragraph are the following:

(A) The administration of parts C and D.

(B) The provision of notice and information under section 1804.

(C) Such other duties as the Secretary may specify.

(4) DEADLINE.—The Secretary shall ensure that the center is carrying out the duties described in paragraph (3) by not later than January 1, 2008.

(b) [15] EMPLOYMENT OF MANAGEMENT STAFF.—

(1) IN GENERAL.—The Secretary may employ, within the Centers for Medicare and Medicaid Services, such individuals as management staff as the Secretary determines to be appropriate. With respect to the administration of parts C and D, such individuals shall include individuals with private sector expertise in negotiations with health benefits plans.

(2) ELIGIBILITY.—To be eligible for employment under paragraph (1) an individual shall be required to have demonstrated, by their education and experience (either in the public or private sector), superior expertise in at least one of the following areas:

(A) The review, negotiation, and administration of health care contracts.

(B) The design of health care benefit plans.

(C) Actuarial sciences.

(D) Compliance with health plan contracts.

(E) Consumer education and decision making.

(F) Any other area specified by the Secretary that requires specialized management or other expertise.

(3) RATES OF PAYMENT.—

(A) PERFORMANCE-RELATED PAY.—Subject to subparagraph (B), the Secretary shall establish the rate of pay for an individual employed under paragraph (1). Such rate shall take into account expertise, experience, and performance.

(B) LIMITATION.—In no case may the rate of compensation determined under subparagraph (A) exceed the highest rate of basic pay for the Senior Executive Service under section 5382(b) of title 5, United States Code.

(c) [16] MEDICARE BENEFICIARY OMBUDSMAN.—

(1) IN GENERAL.—The Secretary shall appoint within the Department of Health and Human Services a Medicare Beneficiary Ombudsman who shall have expertise and experience in the fields of health care and education of (and assistance to) individuals entitled to benefits under this title.

(2) DUTIES.—The Medicare Beneficiary Ombudsman shall—

(A) receive complaints, grievances, and requests for information submitted by individuals entitled to benefits

[15] P.L. 108-173, §900(b), added subsection (b), effective December 8, 2003.

[16] P.L. 108-173, §923(a), added subsection (c), effective December 8, 2003; §923(b) provided that the Secretary shall appoint the Medicare Beneficiary Ombudsman by not later than December 8, 2004.

under part A or enrolled under part B, or both, with respect to any aspect of the medicare program;

(B) provide assistance with respect to complaints, grievances, and requests referred to in subparagraph (A), including—

(i) assistance in collecting relevant information for such individuals, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, MA organization, or the Secretary

(ii) assistance to such individuals with any problems arising from disenrollment from an MA plan under part C; and

(iii) assistance to such individuals in presenting information under section 1839(i)(4)(C) (relating to income-related premium adjustment; and

(C) submit annual reports to Congress and the Secretary that describe the activities of the Office and that include such recommendations for improvement in the administration of this title as the Ombudsman determines appropriate. The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.

(3) WORKING WITH HEALTH INSURANCE COUNSELING PROGRAMS.—To the extent possible, the Ombudsman shall work with health insurance counseling programs (receiving funding under section 4360 of Omnibus Budget Reconciliation Act of 1990) to facilitate the provision of information to individuals entitled to benefits under part A or enrolled under part B, or both regarding MA plans and changes to those plans. Nothing in this paragraph shall preclude further collaboration between the Ombudsman and such programs.

Part A—Hospital Insurance Benefits for the Aged and Disabled [17]

DESCRIPTION OF PROGRAM

SEC. 1811. [42 U.S.C. 1395c] The insurance program for which entitlement is established by sections 226 and 226A provides basic protection against the costs of hospital, related post-hospital, home health services, and hospice care in accordance with this part for (1) individuals who are age 65 or over and are eligible for retirement benefits under title II of this Act (or would be eligible for such benefits if certain government employment were covered employment under such title) or under the railroad retirement system, (2) individuals under age 65 who have been entitled for not less than 24 months to benefits under title II of this Act (or would have been so entitled to such benefits if certain government employment were covered employment under such title) or under the railroad retirement system on the basis of a disability, and (3) certain individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease.

[17] See Vol. II, P.L. 101–508, §4004, with respect to payments for medical education costs.

SCOPE OF BENEFITS

SEC. 1812. [42 U.S.C. 1395d] (a) The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on his behalf or, in the case of payments referred to in section 1814(d)(2) to him (subject to the provisions of this part) for—

(1) inpatient hospital services or inpatient critical access hospital services for up to 150 days during any spell of illness minus 1 day for each day of such services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);

(2)(A) post-hospital extended care services for up to 100 days during any spell of illness, and (B) to the extent provided in subsection (f), extended care services that are not post-hospital extended care services;

(3) in the case of individuals not[18] enrolled in part B, home health services, and for individuals so[19] enrolled, post–institutional home health services furnished during a home health spell of illness for up to 100 visits during such spell of illness;[20]

(4) in lieu of certain other benefits, hospice care with respect to the individual during up to two periods of 90 days each and an unlimited number of subsequent periods of 60 days each with respect to which the individual makes an election under subsection (d)(1); and[21]

(5)[22] for individuals who are terminally ill, have not made an election under subsection (d)(1), and have not previously received services under this paragraph, services that are furnished by a physician (as defined in section 1861(r)(1)) who is either the medical director or an employee of a hospice program and that—

(A) consist of—

(i) an evaluation of the individual's need for pain and symptom management, including the individual's need for hospice care; and

(ii) counseling the individual with respect to hospice care and other care options; and

(B) may include advising the individual regarding advanced care planning.

(b) Payment under this part for services furnished an individual during a spell of illness may not (subject to subsection (c)) be made for—

(1) inpatient hospital services furnished to him during such spell after such services have been furnished to him for 150 days during such spell minus 1 day for each day of inpatient hospital services in excess of 90 received during any preceding

[18] P.L. 108–173, §736(c)(1)(A), struck out "for individuals not" and substituted "in the case of individuals not".

[19] P.L. 108–173, §736(c)(1)(B), struck out "for individuals so" and substituted "in the case of individuals so".

[20] P.L. 108–173, §512(a)(1), struck out "and".

[21] P.L. 108–173, §512(a)(2), struck out the period and substituted "; and".

[22] P.L. 108–173, §512(a)(3), added paragraph (5) applicable to services provided by a hospice program on or after January 1, 2005.

spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);

(2) post-hospital extended care services furnished to him during such spell after such services have been furnished to him for 100 days during such spell; or

(3) inpatient psychiatric hospital services furnished to him after such services have been furnished to him for a total of 190 days during his lifetime.

Payment under this part for post–institutional home health services furnished an individual during a home health spell of illness may not be made for such services beginning after such services have been furnished for a total of 100 visits during such spell

(c) If an individual is an inpatient of a psychiatric hospital on the first day of the first month for which he is entitled to benefits under this part, the days on which he was an inpatient of such a hospital in the 150-day period immediately before such first day shall be included in determining the number of days limit under subsection (b)(1) insofar as such limit applies to (1) inpatient psychiatric hospital services, or (2) inpatient hospital services for an individual who is an inpatient primarily for the diagnosis or treatment of mental illness (but shall not be included in determining such number of days limit insofar as it applies to other inpatient hospital services or in determining the 190-day limit under subsection (b)(3)).

(d)(1) Payment under this part may be made for hospice care provided with respect to an individual only during two periods of 90 days each and an unlimited number of subsequent periods of 60 days each during the individual's lifetime and only, with respect to each such period, if the individual makes an election under this paragraph to receive hospice care under this part provided by, or under arrangements made by, a particular hospice program instead of certain other benefits under this title.

(2)(A) Except as provided in subparagraphs (B) and (C) and except in such exceptional and unusual circumstances as the Secretary may provide, if an individual makes such an election for a period with respect to a particular hospice program, the individual shall be deemed to have waived all rights to have payment made under this title with respect to—

(i) hospice care provided by another hospice program (other than under arrangements made by the particular hospice program) during the period, and

(ii) services furnished during the period that are determined (in accordance with guidelines of the Secretary) to be—

(I) related to the treatment of the individual's condition with respect to which a diagnosis of terminal illness has been made or

(II) equivalent to (or duplicative of) hospice care;

except that clause (ii) shall not apply to physicians' services furnished by the individual's attending physician (if not an employee of the hospice program) or to services provided by (or under arrangements made by) the hospice program.

(B) After an individual makes such an election with respect to a 90–day period or a subsequent 60–day period, the individual may revoke the election during the period, in which case—

(i) the revocation shall act as a waiver of the right to have payment made under this part for any hospice care benefits for the remaining time in such period and (for purposes of subsection (a)(4) and subparagraph (A)) the individual shall be deemed to have been provided such benefits during such entire period, and

(ii) the individual may at any time after the revocation execute a new election for a subsequent period, if the individual otherwise is entitled to hospice care benefits with respect to such a period.

(C) An individual may, once in each such period, change the hospice program with respect to which the election is made and such change shall not be considered a revocation of an election under subparagraph (B).

(D) For purposes of this title, an individual's election with respect to a hospice program shall no longer be considered to be in effect with respect to that hospice program after the date the individual's revocation or change of election with respect to that election takes effect.

(e) For purposes of subsections (b) and (c), inpatient hospital services, inpatient psychiatric hospital services, and post-hospital extended care services shall be taken into account only if payment is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1814(a), made with respect to such services under this part.

(f)(1) The Secretary shall provide for coverage, under clause (B) of subsection (a)(2), of extended care services which are not post-hospital extended care services at such time and for so long as the Secretary determines, and under such terms and conditions (described in paragraph (2)) as the Secretary finds appropriate, that the inclusion of such services will not result in any increase in the total of payments made under this title and will not alter the acute care nature of the benefit decribed in subsection (a)(2).

(2) The Secretary may provide—

(A) for such limitations on the scope and extent of services described in subsection (a)(2)(B) and on the categories of individuals who may be eligible to receive such services, and

(B) notwithstanding sections 1814, 1861(v), and 1886, for such restrictions and alternatives on the amounts and methods of payment for services described in such subsection,

as may be necessary to carry out paragraph (1).

(g) For definition of "spell of illness", and for definitions of other terms used in this part, see section 1861.

DEDUCTIBLES AND COINSURANCE

SEC. 1813. [42 U.S.C. 1395e] (a)(1) The amount payable for inpatient hospital services or inpatient critical access hospital services furnished an individual during any spell of illness shall be reduced by a deduction equal to the inpatient hospital deductible or, if less, the charges imposed with respect to such individual for such services, except that, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed. Such amount shall be further reduced by a coinsurance amount equal to—

(A) one-fourth of the inpatient hospital deductible for each day (before the 91st day) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 60 days during such spell; and

(B) one-half of the inpatient hospital deductible for each day (before the day following the last day for which such individual is entitled under section 1812(a)(1) to have payment made on his behalf for inpatient hospital services or inpatient critical access hospital services during such spell of illness) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 90 days during such spell;

except that the reduction under this sentence for any day shall not exceed the charges imposed for that day with respect to such individual for such services (and for this purpose, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed).

(2)(A) The amount payable to any provider of services under this part for services furnished an individual shall be further reduced by a deduction equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during each calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence.

(B) The deductible under subparagraph (A) for blood or blood cells furnished an individual in a year shall be reduced to the extent that a deductible has been imposed under section 1833(b) to blood or blood cells furnished the individual in the year.

(3) The amount payable for post-hospital extended care services furnished an individual during any spell of illness shall be reduced by a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day (before the 101st day) on which he is furnished such services after such services have been furnished to him for 20 days during such spell.

(4)(A) The amount payable for hospice care shall be reduced—

(i) in the case of drugs and biologicals provided on an outpatient basis by (or under arrangements made by) the hospice program, by a coinsurance amount equal to an amount (not to exceed $5 per prescription) determined in accordance with a drug copayment schedule (established by the hospice program) which is related to, and approximates 5 percent of, the cost of the drug or biological to the program, and

(ii) in the case of respite care provided by (or under arrangements made by) the hospice program, by a coinsurance amount equal to 5 percent of the amount estimated by the hospice pro-

gram (in accordance with regulations of the Secretary) to be equal to the amount of payment under section 1814(i) to that program for respite care;

except that the total of the coinsurance required under clause (ii) for an individual may not exceed for a hospice coinsurance period the inpatient hospital deductible applicable for the year in which the period began. For purposes of this subparagraph, the term "hospice coinsurance period" means, for an individual, a period of consecutive days beginning with the first day for which an election under section 1812(d) is in effect for the individual and ending with the close of the first period of 14 consecutive days on each of which such an election is not in effect for the individual.

(B) During the period of an election by an individual under section 1812(d)(1), no copayments or deductibles other than those under subparagraph (A) shall apply with respect to services furnished to such individual which constitute hospice care, regardless of the setting in which such services are furnished.

(b)(1) The inpatient hospital deductible for 1987 shall be $520. The inpatient hospital deductible for any succeeding year shall be an amount equal to the inpatient hospital deductible for the preceding calendar year, changed by the Secretary's best estimate of the payment-weighted average of the applicable percentage increases (as defined in section 1886(b)(3)(B)) which are applied under section 1886(d)(3)(A) for discharges in the fiscal year that begins on October 1 of such preceding calendar year, and adjusted to reflect changes in real case mix (determined on the basis of the most recent case mix data available). Any amount determined under the preceding sentence which is not a multiple of $4 shall be rounded to the nearest multiple of $4 (or, if it is midway between two multiples of $4, to the next higher multiple of $4).

(2) The Secretary shall promulgate the inpatient hospital deductible and all coinsurance amounts under this section between September 1 and September 15 of the year preceding the year to which they will apply.

(3) The inpatient hospital deductible for a year shall apply to—

(A) the deduction under the first sentence of subsection (a)(1) for the year in which the first day of inpatient hospital services or inpatient critical access hospital services occurs in a spell of illness, and

(B) to the coinsurance amounts under subsection (a) for inpatient hospital services, inpatient critical access hospital services and post-hospital extended care services furnished in that year.

CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

Requirement of Requests and Certifications

SEC. 1814. [42 U.S.C. 1395f] (a) Except as provided in subsections (d) and (g) and in section 1876, payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1866 and only if—

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner, and by such person or persons as the Secretary may

by regulation prescribe, no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year;

(2) a physician, or, in the case of services described in subparagraph (B), a physician, or a nurse practitioner or clinical nurse specialist who does not have a direct or indirect employment relationship with the facility but is working in collaboration with a physician, certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period) that—

(A) in the case of inpatient psychiatric hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the psychiatric treatment of an individual; and (i) such treatment can or could reasonably be expected to improve the condition for which such treatment is or was necessary or (ii) inpatient diagnostic study is or was medically required and such services are or were necessary for such purposes;

(B) in the case of post-hospital extended care services, such services are or were required to be given because the individual needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 1861(e)) prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services;

(C) in the case of home health services, such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needs or needed skilled nursing care (other than solely venipuncture for the purpose of obtaining a blood sample) on an intermittent basis or physical or speech therapy or, in the case of an individual who has been furnished home health services based on such a need and who no longer has such a need for such care or therapy, continues or continued to need occupational therapy; a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician; and such services are or were fur-

nished while the individual was under the care of a physician; or

(D) in the case of inpatient hospital services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services;

(3) with respect to inpatient hospital services (other than inpatient psychiatric hospital services) which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment, or that inpatient diagnostic study is medically required and such services are necessary for such purpose, except that (A) such certification shall be furnished only in such cases, with such frequency, and accompanied by such supporting material, appropriate to the cases involved, as may be provided by regulations, and (B) the first such certification required in accordance with clause (A) shall be furnished no later than the 20th day of such period;

(4) in the case of inpatient psychiatric hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving (A) intensive treatment services, (B) admission and related services necessary for a diagnostic study, or (C) equivalent services;

(5) with respect to inpatient hospital services furnished such individual after the 20th day of a continuous period of such services, there was not in effect, at the time of admission of such individual to the hospital, a decision under section 1866(d) (based on a finding that utilization review of long-stay cases is not being made in such hospital);

(6) with respect to inpatient hospital services or post-hospital extended care services furnished such individual during a continuous period, a finding has not been made (by the physician members of the committee or group, as described in section 1861(k)(4), including any finding made in the course of a sample or other review of admissions to the institution) pursuant to the system of utilization review that further inpatient hospital services or further post-hospital extended care services, as the case may be, are not medically necessary; except that, if such a finding has been made, payment may be made for such services furnished before the 4th day after the day on which the hospital or skilled nursing facility, as the case may be, received notice of such finding;

(7) in the case of hospice care provided an individual—

(A)(i) in the first 90-day period—

(I) the individual's attending physician (as defined in section 1861(dd)(3)(B)) (which for purposes of this subparagraph does not include a nurse practitioner)[23], and

[23] P.L. 108–173, §408(b), added "(which for purposes of this subparagraph does not include a nurse practitioner)", effective December 8, 2003.

(II) the medical director (or physician member of the interdisciplinary group described in section 1861(dd)(2)(B)) of the hospice program providing (or arranging for) the care,

each certify in writing, at the beginning of the period, that the individual is terminally ill (as defined in section 1861(dd)(3)(A)), and based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness [24],

(ii) in a subsequent 90 or 60–day period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill based on such clinical judgment [25];

(B) a written plan for providing hospice care with respect to such individual has been established (before such care is provided by, or under arrangements made by, that hospice program) and is periodically reviewed by the individual's attending physician and by the medical director (and the interdisciplinary group described in section 1861(dd)(2)(B)) of the hospice program; and

(C) such care is being or was provided pursuant to such plan of care; and

(8) in the case of inpatient critical access hospital services, a physician certifies that the individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the critical access hospital.

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician, nurse practitioner, or clinical nurse specialist (as the case may be) makes certification of the kind provided in subparagraph (A), (B), (C), or (D) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than July 1, 1981, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan, except that such prohibition shall not apply with respect to a home health agency which is a sole community home health agency (as determined by the Secretary). For purposes of the preceding sentence, service by a physician as an uncompensated officer or director of a home health agency shall not constitute having a significant ownership interest in, or a significant financial or contractual relationship with, such agency. For purposes of paragraph (2)(C), an individual shall be considered to be "confined to his home" if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the

[24] P.L. 108–173, §736(a)(1)(B)(i), added "based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness".

[25] P.L. 108–173, §736(a)(1)(B)(ii), added "based on such clinical judgment".

assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered "confined to his home", the condition of the individual should be such that there exists a normal inability to leave home and[26], that leaving home requires a considerable and taxing effort by the individual.[27] Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day–care program that is licensed or certified by a State, or accredited, to furnish adult day–care services in the State shall not disqualify an individual from being considered to be "confined to his home". Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day-care services in the State shall not disqualify an individual from being considered to be "confined to his home". Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration.

Amount Paid to Providers

(b) The amount paid to any provider of services (other than a hospice program providing hospice care, other than a critical access hospital providing inpatient critical access hospital services, and other than a home health agency with respect to durable medical equipment) with respect to services for which payment may be made under this part shall, subject to the provisions of sections 1813,[28] 1886, and 1895 be—

(1) except as provided in paragraph (3), the lesser of (A) the reasonable cost of such services, as determined under section 1861(v) and as further limited by section 1881(b)(2)(B), or (B) the customary charges with respect to such services;

(2) if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this paragraph), free of charge or at nominal charges to the public, the amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such reasonable cost which the Secretary finds will provide fair compensation to such provider for such services; or[29]

[26] P.L. 108–173, §736(c)(2)(A), struck out "leave home," and substituted "leave home and".
[27] P.L. 108–173, §736(a)(1), struck out "The certification regarding terminal illness of an individual under paragraph (7) shall be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness.", effective December 8, 2003.
[28] P.L. 108–173, §736(a)(2), inserted a comma.
[29] See Vol. II, P.L. 98–369, §2308(b)(1), with respect to rules applicable to the nominality test.

(3) if some or all of the hospitals in a State have been reimbursed for services (for which payment may be made under this part) pursuant to a reimbursement system approved as a demonstration project under section 402 of the Social Security Amendments of 1967[30] or section 222 of the Social Security Amendments of 1972[31], if the rate of increase in such hospitals in their costs per hospital inpatient admission of individuals entitled to benefits under this part over the duration of such project was equal to or less than such rate of increase for admissions of such individuals with respect to all hospitals in the United States during such period, and if either the State has legislative authority to operate such system and the State elects to have reimbursement to such hospitals made in accordance with this paragraph or the system is operated through a voluntary agreement of hospitals and such hospitals elect to have reimbursement to those hospitals made in accordance with this paragraph, then the Secretary may provide for continuation of reimbursement to such hospitals under such system until the Secretary determines that—

(A) a third-party payor reimburses such a hospital on a basis other than under such system, or

(B) the aggregate rate of increase from January 1, 1981, to the most recent date for which annual data are available in such hospitals in costs per hospital inpatient admission of individuals entitled to benefits under this part is greater than such rate of increase for admissions of such individuals with respect to all hospitals in the United States for such period.

In the case of any State which has had such a demonstration project reimbursement system in continuous operation since July 1, 1977, the Secretary shall provide under paragraph (3) for continuation of reimbursement to hospitals in the State under such system until the first day of the 37th month beginning after the date the Secretary determines and notifies the Governor of the State that either of the conditions described in subparagraph (A) or (B) of such paragraph has occurred. If, by the end of such 36-month period, the Secretary determines, based on evidence submitted by the Governor of the State, that neither of the conditions described in subparagraph (A) or (B) of paragraph (3) continues to apply, the Secretary shall continue without interruption payment to hospitals in the State under the State's system. If, by the end of such 36-month period, the Secretary determines, based on such evidence, that either of the conditions described in subparagraph (A) or (B) of such paragraph continues to apply, the Secretary shall (i) collect any net excess reimbursement to hospitals in the State during such 36-month period (basing such net excess reimbursement on the net difference, if any, in the rate of increase in costs per hospital inpatient admission under the State system compared to the rate of increase in such costs with respect to all hospitals in the United States over the 36-month period, as measured by including the cumulative savings under the State system based on the difference in the rate of increase in costs per hospital inpatient admission under the State system as compared to the rate of increase in such costs

[30] See Vol. II, P.L. 90–248, §402.
[31] See Vol. II, P.L. 92–603, §222.

with respect to all hospitals in the United States between January 1, 1981, and the date of the Secretary's initial notice), and (ii) provide a reasonable period, not to exceed 2 years, for transition from the State system to the national payment system.

No Payments to Federal Providers of Services

(c) Subject to section 1880, no payment may be made under this part (except under subsection (d) or subsection (h)) to any Federal provider of services, except a provider of services which the Secretary determines is providing services to the public generally as a community institution or agency; and no such payment may be made to any provider of services for any item or service which such provider is obligated by a law of, or a contract with, the United States to render at public expense.

Payments for Emergency Hospital Services

(d)(1) Payments shall also be made to any hospital for inpatient hospital services furnished in a calendar year, by the hospital or under arrangements (as defined in section 1861(w)) with it, to an individual entitled to hospital insurance benefits under section 226 even though such hospital does not have an agreement in effect under this title if (A) such services were emergency services, (B) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder, and (C) such hospital has elected to claim payments for all such inpatient emergency services and for the emergency outpatient services referred to in section 1835(b) furnished during such year. Such payments shall be made only in the amounts provided under subsection (b) and then only if such hospital agrees to comply, with respect to the emergency services provided, with the provisions of section 1866(a).

(2) Payment may be made on the basis of an itemized bill to an individual entitled to hospital insurance benefits under section 226 for services described in paragraph (1) which are emergency services if (A) payment cannot be made under paragraph (1) solely because the hospital does not elect to claim such payment, and (B) such individual files application (submitted within such time and in such form and manner and by such person, and containing and supported by such information as the Secretary shall by regulations prescribe) for reimbursement.

(3) The amounts payable under the preceding paragraph with respect to services described therein shall, subject to the provisions of section 1813, be equal to 60 percent of the hospital's reasonable charges for routine services furnished in the accommodations occupied by the individual or in semiprivate accommodations (as defined in section 1861(v)(4)), whichever is less, plus 80 percent of the hospital's reasonable charges for ancillary services. If separate charges for routine and ancillary services are not made by the hospital, reimbursement may be based on two-thirds of the hospital's reasonable charges for the services received but not to exceed the charges which would have been made if the patient had occupied semiprivate accommodations. For purposes of the preceding provisions of this paragraph, the term "routine services" shall mean the regular

room, dietary, and nursing services, minor medical and surgical supplies and the use of equipment and facilities for which a separate charge is not customarily made; the term "ancillary services" shall mean those special services for which charges are customarily made in addition to routine services.

Payment for Inpatient Hospital Services Prior to Notification of Noneligibility

(e) Notwithstanding that an individual is not entitled to have payment made under this part for inpatient hospital services furnished by any hospital, payment shall be made to such hospital (unless it elects not to receive such payment or, if payment has already been made by or on behalf of such individual, fails to refund such payment within the time specified by the Secretary) for such services which are furnished to the individual prior to notification to such hospital from the Secretary of his lack of entitlement, if such payments are precluded only by reason of section 1812 and if such hospital complies with the requirements of and regulations under this title with respect to such payments, has acted in good faith and without knowledge of such lack of entitlement, and has acted reasonably in assuming entitlement existed. Payment under the preceding sentence may not be made for services furnished an individual pursuant to any admission after the 6th elapsed day (not including as an elapsed day Saturday, Sunday, or a legal holiday) after the day on which such admission occurred.

Payment for Certain Inpatient Hospital Services Furnished Outside the United States

(f)(1) Payment shall be made for inpatient hospital services furnished to an individual entitled to hospital insurance benefits under section 226 by a hospital located outside the United States, or under arrangements (as defined in section 1861(w)) with it, if—

(A) such individual is a resident of the United States, and

(B) such hospital was closer to, or substantially more accessible from, the residence of such individual than the nearest hospital within the United States which was adequately equipped to deal with, and was available for the treatment of, such individual's illness or injury.

(2) Payment may also be made for emergency inpatient hospital services furnished to an individual entitled to hospital insurance benefits under section 226 by a hospital located outside the United States if—

(A) such individual was physically present—

(i) in a place within the United States; or

(ii) at a place within Canada while traveling without unreasonable delay by the most direct route (as determined by the Secretary) between Alaska and another State;

at the time the emergency which necessitated such inpatient hospital services occurred, and

(B) such hospital was closer to, or substantially more accessible from, such place than the nearest hospital within the United States which was adequately equipped to deal

with, and was available for the treatment of, such individual's illness or injury.

(3) Payment shall be made in the amount provided under subsection (b) to any hospital for the inpatient hospital services described in paragraph (1) or (2) furnished to an individual by the hospital or under arrangements (as defined in section 1861(w)) with it if (A) the Secretary would be required to make such payment if the hospital had an agreement in effect under this title and otherwise met the conditions of payment hereunder, (B) such hospital elects to claim such payment, and (C) such hospital agrees to comply, with respect to such services, with the provisions of section 1866(a).

(4) Payment for the inpatient hospital services described in paragraph (1) or (2) furnished to an individual entitled to hospital insurance benefits under section 226 may be made on the basis of an itemized bill to such individual if (A) payment for such services cannot be made under paragraph (3) solely because the hospital does not elect to claim such payment, and (B) such individual files application (submitted within such time and in such form and manner and by such person, and continuing and supported by such information as the Secretary shall by regulations prescribe) for reimbursement. The amount payable with respect to such services shall, subject to the provisions of section 1813, be equal to the amount which would be payable under subsection (d)(3).

Payment for Services of a Physician Rendered in a Teaching Hospital

(g) For purposes of services for which the reasonable cost thereof is determined under section 1861(v)(1)(D) (or would be if section 1886 did not apply), payment under this part shall be made to such fund as may be designated by the organized medical staff of the hospital in which such services were furnished or, if such services were furnished in such hospital by the faculty of a medical school, to such fund as may be designated by such faculty, but only if—

(1) such hospital has an agreement with the Secretary under section 1866, and

(2) the Secretary has received written assurances that (A) such payment will be used by such fund solely for the improvement of care of hospital patients or for educational or charitable purposes and (B) the individuals who were furnished such services or any other persons will not be charged for such services (or if charged, provision will be made for return of any moneys incorrectly collected).

Payment for Certain Hospital Services Provided in Department of Veterans Affairs Hospitals

(h)(1) Payments shall also be made to any hospital operated by the Department of Veterans Affairs for inpatient hospital services furnished in a calendar year by the hospital, or under arrangements (as defined in section 1861(w)) with it, to an individual entitled to hospital benefits under section 226 even though the hospital is a Federal provider of services if (A) the individual was not entitled to have the services furnished to him free of charge by the hospital, (B) the individual was admitted to the hospital in the reason-

able belief on the part of the admitting authorities that the individual was a person who was entitled to have the services furnished to him free of charge, (C) the authorities of the hospital, in admitting the individual, and the individual, acted in good faith, and (D) the services were furnished during a period ending with the close of the day on which the authorities operating the hospital first became aware of the fact that the individual was not entitled to have the services furnished to him by the hospital free of charge, or (if later) ending with the first day on which it was medically feasible to remove the individual from the hospital by discharging him therefrom or transferring him to a hospital which has in effect an agreement under this title.

(2) Payment for services described in paragraph (1) shall be in an amount equal to the charge imposed by the Secretary of Veterans Affairs for such services, or (if less) the amount that would be payable for such services under subsection (b) and section 1886 (as estimated by the Secretary). Any such payment shall be made to the entity to which payment for the services involved would have been payable, if payment for such services had been made by the individual receiving the services involved (or by another private person acting on behalf of such individual).

Payment for Hospice Care

(i)(1)(A) Subject to the limitation under paragraph (2) and the provisions of section 1813(a)(4) and except as otherwise provided in this paragraph, the amount paid to a hospice program with respect to hospice care for which payment may be made under this part shall be an amount equal to the costs which are reasonable and related to the cost of providing hospice care or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations (including those authorized under section 1861(v)(1)(A)), except that no payment may be made for bereavement counseling and no reimbursement may be made for other counseling services (including nutritional and dietary counseling) as separate services.

(B) Notwithstanding subparagraph (A), for hospice care furnished on or after April 1, 1986, the daily rate of payment per day for routine home care shall be $63.17 and the daily rate of payment for other services included in hospice care shall be the daily rate of payment recognized under subparagraph (A) as of July 1, 1985, increased by $10.

(C)(i) With respect to routine home care and other services included in hospice care furnished on or after January 1, 1990, and on or before September 30, 1990, the payment rates for such care and services shall be 120 percent of such rates in effect as of September 30, 1989.

(ii) With respect to routine home care and other services included in hospice care furnished during a subsequent fiscal year, the payment rates for such care and services shall be the payment rates in effect under this subparagraph during the previous fiscal year increased by—

(I) for a fiscal year ending on or before September 30, 1993, the market basket percentage increase (as defined in section 1886(b)(3)(B)(iii)) for the fiscal year;

(II) for fiscal year 1994, the market basket percentage increase for the fiscal year minus 2.0 percentage points;

(III) for fiscal year 1995, the market basket percentage increase for the fiscal year minus 1.5 percentage points;

(IV) for fiscal year 1996, the market basket percentage increase for the fiscal year minus 1.5 percentage points;

(V) for fiscal year 1997, the market basket percentage increase for the fiscal year minus 0.5 percentage point;

(VI) for each of fiscal years 1998 through 2002, the market basket percentage increase for the fiscal year involved minus 1.0 percentage points, plus, in the case of fiscal year 2001, 5.0 percentage points; and

(VII) for a subsequent fiscal year, the market basket percentage increase for the fiscal year.

(2)(A) The amount of payment made under this part for hospice care provided by (or under arrangements made by) a hospice program for an accounting year may not exceed the "cap amount" for the year (computed under subparagraph (B)) multiplied by the number of medicare beneficiaries in the hospice program in that year (determined under subparagraph (C)).

(B) For purposes of subparagraph (A), the "cap amount" for a year is $6,500, increased or decreased, for accounting years that end after October 1, 1984, by the same percentage as the percentage increase or decrease, respectively, in the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average), published by the Bureau of Labor Statistics, from March 1984 to the fifth month of the accounting year.

(C) For purposes of subparagraph (A), the "number of medicare beneficiaries" in a hospice program in an accounting year is equal to the number of individuals who have made an election under subsection (d) with respect to the hospice program and have been provided hospice care by (or under arrangements made by) the hospice program under this part in the accounting year, such number reduced to reflect the proportion of hospice care that each such individual was provided in a previous or subsequent accounting year or under a plan of care established by another hospice program.

(D) A hospice program shall submit claims for payment for hospice care furnished in an individual's home under this title only on the basis of the geographic location at which the service is furnished, as determined by the Secretary.

(3) Hospice programs providing hospice care for which payment is made under this subsection shall submit to the Secretary such data with respect to the costs for providing such

care for each fiscal year, beginning with fiscal year 1999, as the Secretary determines necessary.

(4)[32] The amount paid to a hospice program with respect to the services under section 1812(a)(5) for which payment may be made under this part shall be equal to an amount established for an office or other outpatient visit for evaluation and management associated with presenting problems of moderate severity and requiring medical decisionmaking of low complexity under the fee schedule established under section 1848(b), other than the portion of such amount attributable to the practice expense component.

(5)[33] In the case of hospice care provided by a hospice program under arrangements under section 1861(dd)(5)(D) made by another hospice program, the hospice program that made the arrangements shall bill and be paid for the hospice care.

Elimination of Lesser-of-Cost-or-Charges Provision

(j)(1) The lesser-of-cost-or-charges provisions (described in paragraph (2)) will not apply in the case of services provided by a class of provider of services if the Secretary determines and certifies to Congress that the failure of such provisions to apply to the services provided by that class of providers will not result in any increase in the amount of payments made for those services under this title. Such change will take effect with respect to services furnished, or cost reporting periods of providers, on or after such date as the Secretary shall provide in the certification. Such change for a class of provider shall be discontinued if the Secretary determines and notifies Congress that such change has resulted in an increase in the amount of payments made under this title for services provided by that class of provider.

(2) The lesser-of-cost-or-charges provisions referred to in paragraph (1) are as follows:

(A) Clause (B) of paragraph (1) and paragraph (2) of subsection (b).

(B) Section 1834(a)(1)(B).

(C) So much of subparagraph (A) of section 1833(a)(2) as provides for payment other than of the reasonable cost of such services, as determined under section 1861(v).

(D) Subclause (II) of clause (i) and clause (ii) of section 1833(a)(2)(B).

Payments to Home Health Agencies for Durable Medical Equipment

(k) The amount paid to any home health agency with respect to durable medical equipment for which payment may be made under this part shall be the amount described in section 1834(a)(1).

[32] P.L. 108–173, §512(b), added paragraph (4) applicable to services provided by a hospice program on or after January 1, 2005.

[33] P.L. 108–173, §946(b), added paragraph (5), applicable to hospice care provided on or after December 8, 2003.

Payment for Inpatient Critical Access Hospital Services

(l)(1) Except as provided in paragraph (2), the amount[34] of payment under this part for inpatient critical access hospital services is equal to 101 percent of[35] the reasonable costs of the critical access hospital in providing such services.

(2)[36] In the case of a distinct part psychiatric or rehabilitation unit of a critical access hospital described in section 1820(c)(2)(E), the amount of payment for inpatient critical access hospital services of such unit shall be equal to the amount of the payment that would otherwise be made if such services were inpatient hospital services of a distinct part psychiatric or rehabilitation unit, respectively, described in the matter following clause (v) of section 1886(d)(1)(B).

PAYMENT TO PROVIDERS OF SERVICES

SEC. 1815. [42 U.S.C. 1395g] (a) The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) and prior to audit or settlement by the General Accounting Office[37], from the Federal Hospital Insurance Trust Fund, the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments; except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.

(b) No payment shall be made to a provider of services which is a hospital for or with respect to services furnished by it for any period with respect to which it is deemed, under section 1861(w)(2), to have in effect an arrangement with a quality control and peer review organization for the conduct of utilization review activities by such organization unless such hospital has paid to such organization the amount due (as determined pursuant to such section) to such organization for the review activities conducted by it pursuant to such arrangements or such hospital has provided assurances satisfactory to the Secretary that such organization will promptly be paid the amount so due to it from the proceeds of the payment claimed by the hospital. Payment under this title for utilization review activities provided by a quality control and peer review organization pursuant to an arrangement or deemed arrangement with a hospital under section 1861(w)(2) shall be calculated without any requirement that the reasonable cost of such activities be appor-

[34] P.L. 108–173, §405(g)(2)(A), struck out "(l) The amount", and substituted "(l)(1) Except as provided in paragraph (2), the amount", applicable to cost reporting periods beginning on or after October 1, 2004.

[35] P.L. 108–173, §405(a)(1), added "equal to 101 percent of", applicable to payments for services furnished during cost reporting periods beginning on or after October 1, 2004.

[36] P.L. 108–173, §405(g)(2)(B), added paragraph (2), applicable to cost reporting periods beginning on or after January 1, 2004.

[37] P.L. 108-271, §8(b), provided that "Any reference to the General Accounting Office in any law, rule, regulation, certificate, directive, instruction, or other official paper in force on the date of enactment of this Act (July 7, 2004) shall be considered to refer and apply to the Government Accountability Office."

tioned among the patients of such hospital, if any, to whom such activities were not applicable.

(c) No payment which may be made to a provider of services under this title for any service furnished to an individual shall be made to any other person under an assignment or power of attorney; but nothing in this subsection shall be construed (1) to prevent the making of such a payment in accordance with an assignment from the provider 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 (2) to preclude an agent of the provider of services 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 provider under this title 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.

(d) Whenever a final determination is made that the amount of payment made under this part to a provider of services was in excess of or less than the amount of payment that is due, and payment of such excess or deficit is not made (or effected by offset) within 30 days of the date of the determination, interest shall accrue on the balance of such excess or deficit not paid or offset (to the extent that the balance is owed by or owing to the provider) at a rate determined in accordance with the regulations of the Secretary of the Treasury applicable to charges for late payments.

(e)(1) The Secretary shall provide payment under this part for inpatient hospital services furnished by a subsection (d) hospital (as defined in section 1886(d)(1)(B), and including a distinct psychiatric or rehabilitation unit of such a hospital) and a subsection (d) Puerto Rico hospital (as defined in section 1886(d)(9)(A)) on a periodic interim payment basis (rather than on the basis of bills actually submitted) in the following cases:

(A) Upon the request of a hospital which is paid through an agency or organization with an agreement with the Secretary under section 1816, if the agency or organization, for three consecutive calendar months, fails to meet the requirements of subsection (c)(2) of such section and if the hospital meets the requirements (in effect as of October 1, 1986) applicable to payment on such a basis, until such time as the agency or organization meets such requirements for three consecutive calendar months.

(B) In the case of[38] hospital that—

(i) has a disproportionate share adjustment percentage (as established in clause (iv) of such section)[39] of at least 5.1 percent (as computed for purposes of establishing the average standardized amounts for discharges occurring during fiscal year 1987), and

(ii) requests payment on such basis,

but only if the hospital was being paid for inpatient hospital services on such a periodic interim payment basis as of June 30, 1987, and continues to meet the requirements (in effect as of October 1, 1986) applicable to payment on such a basis.

[38] As in original.
[39] See §1886(d)(5)(F)(iv).

(C) In the case of a hospital that—

(i) is located in a rural area,

(ii) has 100 or fewer beds, and

(iii) requests payment on such basis,

but only if the hospital was being paid for inpatient hospital services on such a periodic interim payment basis as of June 30, 1987, and continues to meet the requirements (in effect as of October 1, 1986) applicable to payment on such a basis.

(2) The Secretary shall provide (or continue to provide) for payment on a periodic interim payment basis (under the standards established under section 405.454(j) of title 42, Code of Federal Regulations, as in effect on October 1, 1986, in the cases described in subparagraphs (A) through (D)[40]) with respect to—

(A) inpatient hospital services of a hospital that is not a subsection (d) hospital (as defined in section 1886(d)(1)(B));

(B) a hospital which is receiving payment under a State hospital reimbursement system under section 1814(b)(3) or 1886(c), if payment on a periodic interim payment basis is an integral part of such reimbursement system;

(C) extended care services;[41]

(D) hospice care; and[42]

(E)[43] inpatient critical access hospital services;

if the provider of such services elects to receive, and qualifies for, such payments.

(3) In the case of a subsection (d) hospital or a subsection (d) Puerto Rico hospital (as defined for purposes of section 1886) which has significant cash flow problems resulting from operations of its intermediary or from unusual circumstances of the hospital's operation, the Secretary may make available appropriate accelerated payments.

(4) A hospital created by the merger or consolidation of 2 or more hospitals or hospital campuses shall be eligible to receive periodic interim payment on the basis described in paragraph (1)(B) if—

(A) at least one of the hospitals or campuses received periodic interim payment on such basis prior to the merger or consolidation; and

(B) the merging or consolidating hospitals or campuses would each meet the requirement of paragraph (1)(B)(i) if such hospitals or campuses were treated as independent hospitals for purposes of this title.

USE OF PUBLIC AGENCIES OR PRIVATE ORGANIZATIONS TO FACILITATE PAYMENT TO PROVIDERS OF SERVICES[44]

SEC. 1816. [42 U.S.C. 1395h] (a) If any group or association of providers of services wishes to have payments under this part to such providers made through a national, State, or other public

[40] P.L. 108–173, §405(c)(1)(A), inserted ", in the cases described in subparagraphs (A) through (D)", applicable to payments made on or after July 1, 2004.

[41] P.L. 108–173, §405(c)(1)(B), struck out "and".

[42] P.L. 108–173, §405(c)(1)(C), added "and".

[43] P.L. 108–173, §405(c)(1)(D), added a subparagraph (E), applicable to payments made on or after July 1, 2004.

See Vol. II, P.L. 108-173, §405(c)(2), with respect to the development of alternative timing methods of periodic interim payments.

[44] See Vol. II, P.L. 101–508, §4005(c)(3), with respect to guidance for intermediaries and hospitals.

P.L. 108–173, §911(b), amends §1816 in several places, effective October 1, 2005, pursuant to §911(d). For P.L. 108-173, §911(c), (d) (e) (f) and (g), see Vol. II, P.L. 108-173.

or private agency or organization and nominates such agency or organization for this purpose, the Secretary is authorized to enter into an agreement with such agency or organization providing for the determination by such agency or organization (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the agreement) of the amount of the payments required pursuant to this part to be made to such providers (and to providers assigned to such agency or organization under subsection (e)), and for the making of such payments by such agency or organization to such providers (and to providers assigned to such agency or organization under subsection (e)). Such agreement may also include provision for the agency or organization to do all or any part of the following: (1) to provide consultative services to institutions or agencies to enable them to establish and maintain fiscal records necessary for purposes of this part and otherwise to qualify as hospitals, extended care facilities, or home health agencies, and (2) with respect to the providers of services which are to receive payments through it (A) to serve as a center for, and communicate to providers, any information or instructions furnished to it by the Secretary, and serve as a channel of communication from providers to the Secretary; (B) to make such audits of the records of providers as may be necessary to insure that proper payments are made under this part; and (C) to perform such other functions as are necessary to carry out this subsection. As used in this title and part B of title XI, the term ″fiscal intermediary″ means an agency or organization with a contract under this section.

(b) The Secretary shall not enter into or renew an agreement with any agency or organization under this section unless—

(1) he finds—

(A) after applying the standards, criteria, and procedures developed under subsection (f) of this section, that to do so is consistent with the effective and efficient administration of this part, and

(B) that such agency or organization is willing and able to assist the providers to which payments are made through it under this part in the application of safeguards against unnecessary utilization of services furnished by them to individuals entitled to hospital insurance benefits under section 426 of this title, and the agreement provides for such assistance; and

(2) such agency or organization agrees—

(A) to furnish to the Secretary such of the information acquired by it in carrying out its agreement under this section, and

(B) to provide the Secretary with access to all such data, information, and claims processing operations, as the Secretary may find necessary in performing his functions under this part.]

(c)(1) An agreement with any agency or organization under this section may contain such terms and conditions as the Secretary finds necessary or appropriate, may provide for advances of funds to the agency or organization for the making of payments by it under subsection (a), and shall provide for payment of so much of the cost of administration of the agency or organization as is determined by the Secretary to be necessary and proper for carrying out the functions covered by the agreement. The Secretary shall pro-

vide that in determining the necessary and proper cost of administration, the Secretary shall, with respect to each agreement, take into account the amount that is reasonable and adequate to meet the costs which must be incurred by an efficiently and economically operated agency or organization in carrying out the terms of its agreement. The Secretary shall cause to have published in the Federal Register, by not later than September 1 before each fiscal year, data, standards, and methodology to be used to establish budgets for fiscal intermediaries under this section for that fiscal year, and shall cause to be published in the Federal Register for public comment, at least 90 days before such data, standards, and methodology are published, the data, standards, and methodology proposed to be used. The Secretary may not require, as a condition of entering into or renewing an agreement under this section or under section 1871, that a fiscal intermediary match data obtained other than in its activities under this part with data used in the administration of this part for purposes of identifying situations in which the provisions of section 1862(b) may apply.

(2)(A) Each agreement under this section shall provide that payment shall be issued, mailed, or otherwise transmitted with respect to not less than 95 percent of all claims submitted under this title—

(i) which are clean claims, and

(ii) for which payment is not made on a periodic interim payment basis,

within the applicable number of calendar days after the date on which the claim is received.

(B) In this paragraph:

(i) The term "clean claim" means a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this title.

(ii) The term "applicable number of calendar days" means—

(I) with respect to claims received in the 12-month period beginning October 1, 1986, 30 calendar days,

(II) with respect to claims received in the 12-month period beginning October 1, 1987, 26 calendar days,

(III) with respect to claims received in the 12-month period beginning October 1, 1988, 25 calendar days,[45]

(IV) with respect to claims received in the 12-month period beginning October 1, 1989, and claims received in any succeeding 12-month period ending on or before September 30, 1993, 24 calendar days, and[46]

(V) with respect to claims received in the 12-month period beginning October 1, 1993, and

[45] P.L. 108–173, §736(a)(4)(A), struck out "and".
[46] P.L. 108–173, §736(a)(4)(B), struck out the period and substituted ", and".

claims received in any succeeding 12-month period, 30 calendar days.

(C) If payment is not issued, mailed, or otherwise transmitted within the applicable number of calendar days (as defined in clause (ii) of subparagraph (B)) after a clean claim (as defined in clause (i) of such subparagraph) is received from a hospital, critical access hospital, skilled nursing facility, home health agency, hospice program, comprehensive outpatient rehabilitation facility, or rehabilitation agency that is not receiving payments on a periodic interim payment basis with respect to such services, interest shall be paid at the rate used for purposes of section 3902(a) of title 31, United States Code (relating to interest penalties for failure to make prompt payments) for the period beginning on the day after the required payment date and ending on the date on which payment is made.

(3)(A) Each agreement under this section shall provide that no payment shall be issued, mailed, or otherwise transmitted with respect to any claim submitted under this title within the applicable number of calendar days after the date on which the claim is received.

(B) In this paragraph, the term "applicable number of calendar days" means—

(i) with respect to claims submitted electronically as prescribed by the Secretary, 13 days, and

(ii) with respect to claims submitted otherwise, 26 days.

(d) If the nomination of an agency or organization as provided in this section is made by a group or association of providers of services, it shall not be binding on members of the group or association which notify the Secretary of their election to that effect. Any provider may, upon such notice as may be specified in the agreement under this section with an agency or organization, withdraw its nomination to receive payments through such agency or organization. Any provider which has withdrawn its nomination, and any provider which has not made a nomination, may elect to receive payments from any agency or organization which has entered into an agreement with the Secretary under this section if the Secretary and such agency or organization agree to it.

(e)(1) Notwithstanding subsections (a) and (d), the Secretary, after taking into consideration any preferences of providers of services, may assign or reassign any provider of services to any agency or organization which has entered into an agreement with him under this section, if he determines, after applying the standards, criteria, and procedures developed under subsection (f), that such assignment or reassignment would result in the more effective and efficient administration of this part.

(2) Notwithstanding subsections (a) and (d), the Secretary may (subject to the provisions of paragraph (4)) designate a national or regional agency or organization which has entered into an agreement with him under this section to perform functions under the agreement with respect to a class of providers of services in the Nation or region (as the case may be), if he determines, after applying the standards, criteria, and procedures developed under subsection (f), that such designation

would result in more effective and efficient administration of this part.

(3)(A) Before the Secretary makes an assignment or reassignment under paragraph (1) of a provider of services to other than the agency or organization nominated by the provider, he shall furnish (i) the provider and such agency or organization with a full explanation of the reasons for his determination as to the efficiency and effectiveness of the agency or organization to perform the functions required under this part with respect to the provider, and (ii) such agency or organization with opportunity for a hearing, and such determination shall be subject to judicial review in accordance with chapter 7 of title 5, United States Code[47].

(B) Before the Secretary makes a designation under paragraph (2) with respect to a class of providers of services, he shall furnish (i) such providers and the agencies and organizations adversely affected by such designation with a full explanation of the reasons for his determination as to the efficiency and effectiveness of such agencies and organizations to perform the functions required under this part with respect to such providers, and (ii) the agencies and organizations adversely affected by such designation with opportunity for a hearing, and such determination shall be subject to judicial review in accordance with chapter 7 of title 5, United States Code.

(4) Notwithstanding subsections (a) and (d) and paragraphs (1), (2), and (3) of this subsection, the Secretary shall designate regional agencies or organizations which have entered into an agreement with him under this section to perform functions under such agreement with respect to home health agencies (as defined in section 1861(o)) in the region, except that in assigning such agencies to such designated regional agencies or organizations the Secretary shall assign a home health agency which is a subdivision of a hospital (and such agency and hospital are affiliated or under common control) only if, after applying such criteria relating to administrative efficiency and effectiveness as he shall promulgate, he determines that such assignment would result in the more effective and efficient administration of this title. By not later than July 1, 1987, the Secretary shall limit the number of such regional agencies or organizations to not more than ten.

(5) Notwithstanding any other provision of this subchapter, the Secretary shall designate the agency or organization which has entered into an agreement under this section to perform functions under such an agreement with respect to each hospice program, except that with respect to a hospice program which is a subdivision of a provider of services (and such hospice program and provider of services are under common control) due regard shall be given to the agency or organization which performs the functions under this section for the provider of services.

(f)(1) In order to determine whether the Secretary should enter into, renew, or terminate an agreement under this section with an agency or organization, whether the Secretary should assign or re-

[47] See Vol. II, Title 5, §706.

assign a provider of services to an agency or organization, and whether the Secretary should designate an agency or organization to perform services with respect to a class of providers of services, the Secretary shall develop standards, criteria, and procedures to evaluate such agency's or organization's (A) overall performance of claims processing (including the agency's or organization's success in recovering payments made under this title for services for which payment has been or could be made under a primary plan (as defined in section 1862(b)(2)(A))) and other related functions required to be performed by such an agency or organization under an agreement entered into under this section, and (B) performance of such functions with respect to specific providers of services, and the Secretary shall establish standards and criteria with respect to the efficient and effective administration of this part. No agency or organization shall be found under such standards and criteria not to be efficient or effective or to be less efficient or effective solely on the ground that the agency or organization serves only providers located in a single State.

(2) The standards and criteria established under paragraph (1) shall include—

(A) with respect to claims for services furnished under this part by any provider of services other than a hospital—

(i) whether such agency or organization is able to process 75 percent of reconsiderations within 60 days (except in the case of fiscal year 1989, 66 percent of reconsiderations) and 90 percent of reconsiderations within 90 days, and

(ii) the extent to which such agency's or organization's determinations are reversed on appeal; and

(B) with respect to applications for an exemption from or exception or adjustment to the target amount applicable under section 1886(b) to a hospital that is not a subsection (d) hospital (as defined in section 1886(d)(1)(B))—

(i) if such agency or organization receives a completed application, whether such agency or organization is able to process such application not later than 75 days after the application is filed, and

(ii) if such agency or organization receives an incomplete application, whether such agency or organization is able to return the application with instructions on how to complete the application not later than 60 days after the application is filed.

(g) An agreement with the Secretary under this section may be terminated—

(1) by the agency or organization which entered into such agreement at such time and upon such notice to the Secretary, to the public, and to the providers as may be provided in regulations, or

(2) by the Secretary at such time and upon such notice to the agency or organization, to the providers which have nominated it for purposes of this section, and to the public, as may be provided in regulations, but only if he finds, after applying the standards, criteria, and procedures developed under subsection (f) and after reasonable notice and opportunity for hearing to the agency or organization, that (A) the agency or organization

has failed substantially to carry out the agreement, or (B) the continuation of some or all of the functions provided for in the agreement with the agency or organization is disadvantageous or is inconsistent with the efficient administration of this part.

(h) An agreement with an agency or organization under this section may require any of its officers or employees certifying payments or disbursing funds pursuant to the agreement, or otherwise participating in carrying out the agreement, to give surety bond to the United States in such amount as the Secretary may deem appropriate.[48]

(i)(1) No individual designated pursuant to an agreement under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him under this section.

(2) No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him under this section if it was based upon a voucher signed by a certifying officer designated as provided in paragraph (1) of this subsection.

(3) No such agency or organization shall be liable to the United States for any payments referred to in paragraph (1) or (2).

(j) An agreement with an agency or organization under this section shall require that, with respect to a claim for home health services, extended care services, or post-hospital extended care services submitted by a provider to such agency or organization that is denied, such agency or organization—

(1) furnish the provider and the individual with respect to whom the claim is made with a written explanation of the denial and of the statutory or regulatory basis for the denial; and

(2) in the case of a request for reconsideration of a denial, promptly notify such individual and the provider of the disposition of such reconsideration.

(k) An agreement with an agency or organization under this section shall require that such agency or organization submit an annual report to the Secretary describing the steps taken to recover payments made for items or services for which payment has been or could be made under a primary plan (as defined in section 1862(b)(2)(A)).

(l) No agency or organization may carry out (or receive payment for carrying out) any activity pursuant to an agreement under this section to the extent that the activity is carried out pursuant to a contract under the Medicare Integrity Program under section 1893.

FEDERAL HOSPITAL INSURANCE TRUST FUND[49]

SEC. 1817. [42 U.S.C. 1395i] (a) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Hospital Insurance Trust Fund" (hereinafter in this section referred to as the "Trust Fund"). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as may be deposited in, or

[48] See Vol. II, 31 U.S.C. 9309 with respect to priority of sureties.

[49] See Vol. II, P.L. 108-173, §734 with respect to restoration of Medicare Trust Funds and §801, with respect to inclusion in annual report of Medicare Trustees of information on status of Medicare Trust Funds.

appropriated to, such fund as provided in this part. There are hereby appropriated to the Trust Fund for the fiscal year ending June 30, 1966, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

(1) the taxes imposed by sections 3101(b) and 3111(b) of the Internal Revenue Code of 1954[50] with respect to wages reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of such Code[51] after December 31, 1965, as determined by the Secretary of the Treasury by applying the applicable rates of tax under such sections to such wages, which wages shall be certified by the Commissioner of Social Security on the basis of records of wages established and maintained by the Commissioner of Social Security in accordance with such reports; and

(2) the taxes imposed by section 1401(b) of the Internal Revenue Code of 1954[52] with respect to self-employment income reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of such Code, as determined by the Secretary of the Treasury by applying the applicable rate of tax under such section to such self-employment income, which self-employment income shall be certified by the Commissioner of Social Security on the basis of records of self-employment established and maintained by the Commissioner of Social Security in accordance with such returns.

The amounts appropriated by the preceding sentence shall be transferred from time to time from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes, specified in the preceding sentence, paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the taxes specified in such sentence.

(b) With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this section referred to as the "Board of Trustees") composed of the Commissioner of Social Security, the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, all ex officio, and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of four years and subject to confirmation by the Senate. A member of the Board of Trustees serving as a member of the public and nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term. An individual nominated and confirmed as a member of the public may serve in such position after the expiration of such member's term until the earlier of the time at which the member's successor takes office or the time at which a report of the Board is first issued under paragraph (2) after the expiration of the member's term. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees

[50] See P.L. 83–591, §3101(b) (this volume).

[51] P.L. 83–591.

P.L. 99–514, §2, provides, except when inappropriate, any reference to the Internal Revenue Code of 1954 shall include a reference to the Internal Revenue Code of 1986.

[52] See P.L. 83–591, §1401(b) (this volume).

(hereinafter in this section referred to as the "Managing Trustee"). The Administrator of the Centers for Medicare and Medicaid Services[53] shall serve as the Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

(1) Hold the Trust Fund;

(2) Report to the Congress not later than the first day of April of each year on the operation and status of the Trust Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years;

Each report provided under paragraph (2) beginning with the report in 2005 shall include the information specified in section 801(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.[54]

(3) Report immediately to the Congress whenever the Board is of the opinion that the amount of the Trust Fund is unduly small; and

(4) Review the general policies followed in managing the Trust Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the Trust Fund is to be managed.

The report provided for in paragraph (2) shall include a statement of the assets of, and the disbursements made from, the Trust Fund during the preceding fiscal year, an estimate of the expected income to, and disbursements to be made from, the Trust Fund during the current fiscal year and each of the next 2 fiscal years, and a statement of the actuarial status of the Trust Fund. Such report shall also include an actuarial opinion by the Chief Actuary[55] of the Centers for Medicare and Medicaid Services[56] certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable. Such report shall be printed as a House document of the session of the Congress to which the report is made. A person serving on the Board of Trustees shall not be considered to be a fiduciary and shall not be personally liable for actions taken in such capacity with respect to the Trust Fund.

(c) It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund as is not, in his judgment, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired (1) on original issue at the issue price, or (2) by purchase of outstanding obligations at the market price. The purposes for which obligations of the United States may be issued under chapter 31 of title 31, United States Code, are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Fund. Such obligations issued for purchase by the Trust Fund shall have matu-

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[53] P.L. 108–173, §900(e)(1)(D)(i), struck out "Health Care Financing Administration", and substituted "Centers for Medicare and Medicaid Services".

[54] P.L. 108–173, §801(d)(1), added this sentence, effective December 8, 2003.
See Vol. II, P.L. 108-173, §801(a).

[55] P.L. 108–173, §900(e)(1)(D)(ii), struck out "Chief Actuarial Officer" and substituted "Chief Actuary".

[56] P.L. 108–173, §900(e)(1)(D)(i), struck out "Health Care Financing Administration", and substituted "Centers for Medicare and Medicaid Services".

rities fixed with due regard for the needs of the Trust Fund and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such calendar month; except that where such average market yield is not a multiple of one-eighth of 1 per centum, the rate of interest on such obligations shall be the multiple of one-eighth of 1 per centum nearest such market yield. The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where he determines that the purchase of such other obligations is in the public interest.

(d) Any obligations acquired by the Trust Fund (except public-debt obligations issued exclusively to the Trust Fund) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

(e) The interest on, and the proceeds from the sale or redemption of, any obligations held in the Trust Fund shall be credited to and form a part of the Trust Fund.

(f)(1) The Managing Trustee is directed to pay from time to time from the Trust Fund into the Treasury the amount estimated by him as taxes imposed under section 3101(b) which are subject to refund under section 6413(c) of the Internal Revenue Code of 1954[57] with respect to wages paid after December 31, 1965. Such taxes shall be determined on the basis of the records of wages established and maintained by the Commissioner of Social Security in accordance with the wages reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1954[58], and the Commissioner of Social Security shall furnish the Managing Trustee such information as may be required by the Managing Trustee for such purpose. The payments by the Managing Trustee shall be covered into the Treasury as repayments to the account for refunding internal revenue collections.

(2) Repayments made under paragraph (1) shall not be available for expenditures but shall be carried to the surplus fund of the Treasury. If it subsequently appears that the estimates under such paragraph in any particular period were too high or too low, appropriate adjustments shall be made by the Managing Trustee in future payments.

(g) There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Federal Old-Age and Survivors Insurance Trust Fund and from the Federal Disability Insurance Trust Fund amounts equivalent to the amounts not previously so transferred which the Secretary of Health and Human Services shall have certified as overpayments (other than amounts so certified to the Railroad Retirement Board) pursuant to section 1870(b) of this Act. There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Railroad Retirement Account amounts equiva-

[57] See P.L. 83–591, §3101(b) (this volume).
[58] P.L. 83–591.

lent to the amounts not previously so transferred which the Secretary of Health and Human Services shall have certified as overpayments to the Railroad Retirement Board pursuant to section 1870(b) of this Act.

(h) The Managing Trustee shall also pay from time to time from the Trust Fund such amounts as the Secretary of Health and Human Services certifies are necessary to make the payments provided for by this part, and the payments with respect to administrative expenses in accordance with section 201(g)(1).

(i) There are authorized to be made available for expenditure out of the Trust Fund such amounts as are required to pay travel expenses, either on an actual cost or commuted basis, to parties, their representatives, and all reasonably necessary witnesses for travel within the United States (as defined in section 210(i)) to attend reconsideration interviews and proceedings before administrative law judges with respect to any determination under this title. The amount available under the preceding sentence for payment for air travel by any person shall not exceed the coach fare for air travel between the points involved unless the use of first-class accommodations is required (as determined under regulations of the Secretary) because of such person's health condition or the unavailability of alternative accommodations; and the amount available for payment for other travel by any person shall not exceed the cost of travel (between the points involved) by the most economical and expeditious means of transportation appropriate to such person's health condition, as specified in such regulations. The amount available for payment under this subsection for travel by a representative to attend an administrative proceeding before an administrative law judge or other adjudicator shall not exceed the maximum amount allowable under this subsection for such travel originating within the geographic area of the office having jurisdiction over such proceeding.

(j)(1) If at any time prior to January 1988 the Managing Trustee determines that borrowing authorized under this subsection is appropriate in order to best meet the need for financing the benefit payments from the Federal Hospital Insurance Trust Fund, the Managing Trustee may, subject to paragraph (5), borrow such amounts as he determines to be appropriate from either the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund for transfer to and deposit in the Federal Hospital Insurance Trust Fund.

(2) In any case where a loan has been made to the Federal Hospital Insurance Trust Fund under paragraph (1), there shall be transferred on the last day of each month after such loan is made, from such Trust Fund to the lending Trust Fund, the total interest accrued to such day with respect to the unrepaid balance of such loan at a rate equal to the rate which the lending Trust Fund would earn on the amount involved if the loan were an investment under subsection (c) (even if such an investment would earn interest at a rate different than the rate earned by investments redeemed by the lending fund in order to make the loan).

(3)(A) If in any month after a loan has been made to the Federal Hospital Insurance Trust Fund under paragraph (1), the Managing Trustee determines that the assets of such Trust Fund are sufficient to permit repayment of all or part of any

loans made to such Fund under paragraph (1), he shall make such repayments as he determines to be appropriate.

(B)(i) If on the last day of any year after a loan has been made under paragraph (1) by the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund to the Federal Hospital Insurance Trust Fund, the Managing Trustee determines that the Hospital Insurance Trust Fund ratio exceeds 15 percent, he shall transfer from such Trust Fund to the lending trust fund an amount that—

(I) together with any amounts transferred to another lending trust fund under this paragraph for such year, will reduce the Hospital Insurance Trust Fund ratio to 15 percent; and

(II) does not exceed the outstanding balance of such loan.

(ii) Amounts required to be transferred under clause (i) shall be transferred on the last day of the first month of the year succeeding the year in which the determination described in clause (i) is made.

(iii) For purposes of this subparagraph, the term " Hospital Insurance Trust Fund ratio" means, with respect to any calendar year, the ratio of—

(I) the balance in the Federal Hospital Insurance Trust Fund, as of the last day of such calendar year; to

(II) the amount estimated by the Secretary to be the total amount to be paid from the Federal Hospital Insurance Trust Fund during the calendar year following such calendar year (other than payments of interest on, and repayments of, loans from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund under paragraph (1)), and reducing the amount of any transfer to the Railroad Retirement Account by the amount of any transfers into such Trust Fund from the Railroad Retirement Account.

(C)(i) The full amount of all loans made under paragraph (1) (whether made before or after January 1, 1983) shall be repaid at the earliest feasible date and in any event no later than December 31, 1989.

(ii) For the period after December 31, 1987 and before January 1, 1990, the Managing Trustee shall transfer each month from the Federal Hospital Insurance Trust Fund to any Trust Fund that is owed any amount by the Federal Hospital Insurance Trust Fund on a loan made under paragraph (1), an amount not less than an amount equal to (I) the amount owed to such Trust Fund by the Federal Hospital Insurance Trust Fund at the beginning of such month (plus the interest accrued on the outstanding balance of such loan during such month), divided by (II) the number of months elapsing after the preceding month and before January 1990. The Managing Trustee may, dur-

ing this period, transfer larger amounts than prescribed by the preceding sentence.

(4) The Board of Trustees shall make a timely report to the Congress of any amounts transferred (including interest payments) under this subsection.

(5)(A) No amounts may be loaned by the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund under paragraph (1) during any month if the OASDI trust fund ratio for such month is less than 10 percent.

(B) For purposes of this paragraph, the term "OASDI trust fund ratio" means, with respect to any month, the ratio of—

(i) the combined balance in the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, reduced by the outstanding amount of any loan (including interest thereon) theretofore made to either such Trust Fund from the Federal Hospital Insurance Trust Fund under section 201(l), as of the last day of the second month preceding such month, to

(ii) the amount obtained by multiplying by twelve the total amount which (as estimated by the Secretary) will be paid from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund during the month for which such ratio is to be determined for all purposes authorized by section 201 (other than payments of interest on, or repayments of, loans from the Federal Hospital Insurance Trust Fund under section 201(l)), but excluding any transfer payments between such trust funds and reducing the amount of any transfers to the Railroad Retirement Account by the amount of any transfers into either such trust fund from that Account.

(k) HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.—

(1) ESTABLISHMENT.—There is hereby established in the Trust Fund an expenditure account to be known as the "Health Care Fraud and Abuse Control Account" (in this subsection referred to as the "Account").

(2) APPROPRIATED AMOUNTS TO TRUST FUND.—

(A) IN GENERAL.—There are hereby appropriated to the Trust Fund—

(i) such gifts and bequests as may be made as provided in subparagraph (B);

(ii) such amounts as may be deposited in the Trust Fund as provided in sections 242(b) and 249(c) of the Health Insurance Portability and Accountability Act of 1996[59], and title XI; and

(iii) such amounts as are transferred to the Trust Fund under subparagraph (C).

(B) AUTHORIZATION TO ACCEPT GIFTS.—The Trust Fund is authorized to accept on behalf of the United States

[59] See Vol. II, P.L. 104–191, §242(b), with respect to criminal fines deposited in Federal Hospital Insurance Trust Fund and §249(c), with respect to property forfeited deposited in Federal Hospital Insurance Trust Fund.

money gifts and bequests made unconditionally to the Trust Fund, for the benefit of the Account or any activity financed through the Account.

(C)[60] TRANSFER OF AMOUNTS.—The Managing Trustee shall transfer to the Trust Fund, under rules similar to the rules in section 9601 of the Internal Revenue Code of 1986, an amount equal to the sum of the following:

(i) Criminal fines recovered in cases involving a Federal health care offense (as defined in section 24(a) of title 18, United States Code).

(ii) Civil monetary penalties and assessments imposed in health care cases, including amounts recovered under titles XI, XVIII, and XIX, and chapter 38 of title 31, United States Code (except as otherwise provided by law).

(iii) Amounts resulting from the forfeiture of property by reason of a Federal health care offense.

(iv) Penalties and damages obtained and otherwise creditable to miscellaneous receipts of the general fund of the Treasury obtained under sections 3729 through 3733 of title 31, United States Code (known as the False Claims Act), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator, for restitution or otherwise authorized by law).

(D) APPLICATION.—Nothing in subparagraph (C)(iii) shall be construed to limit the availability of recoveries and forfeitures obtained under title I of the Employee Retirement Income Security Act of 1974 for the purpose of providing equitable or remedial relief for employee welfare benefit plans, and for participants and beneficiaries under such plans, as authorized under such title.

(3) APPROPRIATED AMOUNTS TO ACCOUNT FOR FRAUD AND ABUSE CONTROL PROGRAM, ETC.—

(A) DEPARTMENTS OF HEALTH AND HUMAN SERVICES AND JUSTICE.—

(i) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund such sums as the Secretary and the Attorney General certify are necessary to carry out the purposes described in subparagraph (C), to be available without further appropriation, in an amount not to exceed—

(I) for fiscal year 1997, $104,000,000.

(II) for each of the fiscal years 1998 through 2003, the limit for the preceding fiscal year, increased by 15 percent; and

(III) for each fiscal year after fiscal year 2003, the limit for fiscal year 2003.

(ii) MEDICARE AND MEDICAID ACTIVITIES.—For each fiscal year, of the amount appropriated in clause (i), the following amounts shall be available only for the purposes of the activities of the Office of the Inspector General of the Department of Health and Human

[60] See Vol. II, Title 18, §24(a); Title 31, P.L. 83-591, §9601 and P.L. 93-406.

Services with respect to the Medicare and medicaid programs—

(I) for fiscal year 1997, not less than $60,000,000 and not more than $70,000,000;

(II) for fiscal year 1998, not less than $80,000,000 and not more than $90,000,000;

(III) for fiscal year 1999, not less than $90,000,000 and not more than $100,000,000;

(IV) for fiscal year 2000, not less than $110,000,000 and not more than $120,000,000;

(V) for fiscal year 2001, not less than $120,000,000 and not more than $130,000,000;

(VI) for fiscal year 2002, not less than $140,000,000 and not more than $150,000,000; and

(VII) for each fiscal year after fiscal year 2002, not less than $150,000,000 and not more than $160,000,000.

(B) FEDERAL BUREAU OF INVESTIGATION.—There are hereby appropriated from the general fund of the United States Treasury and hereby appropriated to the Account for transfer to the Federal Bureau of Investigation to carry out the purposes described in subparagraph (C), to be available without further appropriation—

(i) for fiscal year 1997, $47,000,000;

(ii) for fiscal year 1998, $56,000,000;

(iii) for fiscal year 1999, $66,000,000;

(iv) for fiscal year 2000, $76,000,000;

(v) for fiscal year 2001, $88,000,000;

(vi) for fiscal year 2002, $101,000,000; and

(vii) for each fiscal year after fiscal year 2002, $114,000,000.

(C) USE OF FUNDS.—The purposes described in this subparagraph are to cover the costs (including equipment, salaries and benefits, and travel and training) of the administration and operation of the health care fraud and abuse control program established under section 1128C(a), including the costs of—

(i) prosecuting health care matters (through criminal, civil, and administrative proceedings);

(ii) investigations;

(iii) financial and performance audits of health care programs and operations;

(iv) inspections and other evaluations; and

(v) provider and consumer education regarding compliance with the provisions of title XI.

(4) APPROPRIATED AMOUNTS TO ACCOUNT FOR MEDICARE INTEGRITY PROGRAM.—

(A) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund for each fiscal year such amounts as are necessary to carry out the Medicare Integrity Program under section 1893, subject to subparagraph (B) and to be available without further appropriation.

(B) AMOUNTS SPECIFIED.— The amount appropriated under subparagraph (A) for a fiscal year is as follows:

(i) For fiscal year 1997, such amount shall be not less than $430,000,000 and not more than $440,000,000.

(ii) For fiscal year 1998, such amount shall be not less than $490,000,000 and not more than $500,000,000.

(iii) For fiscal year 1999, such amount shall be not less than $550,000,000 and not more than $560,000,000.

(iv) For fiscal year 2000, such amount shall be not less than $620,000,000 and not more than $630,000,000.

(v) For fiscal year 2001, such amount shall be not less than $670,000,000 and not more than $680,000,000.

(vi) For fiscal year 2002, such amount shall be not less than $690,000,000 and not more than $700,000,000.

(vii) For each fiscal year after fiscal year 2002, such amount shall be not less than $710,000,000 and not more than $720,000,000.

(5) ANNUAL REPORT.—Not later than January 1, the Secretary and the Attorney General shall submit jointly a report to Congress which identifies—

(A) the amounts appropriated to the Trust Fund for the previous fiscal year under paragraph (2)(A) and the source of such amounts; and

(B) the amounts appropriated from the Trust Fund for such year under paragraph (3) and the justification for the expenditure of such amounts.

(6) GAO REPORT.—Not later than June 1, 1998, and January 1 of 2000, 2002, and 2004, the Comptroller General of the United States shall submit a report to Congress which—

(A) identifies—

(i) the amounts appropriated to the Trust Fund for the previous two fiscal years under paragraph (2)(A) and the source of such amounts; and

(ii) the amounts appropriated from the Trust Fund for such fiscal years under paragraph (3) and the justification for the expenditure of such amounts;

(B) identifies any expenditures from the Trust Fund with respect to activities not involving the program under this title[61];

(C) identifies any savings to the Trust Fund, and any other savings, resulting from expenditures from the Trust Fund; and

(D) analyzes such other aspects of the operation of the Trust Fund as the Comptroller General of the United States considers appropriate.

[61] P.L. 108–173, §736(a)(6), struck out "Medicare program under title XVIII" and substituted "program under this title".

HOSPITAL INSURANCE BENEFITS FOR UNINSURED ELDERLY INDIVIDUALS NOT OTHERWISE ELIGIBLE

SEC. 1818. [42 U.S.C. 1395i–2] (a) Every individual who—

(1) has attained the age of 65,

(2) is enrolled under part B of this title,

(3) is a resident of the United States, and is either (A) a citizen or (B) an alien lawfully admitted for permanent residence who has resided in the United States continuously during the 5 years immediately preceding the month in which he applies for enrollment under this section, and

(4) is not otherwise entitled to benefits under this part,

shall be eligible to enroll in the insurance program established by this part. Except as otherwise provided, any reference to an individual entitled to benefits under this part includes an individual entitled to benefits under this part pursuant to an enrollment under this section or section 1818A.[62]

(b) An individual may enroll under this section only in such manner and form as may be prescribed in regulations, and only during an enrollment period prescribed in or under this section.

(c) The provisions of section 1837 (except subsection (f) thereof), section 1838, subsection (b) of section 1839, and subsections (f) and (h) of section 1840 shall apply to persons authorized to enroll under this section except that—

(1) individuals who meet the conditions of subsection (a)(1), (3), and (4) on or before the last day of the seventh month after the month in which this section is enacted[63] may enroll under this part and (if not already so enrolled) may also enroll under part B during an initial general enrollment period which shall begin on the first day of the second month which begins after the date on which this section is enacted and shall end on the last day of the tenth month after the month in which this section is enacted;

(2) in the case of an individual who first meets the conditions of eligibility under this section on or after the first day of the eighth month after the month in which this section is enacted, the initial enrollment period shall begin on the first day of the third month before the month in which he first becomes eligible and shall end 7 months later;

(3) in the case of an individual who enrolls pursuant to paragraph (1) of this subsection, entitlement to benefits shall begin on—

(A) the first day of the second month after the month in which he enrolls,

(B) July 1, 1973, or

(C) the first day of the first month in which he meets the requirements of subsection (a),

whichever is the latest;

(4) an individual's entitlement under this section shall terminate with the month before the first month in which he becomes eligible for hospital insurance benefits under section 226 of this Act or section 103 of the Social Security Amendments of 1965[64]; and upon such termination, such individual shall be

[62] P.L. 108–173, §101(e)(5), added this sentence, effective December 8, 2003.
[63] October 30, 1972 [P.L. 92–603; 86 Stat. 1374].
[64] See Vol. II, P.L. 89–97.

deemed, solely for purposes of hospital insurance entitlement, to have filed in such first month the application required to establish such entitlement;

(5) termination of coverage for supplementary medical insurance shall result in simultaneous termination of hospital insurance benefits for uninsured individuals who are not otherwise entitled to benefits under this Act;

(6) any percent increase effected under section 1839(b) in an individual's monthly premium may not exceed 10 percent and shall only apply to premiums paid during a period equal to twice the number of months in the full 12–month periods described in that section and shall be subject to reduction in accordance with subsection (d)(6);

(7) an individual who meets the conditions of subsection (a) may enroll under this part during a special enrollment period that includes any month during any part of which the individual is enrolled under section 1876 with an eligible organization and ending with the last day of the 8th consecutive month in which the individual is at no time so enrolled;

(8) in the case of an individual who enrolls during a special enrollment period under paragraph (7)—

(A) in any month of the special enrollment period in which the individual is at any time enrolled under section 1876 with an eligible organization or in the first month following such a month, the coverage period shall begin on the first day of the month in which the individual so enrolls (or, at the option of the individual, on the first day of any of the following three months), or

(B) in any other month of the special enrollment period, the coverage period shall begin on the first day of the month following the month in which the individual so enrolls; and

(9) in applying the provisions of section 1839(b), there shall not be taken into account months for which the individual can demonstrate that the individual was enrolled under section 1876 with an eligible organization.

(d)(1) The Secretary shall, during September of each year (beginning with 1988), estimate the monthly actuarial rate for months in the succeeding year. Such actuarial rate shall be one–twelfth of the amount which the Secretary estimates (on an average, per capita basis) is equal to 100 percent of the benefits and administrative costs which will be payable from the Federal Hospital Insurance Trust Fund for services performed and related administrative costs incurred in the succeeding year with respect to individuals age 65 and over who will be entitled to benefits under this part during that year.

(2) The Secretary shall, during September of each year determine and promulgate the dollar amount which shall be applicable for premiums for months occurring in the following year. Subject to paragraphs (4) and (5), the amount of an individual's monthly premium under this section shall be equal to the monthly actuarial rate determined under paragraph (1) for that following year. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1).

(3) Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium under this section, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for individuals 65 and older as provided in paragraph (1).

(4)(A) In the case of an individual described in subparagraph (B), the monthly premium for a month shall be reduced by the applicable reduction percent specified in the following table:

For a month in:	**The applicable reduction percent is:**
1994	25 percent
1995	30 percent
1996	35 percent
1997	40 percent
1998 or subsequent year	45 percent.

(B) An individual described in this subparagraph with respect to a month is an individual who establishes to the satisfaction of the Secretary that, as of the last day of the previous month, the individual—

(i) had at least 30 quarters of coverage under title II;

(ii) was married (and had been married for the previous 1–year period) to an individual who had at least 30 quarters of coverage under such title;

(iii) had been married to an individual for a period of at least 1 year (at the time of such individual's death) if at such time the individual had at least 30 quarters of coverage under such title; or

(iv) is divorced from an individual and had been married to the individual for a period of at least 10 years (at the time of the divorce) if at such time the individual had at least 30 quarters of coverage under such title.

(5)(A) The amount of the monthly premium shall be zero in the case of an individual who is a person described in subparagraph (B) for a month, if—

(i) the individual's premium under this section for the month is not (and will not be) paid for, in whole or in part, by a State (under title XIX or otherwise), a political subdivision of a State, or an agency or instrumentality of one or more States or political subdivisions thereof; and

(ii) in each of 84 months before such month, the individual was enrolled in this part under this section and the payment of the individual's premium under this section for the month was not paid for, in whole or in part, by a State (under title XIX or otherwise), a political subdivision of a State, or an agency or instrumentality of one or more States or political subdivisions thereof.

(B) A person described in this subparagraph for a month is a person who establishes to the satisfaction of the Secretary that, as of the last day of the previous month—

(i)(I) the person was receiving cash benefits under a qualified State or local government retirement system (as defined in subparagraph (C)) on the basis of the person's employment in one or more positions covered under any such system, and (II) the person would have at least 40 quarters of coverage under title II if remuneration for medicare qualified government employment (as defined in paragraph (1) of section 210(p), but determined without regard to paragraph (3) of such section) paid to such person were treated as wages paid to such person and credited for purposes of determining quarters of coverage under section 213;

(ii)(I) the person was married (and had been married for the previous 1–year period) to an individual who is described in clause (i), or (II) the person met the requirement of clause (i)(II) and was married (and had been married for the previous 1–year period) to an individual described in clause (i)(I);

(iii) the person had been married to an individual for a period of at least 1 year (at the time of such individual's death) if (I) the individual was described in clause (i) at the time of the individual's death, or (II) the person met the requirement of clause (i)(II) and the individual was described in clause (i)(I) at the time of the individual's death; or

(iv) the person is divorced from an individual and had been married to the individual for a period of at least 10 years (at the time of the divorce) if (I) the individual was described in clause (i) at the time of the divorce, or (II) the person met the requirement of clause (i)(II) and the individual was described in clause (i)(I) at the time of the divorce.

(C) For purposes of subparagraph (B)(i)(I), the term "qualified State or local government retirement system" means a retirement system that—

(i) is established or maintained by a State or political subdivision thereof, or an agency or instrumentality of one or more States or political subdivisions thereof;

(ii) covers positions of some or all employees of such a State, subdivision, agency, or instrumentality; and

(iii) does not adjust cash retirement benefits based on eligibility for a reduction in premium under this paragraph.

(6)(A) In the case where a State, a political subdivision of a State, or an agency or instrumentality of a State or political subdivision thereof determines to pay, for the life of each individual, the monthly premiums due under paragraph (1) on behalf of each of the individuals in a qualified State or local government retiree group who meets the conditions of subsection (a), the amount of any increase otherwise applicable under section 1839(b) (as applied and modified by subsection (c)(6) of

this section) with respect to the monthly premium for benefits under this part for an individual who is a member of such group shall be reduced by the total amount of taxes paid under section 3101(b) of the Internal Revenue Code of 1986 by such individual and under 3111(b) of such Code[65] by the employers of such individual on behalf of such individual with respect to employment (as defined in section 3121(b) of such Code).

(B) For purposes of this paragraph, the term "qualified State or local government retiree group" means all of the individuals who retire prior to a specified date that is before January 1, 2002, from employment in one or more occupations or other broad classes of employees of—

(i) the State;

(ii) a political subdivision of the State; or

(iii) an agency or instrumentality of the State or political subdivision of the State.

(e) Payment of the monthly premiums on behalf of any individual who meets the conditions of subsection (a) may be made by any public or private agency or organization under a contract or other arrangement entered into between it and the Secretary if the Secretary determines that payment of such premiums under such contract or arrangement is administratively feasible.

(f) Amounts paid to the Secretary for coverage under this section shall be deposited in the Treasury to the credit of the Federal Hospital Insurance Trust Fund.

(g)(1) The Secretary shall, at the request of a State made after 1989, enter into a modification of an agreement entered into with the State pursuant to section 1843(a) under which the agreement provides for enrollment in the program established by this part of qualified medicare beneficiaries (as defined in section 1905(p)(1)).

(2)(A) Except as provided in subparagraph (B), the provisions of subsections (c), (d), (e), and (f) of section 1843 shall apply to qualified medicare beneficiaries enrolled, pursuant to such agreement, in the program established by this part in the same manner and to the same extent as they apply to qualified medicare beneficiaries enrolled, pursuant to such agreement, in part B.

(B) For purposes of this subsection, section 1843(d)(1) shall be applied by substituting "section 1818" for "section 1839" and "subsection (c)(6) (with reference to subsection (b) of section 1839)" for "subsection (b)"[66].

HOSPITAL INSURANCE BENEFITS FOR DISABLED INDIVIDUALS WHO HAVE EXHAUSTED OTHER ENTITLEMENT

SEC. 1818A. [42 U.S.C. 1395i–2a] (a) Every individual who—

(1) has not attained the age of 65;

(2)(A) has been entitled to benefits under this part under section 226(b), and

(B)(i) continues to have the disabling physical or mental impairment on the basis of which the individual was found to be under a disability or to be a disabled qualified rail-

[65] P.L. 108–173, §736(a)(7)(A), added "of such Code". See P.L. 83-591 §3101(b) and §3111(b) (this volume).

[66] P.L. 108–173, §736(a)(7)(B), struck out "subsection (b)." and substituted "subsection (b)".

road retirement beneficiary, or (ii) is blind (within the meaning of section 216(i)(1)), but

(C) whose entitlement under section 226(b) ends due solely to the individual having earnings that exceed the substantial gainful activity amount (as defined in section 223(d)(4)); and

(3) is not otherwise entitled to benefits under this part,

shall be eligible to enroll in the insurance program established by this part.

(b)(1) An individual may enroll under this section only in such manner and form as may be prescribed in regulations, and only during an enrollment period prescribed in or under this section.

(2) The individual's initial enrollment period shall begin with the month in which the individual receives notice that the individual's entitlement to benefits under section 226(b) will end due solely to the individual having earnings that exceed the substantial gainful activity amount (as defined in section 223(d)(4)) and shall end 7 months later.

(3) There shall be a general enrollment period during the period beginning on January 1 and ending on March 31 of each year (begining with 1990).

(c)(1) The period (in this subsection referred to as a "coverage period") during which an individual is entitled to benefits under the insurance program under this part shall begin on whichever of the following is the latest:

(A) In the case of an individual who enrolls under subsection (b)(2) before the month in which the individual first satisfies subsection (a), the first day of such month.

(B) In the case of an individual who enrolls under subsection (b)(2) in the month in which the individual first satisfies subsection (a), the first day of the month following the month in which the individual so enrolls.

(C) In the case of an individual who enrolls under subsection (b)(2) in the month following the month in which the individual first satisfies subsection (a), the first day of the second month following the month in which the individual so enrolls.

(D) In the case of an individual who enrolls under subsection (b)(2) more than one month following the month in which the individual first satisfies subsection (a), the first day of the third month following the month in which the individual so enrolls.

(E) In the case of an individual who enrolls under subsection (b)(3), the July 1 following the month in which the individual so enrolls.

(2) An individual's coverage period under this section shall continue until the individual's enrollment is terminated as follows:

(A) As of the month following the month in which the Secretary provides notice to the individual that the individual no longer meets the condition described in subsection (a)(2)(B).

(B) As of the month following the month in which the individual files notice that the individual no longer wishes to participate in the insurance program established by this part.

(C) As of the month before the first month in which the individual becomes eligible for hospital insurance benefits under section 226(a) or 226A.

(D) As of a date, determined under regulations of the Secretary, for nonpayment of premiums.

The regulations under subparagraph (D) may provide a grace period of not longer than 90 days, which may be extended to not to exceed 180 days in any case where the Secretary determines that there was good cause for failure to pay the overdue premiums within such 90 day period. Termination of coverage under this section shall result in simultaneous termination of any coverage affected under any other part of this title.

(3) The provisions of subsections (h) and (i) of section 1837 apply to enrollment and nonenrollment under this section in the same manner as they apply to enrollment and nonenrollment and special enrollment periods under section 1818.

(d)(1)(A) Premiums for enrollment under this section shall be paid to the Secretary at such times, and in such manner, as the Secretary shall by regulations prescribe, and shall be deposited in the Treasury to the credit of the Federal Hospital Insurance Trust Fund.

(B)(i) Subject to clause (ii), such premiums shall be payable for the period commencing with the first month of an individual's coverage period and ending with the month in which the individual dies or, if earlier, in which the individual's coverage period terminates.

(ii) Such premiums shall not be payable for any month in which the individual is eligible for benefits under this part pursuant to section 226(b).

(2) The provisions of subsections (d) through (f) of section 1818 (relating to premiums) shall apply to individuals enrolled under this section in the same manner as they apply to individuals enrolled under that section.

REQUIREMENTS FOR, AND ASSURING QUALITY OF CARE IN, SKILLED NURSING FACILITIES[67]

SEC. 1819. [42 U.S.C. 1395i–3] (a) SKILLED NURSING FACILITY DEFINED.—In this title, the term "skilled nursing facility" means an institution (or a distinct part of an institution) which—

(1) is primarily engaged in providing to residents—

(A) skilled nursing care and related services for residents who require medical or nursing care, or

(B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons,

and is not primarily for the care and treatment of mental diseases;

(2) has in effect a transfer agreement (meeting the requirements of section 1861(l)) with one or more hospitals having agreements in effect under section 1866; and

(3) meets the requirements for a skilled nursing facility described in subsections (b), (c), and (d) of this section.

[67] See Vol. II, P.L. 100–203, §4205, with respect to the annual report to Congress.
See Vol. II, P.L. 108-173, §107(b), with respect to a review and report on current standards of practice for pharmacy services provided to patients in nursing facilities.

(b) REQUIREMENTS RELATING TO PROVISION OF SERVICES.—

(1) QUALITY OF LIFE.—

(A) IN GENERAL.—A skilled nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

(B) QUALITY ASSESSMENT AND ASSURANCE.—A skilled nursing facility must maintain a quality assessment and assurance committee, consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff, which (i) meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and (ii) develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this subparagraph.

(2) SCOPE OF SERVICES AND ACTIVITIES UNDER PLAN OF CARE.—A skilled nursing facility must provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, in accordance with a written plan of care which—

(A) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met;

(B) is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending physician and a registered professional nurse with responsibility for the resident; and

(C) is periodically reviewed and revised by such team after each assessment under paragraph (3).

(3) RESIDENTS' ASSESSMENT.—

(A) REQUIREMENT.—A skilled nursing facility must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, which assessment—

(i) describes the resident's capability to perform daily life functions and significant impairments in functional capacity;

(ii) is based on a uniform minimum data set specified by the Secretary under subsection (f)(6)(A);

(iii) uses an instrument which is specified by the State under subsection (e)(5); and

(iv) includes the identification of medical problems.

(B) CERTIFICATION.—

(i) IN GENERAL.—Each such assessment must be conducted or coordinated (with the appropriate participation of health professionals) by a registered professional nurse who signs and certifies the completion of the assessment. Each individual who completes a portion of such an assessment shall sign and certify as to the accuracy of that portion of the assessment.

(ii) PENALTY FOR FALSIFICATION.—

(I) An individual who willfully and knowingly certifies under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 with respect to each assessment.

(II) An individual who willfully and knowingly causes another individual to certify under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 with respect to each assessment.

(III) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this clause in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(iii) USE OF INDEPENDENT ASSESSORS.—If a State determines, under a survey under subsection (g) or otherwise, that there has been a knowing and willful certification of false assessments under this paragraph, the State may require (for a period specified by the State) that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the State.

(C) FREQUENCY.—

(i) IN GENERAL.—Subject to the timeframes prescribed by the Secretary under section 1888(e)(6), such an assessment must be conducted—

(I) promptly upon (but no later than 14 days after the date of) admission for each individual admitted on or after October 1, 1990, and by not later than January 1, 1991, for each resident of the facility on that date;

(II) promptly after a significant change in the resident's physical or mental condition; and

(III) in no case less often than once every 12 months.

(ii) RESIDENT REVIEW.—The skilled nursing facility must examine each resident no less frequently than once every 3 months and, as appropriate, revise the resident's assessment to assure the continuing accuracy of the assessment.

(D) USE.—The results of such an assessment shall be used in developing, reviewing, and revising the resident's plan of care under paragraph (2).

(E) COORDINATION.—Such assessments shall be coordinated with any State-required preadmission screening program to the maximum extent practicable in order to avoid duplicative testing and effort.

(4) PROVISION OF SERVICES AND ACTIVITIES.—

(A)[68] IN GENERAL.—To the extent needed to fulfill all plans of care described in paragraph (2), a skilled nursing

[68] See Vol. II, P.L. 101–508, §4008(h)(2)(O), with respect to maintaining regulatory standards for certain services.

facility must provide, directly or under arrangements (or, with respect to dental services, under agreements) with others for the provision of—

(i) nursing services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

(ii) medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

(iii) pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident;

(iv) dietary services that assure that the meals meet the daily nutritional and special dietary needs of each resident;

(v) an on-going program, directed by a qualified professional, of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident;

(vi) routine and emergency dental services to meet the needs of each resident; and

(vii) treatment and services required by mentally ill and mentally retarded residents not otherwise provided or arranged for (or required to be provided or arranged for) by the State.

The services provided or arranged by the facility must meet professional standards of quality. Nothing in clause (vi) shall be construed as requiring a facility to provide or arrange for dental services described in that clause without additional charge.

(B) QUALIFIED PERSONS PROVIDING SERVICES.—Services described in clauses (i), (ii), (iii), (iv), and (vi) of subparagraph (A) must be provided by qualified persons in accordance with each resident's written plan of care.

(C) REQUIRED NURSING CARE.—

(i) IN GENERAL.—Except as provided in clause (ii), a skilled nursing facility must provide 24-hour licensed nursing service which is sufficient to meet nursing needs of its residents and must use the services of a registered professional nurse at least[69] 8 consecutive hours a day, 7 days a week.

(ii) EXCEPTION.—To the extent that clause (i) may be deemed to require that a skilled nursing facility engage the services of a registered professional nurse for more than 40 hours a week, the Secretary is authorized to waive such requirement if the Secretary finds that—

(I) the facility is located in a rural area and the supply of skilled nursing facility services in such area is not sufficient to meet the needs of individuals residing therein,

[69] P.L. 108–173, §736(a)(8)(A), struck out "at least at least" and substituted "at least".

(II) the facility has one full-time registered professional nurse who is regularly on duty at such facility 40 hours a week,

(III) the facility either has only patients whose physicians have indicated (through physicians' orders or admission notes) that each such patient does not require the services of a registered nurse or a physician for a 48-hour period, or has made arrangements for a registered professional nurse or a physician to spend such time at such facility as may be indicated as necessary by the physician to provide necessary skilled nursing services on days when the regular full-time registered professional nurse is not on duty,

(IV) the Secretary provides notice of the waiver to the State long-term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965 [70]) and the protection and advocacy system in the State for the mentally ill and the mentally retarded, and

(V) the facility that is granted such a waiver notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.

A waiver under this subparagraph shall be subject to annual renewal.

(5) REQUIRED TRAINING OF NURSE AIDES.—

(A) IN GENERAL.—(i) Except as provided in clause (ii), a skilled nursing facility must not use on a full-time basis any individual as a nurse aide in the facility on or after October 1, 1990 for more than 4 months unless the individual—

(I) has completed a training and competency evaluation program, or a competency evaluation program, approved by the State under subsection (e)(1)(A), and

(II) is competent to provide nursing or nursing-related services.

(ii) [71] A skilled nursing facility must not use on a temporary, per diem, leased, or on any basis other than as a permanent employee any individual as a nurse aide in the facility on or after January 1, 1991, unless the individual meets the requirements described in clause (i).

(B) OFFERING COMPETENCY EVALUATION PROGRAMS FOR CURRENT EMPLOYEES.—A skilled nursing facility must provide, for individuals used as a nurse aide by the facility as of January 1, 1990, for a competency evaluation program approved by the State under subsection (e)(1) and such preparation as may be necessary for the individual to complete such a program by October 1, 1990.

[70] See Vol. II, P.L. 89–73.
[71] Margin as in original.

(C) COMPETENCY.—The skilled nursing facility must not permit an individual, other than in a training and competency evaluation program approved by the State, to serve as a nurse aide or provide services of a type for which the individual has not demonstrated competency and must not use such an individual as a nurse aide unless the facility has inquired of any State registry established under subsection (e)(2)(A) that the facility believes will include information concerning the individual.

(D) RE-TRAINING REQUIRED.—For purposes of subparagraph (A), if, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual performed nursing or nursing-related services for monetary compensation, such individual shall complete a new training and competency evaluation program or a new competency evaluation program.

(E) REGULAR IN-SERVICE EDUCATION.—The skilled nursing facility must provide such regular performance review and regular in-service education as assures that individuals used as nurse aides are competent to perform services as nurse aides, including training for individuals providing nursing and nursing-related services to residents with cognitive impairments.

(F) NURSE AIDE DEFINED.—In this paragraph, the term "nurse aide" means any individual providing nursing or nursing-related services to residents in a skilled nursing facility, but does not include an individual—

(i) who is a licensed health professional (as defined in subparagraph (G)) or a registered dietician, or

(ii) who volunteers to provide such services without monetary compensation.

(G) LICENSED HEALTH PROFESSIONAL DEFINED.—In this paragraph, the term "licensed health professional" means a physician, physician assistant, nurse practitioner, physical, speech, or occupational therapist, physical or occupational therapy assistant, registered professional nurse, licensed practical nurse, or licensed certified social worker, registered respiratory therapist, or certified respiratory therapy technician.

(6) PHYSICIAN SUPERVISION AND CLINICAL RECORDS.—A skilled nursing facility must—

(A) require that the medical care of every resident be provided under the supervision of a physician;

(B) provide for having a physician available to furnish necessary medical care in case of emergency; and

(C) maintain clinical records on all residents, which records include the plans of care (described in paragraph (2)) and the residents' assessments (described in paragraph (3)).

(7) REQUIRED SOCIAL SERVICES.—In the case of a skilled nursing facility with more than 120 beds, the facility must have at least one social worker (with at least a bachelor's degree in social work or similar professional qualifications) em-

ployed full-time to provide or assure the provision of social services.

(8) INFORMATION ON NURSE STAFFING.—

(A) IN GENERAL.—A skilled nursing facility shall post daily for each shift the current number of licensed and unlicensed nursing staff directly responsible for resident care in the facility. The information shall be displayed in a uniform manner (as specified by the Secretary) and in a clearly visible place.

(B) PUBLICATION OF DATA.—A skilled nursing facility shall, upon request, make available to the public the nursing staff data described in subparagraph (A).

(c) REQUIREMENTS RELATING TO RESIDENTS' RIGHTS.—

(1) GENERAL RIGHTS.—

(A) SPECIFIED RIGHTS.—A skilled nursing facility must protect and promote the rights of each resident, including each of the following rights:

(i) FREE CHOICE.—The right to choose a personal attending physician, to be fully informed in advance about care and treatment, to be fully informed in advance of any changes in care or treatment that may affect the resident's well-being, and (except with respect to a resident adjudged incompetent) to participate in planning care and treatment or changes in care and treatment.

(ii) FREE FROM RESTRAINTS.—The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed—

(I) to ensure the physical safety of the resident or other residents, and

(II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary until such an order could reasonably be obtained).

(iii) PRIVACY.—The right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of resident groups.

(iv) CONFIDENTIALITY.—The right to confidentiality of personal and clinical records and to access to current clinical records of the resident upon request by the resident or the resident's legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

(v) ACCOMMODATION OF NEEDS.—The right—

(I) to reside and receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered, and

(II) to receive notice before the room or roommate of the resident in the facility is changed.

(vi) GRIEVANCES.—The right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances and the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

(vii) PARTICIPATION IN RESIDENT AND FAMILY GROUPS.—The right of the resident to organize and participate in resident groups in the facility and the right of the resident's family to meet in the facility with the families of other residents in the facility.

(viii) PARTICIPATION IN OTHER ACTIVITIES.—The right of the resident to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

(ix) EXAMINATION OF SURVEY RESULTS.—The right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the Secretary or a State with respect to the facility and any plan of correction in effect with respect to the facility.

(x) REFUSAL OF CERTAIN TRANSFERS.—The right to refuse a transfer to another room within the facility, if a purpose of the transfer is to relocate the resident from a portion of the facility that is a skilled nursing facility (for purposes of this title) to a portion of the facility that is not such a skilled nursing facility.

(xi) OTHER RIGHTS.—Any other right established by the Secretary.

Clause (iii) shall not be construed as requiring the provision of a private room. A resident's exercise of a right to refuse transfer under clause (x) shall not affect the resident's eligibility or entitlement to benefits under this title or to medical assistance under title XIX of this Act.

(B) NOTICE OF RIGHTS AND SERVICES.—A skilled nursing facility must—

(i) inform each resident, orally and in writing at the time of admission to the facility, of the resident's legal rights during the stay at the facility;

(ii) make available to each resident, upon reasonable request, a written statement of such rights (which statement is updated upon changes in such rights) including the notice (if any) of the State developed under section 1919(e)(6); and

(iii) inform each other resident, in writing before or at the time of admission and periodically during the resident's stay, of services available in the facility and of related charges for such services, including any charges for services not covered under this title or by the facility's basic per diem charge.

The written description of legal rights under this subparagraph shall include a description of the protection of per-

sonal funds under paragraph (6) and a statement that a resident may file a complaint with a State survey and certification agency respecting resident abuse and neglect and misappropriation of resident property in the facility.

(C) RIGHTS OF INCOMPETENT RESIDENTS.—In the case of a resident adjudged incompetent under the laws of a State, the rights of the resident under this title shall devolve upon, and, to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the resident's behalf.

(D) USE OF PSYCHOPHARMACOLOGIC DRUGS.—Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the written plan of care described in paragraph (2)) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each resident receiving such drugs. In determining whether such a consultant is qualified to conduct reviews under the preceding sentence, the Secretary shall take into account the needs of nursing facilities under this title to have access to the services of such a consultant on a timely basis.

(E) INFORMATION RESPECTING ADVANCE DIRECTIVES.—A skilled nursing facility must comply with the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).

(2) TRANSFER AND DISCHARGE RIGHTS.—

(A) IN GENERAL.—A skilled nursing facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless—

(i) the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;

(ii) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(iii) the safety of individuals in the facility is endangered;

(iv) the health of individuals in the facility would otherwise be endangered;

(v) the resident has failed, after reasonable and appropriate notice, to pay (or to have paid under this title or title XIX on the resident's behalf) for a stay at the facility; or

(vi) the facility ceases to operate.

In each of the cases described in clauses (i) through (v), the basis for the transfer or discharge must be documented in the resident's clinical record. In the cases described in clauses (i) and (ii), the documentation must be made by the resident's physician, and in the cases described in clauses (iii) and (iv) the documentation must be made by a physician.

(B) PRE-TRANSFER AND PRE-DISCHARGE NOTICE.—

(i) IN GENERAL.—Before effecting a transfer or discharge of a resident, a skilled nursing facility must—

(I) notify the resident (and, if known, a family member of the resident or legal representative) of the transfer or discharge and the reasons therefor,

(II) record the reasons in the resident's clinical record (including any documentation required under subparagraph (A)), and

(III) include in the notice the items described in clause (iii).

(ii) TIMING OF NOTICE.—The notice under clause (i)(I) must be made at least 30 days in advance of the resident's transfer or discharge except—

(I) in a case described in clause (iii) or (iv) of subparagraph (A);

(II) in a case described in clause (ii) of subparagraph (A), where the resident's health improves sufficiently to allow a more immediate transfer or discharge;

(III) in a case described in clause (i) of subparagraph (A), where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs; or

(IV) in a case where a resident has not resided in the facility for 30 days.

In the case of such exceptions, notice must be given as many days before the date of the transfer or discharge as is practicable.

(iii) ITEMS INCLUDED IN NOTICE.—Each notice under clause (i) must include—

(I) for transfers or discharges effected on or after October 1, 1990, notice of the resident's right to appeal the transfer or discharge under the State process established under subsection (e)(3); and

(II) the name, mailing address, and telephone number of the State long-term care ombudsman (established under title III or VII of the Older Americans Act of 1965 [72] in accordance with section 712 of the Act).

(C) ORIENTATION.—A skilled nursing facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(3) ACCESS AND VISITATION RIGHTS.—A skilled nursing facility must—

(A) permit immediate access to any resident by any representative of the Secretary, by any representative of the State, by an ombudsman described in paragraph (2)(B)(iii)(II), or by the resident's individual physician;

(B) permit immediate access to a resident, subject to the resident's right to deny or withdraw consent at any time, by immediate family or other relatives of the resident;

[72] See Vol. II, P.L. 89–73.

(C) permit immediate access to a resident, subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, by others who are visiting with the consent of the resident;

(D) permit reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and

(E) permit representatives of the State ombudsman (described in paragraph (2)(B)(iii)(II)), with the permission of the resident (or the resident's legal representative) and consistent with State law, to examine a resident's clinical records.

(4) EQUAL ACCESS TO QUALITY CARE.—A skilled nursing facility must establish and maintain identical policies and practices regarding transfer, discharge, and covered services under this title for all individuals regardless of source of payment.

(5) ADMISSIONS POLICY.—

(A) ADMISSIONS.—With respect to admissions practices, a skilled nursing facility must—

(i)(I) not require individuals applying to reside or residing in the facility to waive their rights to benefits under this title or under a State plan under title XIX, (II) not require oral or written assurance that such individuals are not eligible for, or will not apply for, benefits under this title or such a State plan, and (III) prominently display in the facility and provide to such individuals written information about how to apply for and use such benefits and how to receive refunds for previous payments covered by such benefits; and

(ii) not require a third party guarantee of payment to the facility as a condition of admission (or expedited admission) to, or continued stay in, the facility.

(B) CONSTRUCTION.—

(i) NO PREEMPTION OF STRICTER STANDARDS.—Subparagraph (A) shall not be construed as preventing States or political subdivisions therein from prohibiting, under State or local law, the discrimination against individuals who are entitled to medical assistance under this title with respect to admissions practices of skilled nursing facilities.

(ii) CONTRACTS WITH LEGAL REPRESENTATIVES.—Subparagraph (A)(ii) shall not be construed as preventing a facility from requiring an individual, who has legal access to a resident's income or resources available to pay for care in the facility, to sign a contract (without incurring personal financial liability) to provide payment from the resident's income or resources for such care.

(6) PROTECTION OF RESIDENT FUNDS.—

(A) IN GENERAL.—The skilled nursing facility—

(i) may not require residents to deposit their personal funds with the facility, and

(ii) upon the written authorization of the resident, must hold, safeguard, and account for such personal

funds under a system established and maintained by the facility in accordance with this paragraph.

(B) MANAGEMENT OF PERSONAL FUNDS.—Upon written authorization of a resident under subparagraph (A)(ii), the facility must manage and account for the personal funds of the resident deposited with the facility as follows:

(i) DEPOSIT.—The facility must deposit any amount of personal funds in excess of $100 with respect to a resident in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the facility must maintain such funds in a non-interest bearing account or petty cash fund.

(ii) ACCOUNTING AND RECORDS.—The facility must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a resident deposited with the facility, and afford the resident (or a legal representative of the resident) reasonable access to such record.

(iii) CONVEYANCE UPON DEATH.—Upon the death of a resident with such an account, the facility must convey promptly the resident's personal funds (and a final accounting of such funds) to the individual administering the resident's estate.

(C) ASSURANCE OF FINANCIAL SECURITY.—The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.

(D) LIMITATION ON CHARGES TO PERSONAL FUNDS.—The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under this title or title XIX.

(d) REQUIREMENTS RELATING TO ADMINISTRATION AND OTHER MATTERS.—

(1) ADMINISTRATION.—

(A) IN GENERAL.—A skilled nursing facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental[73], and psychosocial well-being of each resident (consistent with requirements established under subsection (f)(5)).

(B) REQUIRED NOTICES.—If a change occurs in—

(i) the persons with an ownership or control interest (as defined in section 1124(a)(3)) in the facility,

(ii) the persons who are officers, directors, agents, or managing employees (as defined in section 1126(b)) of the facility,

(iii) the corporation, association, or other company responsible for the management of the facility, or

(iv) the individual who is the administrator or director of nursing of the facility,

[73] P.L. 108–173, §736(a)(8)(B), struck out "physical mental" and substituted "physical, mental".

the skilled nursing facility must provide notice to the State agency responsible for the licensing of the facility, at the time of the change, of the change and of the identity of each new person, company, or individual described in the respective clause.

(C) SKILLED NURSING FACILITY ADMINISTRATOR.— The administrator of a skilled nursing facility must meet standards established by the Secretary under subsection (f)(4).

(2) LICENSING AND LIFE SAFETY CODE.—

(A) LICENSING.—A skilled nursing facility must be licensed under applicable State and local law.

(B) LIFE SAFETY CODE.—A skilled nursing facility must meet such provisions of such edition (as specified by the Secretary in regulation) of the Life Safety Code of the National Fire Protection Association as are applicable to nursing homes; except that—

(i) the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a facility, but only if such waiver would not adversely affect the health and safety of residents or personnel, and

(ii) the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects residents of and personnel in skilled nursing facilities.

(3) SANITARY AND INFECTION CONTROL AND PHYSICAL ENVIRONMENT.—A skilled nursing facility must—

(A) establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection, and

(B) be designed, constructed, equipped, and maintained in a manner to protect the health and safety of residents, personnel, and the general public.

(4) MISCELLANEOUS.—

(A) COMPLIANCE WITH FEDERAL, STATE, AND LOCAL LAWS AND PROFESSIONAL STANDARDS.—A skilled nursing facility must operate and provide services in compliance with all applicable Federal, State, and local laws and regulations (including the requirements of section 1124) and with accepted professional standards and principles which apply to professionals providing services in such a facility.

(B) OTHER.—A skilled nursing facility must meet such other requirements relating to the health, safety, and well-being of residents or relating to the physical facilities thereof as the Secretary may find necessary.

(e) STATE REQUIREMENTS RELATING TO SKILLED NURSING FACILITY REQUIREMENTS.—The requirements, referred to in section 1864(d), with respect to a State are as follows:

(1) SPECIFICATION AND REVIEW OF NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS AND OF NURSE AIDE COMPETENCY EVALUATION PROGRAMS.—The State must—

(A) by not later than January 1, 1989, specify those training and competency evaluation programs, and those competency evaluation programs, that the State approves for purposes of subsection (b)(5) and that meet the requirements established under subsection (f)(2), and

(B) by not later than January 1, 1990, provide for the review and reapproval of such programs, at a frequency and using a methodology consistent with the requirements established under subsection (f)(2)(A)(iii).

The failure of the Secretary to establish requirements under subsection (f)(2) shall not relieve any State of its responsibility under this paragraph.

(2) NURSE AIDE REGISTRY.—

(A) IN GENERAL.—By not later than January 1, 1989, the State shall establish and maintain a registry of all individuals who have satisfactorily completed a nurse aide training and competency evaluation program, or a nurse aide competency evaluation program, approved under paragraph (1) in the State, or any individual described in subsection (f)(2)(B)(ii) or in subparagraph (B), (C), or (D) of section 6901(b)(4) of the Omnibus Budget Reconciliation Act of 1989.

(B) INFORMATION IN REGISTRY.—The registry under subparagraph (A) shall provide (in accordance with regulations of the Secretary) for the inclusion of specific documented findings by a State under subsection (g)(1)(C) of resident neglect or abuse or misappropriation of resident property involving an individual listed in the registry, as well as any brief statement of the individual disputing the findings, but shall not include any allegations of resident abuse or neglect or misappropriation of resident property that are not specifically documented by the State under such subsection. The State shall make available to the public information in the registry. In the case of inquiries to the registry concerning an individual listed in the registry, any information disclosed concerning such a finding shall also include disclosure of any such statement in the registry relating to the finding or a clear and accurate summary of such a statement.

(C) PROHIBITION AGAINST CHARGES.—A State may not impose any charges on a nurse aide relating to the registry established and maintained under subparagraph (A).

(3) STATE APPEALS PROCESS FOR TRANSFERS AND DISCHARGES.—The State, for transfers and discharges from skilled nursing facilities effected on or after October 1, 1989, must provide for a fair mechanism for hearing appeals on transfers and discharges of residents of such facilities. Such mechanism must meet the guidelines established by the Secretary under subsection (f)(3); but the failure of the Secretary to establish such guidelines shall not relieve any State of its responsibility to provide for such a fair mechanism.

(4) SKILLED NURSING FACILITY ADMINISTRATOR STANDARDS.—By not later than January 1, 1990, the State must have implemented and enforced the skilled nursing facility administrator standards developed under subsection (f)(4) respecting the qualification of administrators of skilled nursing facilities.

(5) SPECIFICATION OF RESIDENT ASSESSMENT INSTRUMENT.—Effective July 1, 1990, the State shall specify the instrument to be used by nursing facilities in the State in complying with the requirement of subsection (b)(3)(A)(iii). Such instrument shall be—

(A) one of the instruments designated under subsection (f)(6)(B), or

(B) an instrument which the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by the Secretary under subsection (f)(6)(A).

(f) RESPONSIBILITIES OF SECRETARY RELATING TO SKILLED NURSING FACILITY REQUIREMENTS.—

(1) GENERAL RESPONSIBILITY.—It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in skilled nursing facilities under this title, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.

(2) REQUIREMENTS FOR NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS AND FOR NURSE AIDE COMPETENCY EVALUATION PROGRAMS.—

(A) IN GENERAL.—For purposes of subsections (b)(5) and (e)(1)(A), the Secretary shall establish, by not later than September 1, 1988—

(i) requirements for the approval of nurse aide training and competency evaluation programs, including requirements relating to (I) the areas to be covered in such a program (including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents, basic restorative services, and residents' rights) and content of the curriculum, (II) minimum hours of initial and ongoing training and retraining (including not less than 75 hours in the case of initial training), (III) qualifications of instructors, and (IV) procedures for determination of competency;

(ii) requirements for the approval of nurse aide competency evaluation programs, including requirement relating to the areas to be covered in such a program, including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents, basic restorative services, residents' rights, and procedures for determination of competency;

(iii) requirements respecting the minimum frequency and methodology to be used by a State in reviewing such programs' compliance with the requirements for such programs; and

(iv) requirements, under both such programs, that—

(I) provide procedures for determining competency that permit a nurse aide, at the nurse aide's option, to establish competency through procedures or methods other than the passing of a written examination and to have the competency evaluation conducted at the nursing facility at

which the aide is (or will be) employed (unless the facility is described in subparagraph (B)(iii)(I)),

(II) prohibit the imposition on a nurse aide who is employed by (or who has received an offer of employment from) a facility on the date on which the aide begins either such program of any charges (including any charges for textbooks and other required course materials and any charges for the competency evaluation) for either such program, and

(III) in the case of a nurse aide not described in subclause (II) who is employed by (or who has received an offer of employment from) a facility not later than 12 months after completing either such program, the State shall provide for the reimbursement of costs incurred in completing such program on a prorata basis during the period in which the nurse aide is so employed.

(B) APPROVAL OF CERTAIN PROGRAMS.—Such requirements—

(i) may permit approval of programs offered by or in facilities, as well as outside facilities (subject to clause (iii)), (including employee organizations), and of programs in effect on the date of the enactment of this section[74];

(ii) shall permit a State to find that an individual who has completed (before July 1, 1989) a nurse aide training and competency evaluation program shall be deemed to have completed such a program approved under subsection (b)(5) if the State determines that, at the time the program was offered, the program met the requirements for approval under such paragraph; and

(iii) subject to subparagraphs (C) and (D)[75], shall prohibit approval of such a program—

(I) offered by or in a skilled nursing facility which, within the previous 2 years—

(a) has operated under a waiver under subsection (b)(4)(C)(ii)(II);

(b) has been subject to an extended (or partial extended) survey under subsection (g)(2)(B)(i) or section 1919(g)(2)(B)(i), unless the survey shows that the facility is in compliance with the requirements of subsections (b), (c), and (d) of this section; or

(c) has been assessed a civil money penalty described in subsection (h)(2)(B)(ii) or section 1919(h)(2)(A)(ii) of not less than $5,000, or has been subject to a remedy described in clause (i) or (iii) of subsection (h)(2)(B), subsection (h)(4), section 1919(h)(1)(B)(i), or in clause (i), (iii), or (iv) of section 1919(h)(2)(A), or

[74] December 22, 1987 [P.L. 100–203; 101 Stat. 1330–160].

[75] P.L. 108–173, §932(c)(2)(A), struck out "subparagraph (C)" and substituted "subparagraphs (C) and (D)", effective December 8, 2003, applicable to appeals filed on or after October 1, 2004.

(II) offered by or in a skilled nursing facility unless the State makes the determination, upon an individual's completion of the program, that the individual is competent to provide nursing and nursing-related services in skilled nursing facilities.

A State may not delegate (through subcontract or otherwise) its responsibility under clause (iii)(II) to the skilled nursing facility.[76]

(C) WAIVER AUTHORIZED.—Clause (iii)(I) of subparagraph (B) shall not apply to a program offered in (but not by) a nursing facility (or skilled nursing facility for purposes of title XVIII) in a State if the State—

(i) determines that there is no other such program offered within a reasonable distance of the facility,

(ii) assures, through an oversight effort, that an adequate environment exists for operating the program in the facility, and

(iii) provides notice of such determination and assurances to the State long–term care ombudsman.

(D)[77] WAIVER OF DISAPPROVAL OF NURSE-AIDE TRAINING PROGRAMS.—Upon application of a nursing facility, the Secretary may waive the application of subparagraph (B)(iii)(I)(c) if the imposition of the civil monetary penalty was not related to the quality of care provided to residents of the facility. Nothing in this subparagraph shall be construed as eliminating any requirement upon a facility to pay a civil monetary penalty described in the preceding sentence.

(3) FEDERAL GUIDELINES FOR STATE APPEALS PROCESS FOR TRANSFERS AND DISCHARGES.—For purposes of subsections (c)(2)(B)(iii)(I) and (e)(3), by not later than October 1, 1988, the Secretary shall establish guidelines for minimum standards which State appeals processes under subsection (e)(3) must meet to provide a fair mechanism for hearing appeals on transfers and discharges of residents from skilled nursing facilities.

(4) SECRETARIAL STANDARDS FOR QUALIFICATION OF ADMINISTRATORS.—For purposes of subsections (d)(1)(C) and (e)(4), the Secretary shall develop, by not later than March 1, 1989, standards to be applied in assuring the qualifications of administrators of skilled nursing facilities.

(5) CRITERIA FOR ADMINISTRATION.—The Secretary shall establish criteria for assessing a skilled nursing facility's compliance with the requirement of subsection (d)(1) with respect to—

(A) its governing body and management,

(B) agreements with hospitals regarding transfers of residents to and from the hospitals and to and from other skilled nursing facilities,

(C) disaster preparedness,

(D) direction of medical care by a physician,

(E) laboratory and radiological services,

(F) clinical records, and

[76] P.L. 108–173, §736(a)(8)(C), moved this sentence 2 ems to the left.

[77] P.L. 108–173, §932(c)(2)(B), added subparagraph (D), effective December 8, 2003, applicable to appeals filed on or after October 1, 2004.

(G) resident and advocate participation.

(6) SPECIFICATION OF RESIDENT ASSESSMENT DATA SET AND INSTRUMENTS.—The Secretary shall—

(A) not later than January 1, 1989, specify a minimum data set of core elements and common definitions for use by nursing facilities in conducting the assessments required under subsection (b)(3), and establish guidelines for utilization of the data set; and

(B) by not later than April 1, 1990, designate one or more instruments which are consistent with the specification made under subparagraph (A) and which a State may specify under subsection (e)(5)(A) for use by nursing facilities in complying with the requirements of subsection (b)(3)(A)(iii).

(7) LIST OF ITEMS AND SERVICES FURNISHED IN SKILLED NURSING FACILITIES NOT CHARGEABLE TO THE PERSONAL FUNDS OF A RESIDENT.—

(A) REGULATIONS REQUIRED.—Pursuant to the requirement of section 21(b) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977[78], the Secretary shall issue regulations, on or before the first day of the seventh month to begin after the date of enactment of this section[79], that define those costs which may be charged to the personal funds of residents in skilled nursing facilities who are individuals receiving benefits under this part and those costs which are to be included in the reasonable cost (or other payment amount) under this title for extended care services.

(B) RULE IF FAILURE TO PUBLISH REGULATIONS.— If the Secretary does not issue the regulations under subparagraph (A) on or before the date required in such subparagraph, in the case of a resident of a skilled nursing facility who is eligible to receive benefits under this part, the costs which may not be charged to the personal funds of such resident (and for which payment is considered to be made under this title) shall include, at a minimum, the costs for routine personal hygiene items and services furnished by the facility.

(g) SURVEY AND CERTIFICATION PROCESS.—

(1) STATE AND FEDERAL RESPONSIBILITY.—

(A) IN GENERAL.—Pursuant to an agreement under section 1864, each State shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of skilled nursing facilities (other than facilities of the State) with the requirements of subsections (b), (c), and (d). The Secretary shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of State skilled nursing facilities with the requirements of such subsections.

(B) EDUCATIONAL PROGRAM.—Each State shall conduct periodic educational programs for the staff and residents (and their representatives) of skilled nursing facilities in

[78] See Vol. II, P.L. 95–142.
[79] December 22, 1987 [P.L. 100–203; 101 Stat. 1330–160].

order to present current regulations, procedures, and policies under this section.

(C) INVESTIGATION OF ALLEGATIONS OF RESIDENT NEGLECT AND ABUSE AND MISAPPROPRIATION OF RESIDENT PROPERTY.—The State shall provide, through the agency responsible for surveys and certification of nursing facilities under this subsection, for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility in providing services to such a resident. The State shall, after providing the individual involved with a written notice of the allegations (including a statement of the availability of a hearing for the individual to rebut the allegations) and the opportunity for a hearing on the record, make a written finding as to the accuracy of the allegations. If the State finds that a nurse aide has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding. If the State finds that any other individual used by the facility has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the appropriate licensure authority. A State shall not make a finding that an individual has neglected a resident if the individual demonstrates that such neglect was caused by factors beyond the control of the individual.

(D) REMOVAL OF NAME FROM NURSE AIDE REGISTRY.—

(i) IN GENERAL.—In the case of a finding of neglect under subparagraph (C), the State shall establish a procedure to permit a nurse aide to petition the State to have his or her name removed from the registry upon a determination by the State that—

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

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

(ii) TIMING OF DETERMINATION.—In no case shall a determination on a petition submitted under clause (i) be made prior to the expiration of the 1–year period beginning on the date on which the name of the petitioner was added to the registry under subparagraph (C).

(E) CONSTRUCTION.—The failure of the Secretary to issue regulations to carry out this subsection shall not relieve a State of its responsibility under this subsection.

(2) SURVEYS.—

(A) STANDARD SURVEY.—

(i) IN GENERAL.—Each skilled nursing facility shall be subject to a standard survey, to be conducted without any prior notice to the facility. Any individual who notifies (or causes to be notified) a skilled nursing facility of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed $2,000. The provisions of sec-

tion 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). The Secretary shall review each State's procedures for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

(ii) CONTENTS.—Each standard survey shall include, for a case-mix stratified sample of residents—

(I) a survey of the quality of care furnished, as measured by indicators of medical, nursing, and rehabilitative care, dietary and nutrition services, activities and social participation, and sanitation, infection control, and the physical environment,

(II) written plans of care provided under subsection (b)(2) and an audit of the residents' assessments under subsection (b)(3) to determine the accuracy of such assessments and the adequacy of such plans of care, and

(III) a review of compliance with residents' rights under subsection (c).

(iii) FREQUENCY.—

(I) IN GENERAL.—Each skilled nursing facility shall be subject to a standard survey not later than 15 months after the date of the previous standard survey conducted under this subparagraph. The Statewide average interval between standard surveys of skilled nursing facilities under this subsection shall not exceed 12 months.

(II) SPECIAL SURVEYS.—If not otherwise conducted under subclause (I), a standard survey (or an abbreviated standard survey) may be conducted within 2 months of any change of ownership, administration, management of a skilled nursing facility, or the director of nursing in order to determine whether the change has resulted in any decline in the quality of care furnished in the facility.

(B) EXTENDED SURVEYS.—

(i) IN GENERAL.—Each skilled nursing facility which is found, under a standard survey, to have provided substandard quality of care shall be subject to an extended survey. Any other facility may, at the Secretary's or State's discretion, be subject to such an extended survey (or a partial extended survey).

(ii) TIMING.—The extended survey shall be conducted immediately after the standard survey (or, if not practicable, not later than 2 weeks after the date of completion of the standard survey).

(iii) CONTENTS.—In such an extended survey, the survey team shall review and identify the policies and procedures which produced such substandard quality of care and shall determine whether the facility has

complied with all the requirements described in subsections (b), (c), and (d). Such review shall include an expansion of the size of the sample of residents' assessments reviewed and a review of the staffing, of in-service training, and, if appropriate, of contracts with consultants.

(iv) CONSTRUCTION.—Nothing in this paragraph shall be construed as requiring an extended or partial extended survey as a prerequisite to imposing a sanction against a facility under subsection (h) on the basis of findings in a standard survey.

(C) SURVEY PROTOCOL.—Standard and extended surveys shall be conducted—

(i) based upon a protocol which the Secretary has developed, tested, and validated by not later than January 1, 1990, and

(ii) by individuals, of a survey team, who meet such minimum qualifications as the Secretary establishes by not later than such date.

The failure of the Secretary to develop, test, or validate such protocols or to establish such minimum qualifications shall not relieve any State of its responsibility (or the Secretary of the Secretary's responsibility) to conduct surveys under this subsection.

(D) CONSISTENCY OF SURVEYS.—Each State and the Secretary shall implement programs to measure and reduce inconsistency in the application of survey results among surveyors.

(E) SURVEY TEAMS.—

(i) IN GENERAL.—Surveys under this subsection shall be conducted by a multidisciplinary team of professionals (including a registered professional nurse).

(ii) PROHIBITION OF CONFLICTS OF INTEREST.—A State may not use as a member of a survey team under this subsection an individual who is serving (or has served within the previous 2 years) as a member of the staff of, or as a consultant to, the facility surveyed respecting compliance with the requirements of subsections (b), (c), and (d), or who has a personal or familial financial interest in the facility being surveyed.

(iii) TRAINING.—The Secretary shall provide for the comprehensive training of State and Federal surveyors in the conduct of standard and extended surveys under this subsection, including the auditing of resident assessments and plans of care. No individual shall serve as a member of a survey team unless the individual has successfully completed a training and testing program in survey and certification techniques that has been approved by the Secretary.

(3) VALIDATION SURVEYS.—

(A) IN GENERAL.—The Secretary shall conduct onsite surveys of a representative sample of skilled nursing facilities in each State, within 2 months of the date of surveys conducted under paragraph (2) by the State, in a sufficient number to allow inferences about the adequacies of each

State's surveys conducted under paragraph (2). In conducting such surveys, the Secretary shall use the same survey protocols as the State is required to use under paragraph (2). If the State has determined that an individual skilled nursing facility meets the requirements of subsections (b), (c), and (d), but the Secretary determines that the facility does not meet such requirements, the Secretary's determination as to the facility's noncompliance with such requirements is binding and supersedes that of the State survey.

(B) SCOPE.—With respect to each State, the Secretary shall conduct surveys under subparagraph (A) each year with respect to at least 5 percent of the number of skilled nursing facilities surveyed by the State in the year, but in no case less than 5 skilled nursing facilities in the State.

(C) REMEDIES FOR SUBSTANDARD PERFORMANCE.—If the Secretary finds, on the basis of such surveys, that a State has failed to perform surveys as required under paragraph (2) or that a State's survey and certification performance otherwise is not adequate, the Secretary shall provide for an appropriate remedy, which may include the training of survey teams in the State.

(D) SPECIAL SURVEYS OF COMPLIANCE.—Where the Secretary has reason to question the compliance of a skilled nursing facility with any of the requirements of subsections (b), (c), and (d), the Secretary may conduct a survey of the facility and, on the basis of that survey, make independent and binding determinations concerning the extent to which the skilled nursing facility meets such requirements.

(4) INVESTIGATION OF COMPLAINTS AND MONITORING COMPLIANCE.—Each State shall maintain procedures and adequate staff to—

(A) investigate complaints of violations of requirements by skilled nursing facilities, and

(B) monitor, on-site, on a regular, as needed basis, a skilled nursing facility's compliance with the requirements of subsections (b), (c), and (d), if—

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements, has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

A State may maintain and utilize a specialized team (including an attorney, an auditor, and appropriate health care professionals) for the purpose of identifying, surveying, gathering and preserving evidence, and carrying out appropriate enforcement actions against substandard skilled nursing facilities.

(5) DISCLOSURE OF RESULTS OF INSPECTIONS AND ACTIVITIES.—

(A) PUBLIC INFORMATION.—Each State, and the Secretary, shall make available to the public—

(i) information respecting all surveys and certifications made respecting skilled nursing facilities, including statements of deficiencies, within 14 calendar days after such information is made available to those facilities, and approved plans of correction,

(ii) copies of cost reports of such facilities filed under this title or title XIX,

(iii) copies of statements of ownership under section 1124, and

(iv) information disclosed under section 1126.

(B) NOTICE TO OMBUDSMAN.—Each State shall notify the State long-term care ombudsman (established under title III or VII of the Older Americans Act of 1965[80] in accordance with section 712 of the Act) of the State's findings of noncompliance with any of the requirements of subsections (b), (c), and (d), or of any adverse action taken against a skilled nursing facility under paragraph (1), (2), or (4) of subsection (h), with respect to a skilled nursing facility in the State.

(C) NOTICE TO PHYSICIANS AND SKILLED NURSING FACILITY ADMINISTRATOR LICENSING BOARD.—If a State finds that a skilled nursing facility has provided substandard quality of care, the State shall notify—

(i) the attending physician of each resident with respect to which such finding is made, and

(ii) the State board responsible for the licensing of the skilled nursing facility administrator at the facility.

(D) ACCESS TO FRAUD CONTROL UNITS.—Each State shall provide its State medicaid fraud and abuse control unit (established under section 1903(q)) with access to all information of the State agency responsible for surveys and certifications under this subsection.

(h) ENFORCEMENT PROCESS.—

(1) IN GENERAL.—If a State finds, on the basis of a standard, extended, or partial extended survey under subsection (g)(2) or otherwise, that a skilled nursing facility no longer meets a requirement of subsection (b), (c), or (d), and further finds that the facility's deficiencies—

(A) immediately jeopardize the health or safety of its residents, the State shall recommend to the Secretary that the Secretary take such action as described in paragraph (2)(A)(i); or

(B) do not immediately jeopardize the health or safety of its residents, the State may recommend to the Secretary that the Secretary take such action as described in paragraph (2)(A)(ii).

If a State finds that a skilled nursing facility meets the requirements of subsections (b), (c), and (d), but, as of a previous period, did not meet such requirements, the State may recommend a civil money penalty under paragraph (2)(B)(ii) for the days in which it finds that the facility was not in compliance with such requirements.

(2) SECRETARIAL AUTHORITY.—

[80] See Vol. II, P.L. 89–73.

(A) IN GENERAL.—With respect to any skilled nursing facility in a State, if the Secretary finds, or pursuant to a recommendation of the State under paragraph (1) finds, that a skilled nursing facility no longer meets a requirement of subsection (b), (c), (d), or (e), and further finds that the facility's deficiencies—

(i) immediately jeopardize the health or safety of its residents, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subparagraph (B)(iii), or terminate the facility's participation under this title and may provide, in addition, for one or more of the other remedies described in subparagraph (B); or

(ii) do not immediately jeopardize the health or safety of its residents, the Secretary may impose any of the remedies described in subparagraph (B).

Nothing in this subparagraph shall be construed as restricting the remedies available to the Secretary to remedy a skilled nursing facility's deficiencies. If the Secretary finds, or pursuant to the recommendation of the State under paragraph (1) finds, that a skilled nursing facility meets such requirements but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subparagraph (B)(ii) for the days on which he finds that the facility was not in compliance with such requirements.

(B) SPECIFIED REMEDIES.—The Secretary may take the following actions with respect to a finding that a facility has not met an applicable requirement:

(i) DENIAL OF PAYMENT.—The Secretary may deny any further payments under this title with respect to all individuals entitled to benefits under this title in the facility or with respect to such individuals admitted to the facility after the effective date of the finding.

(ii) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—The Secretary may impose a civil money penalty in an amount not to exceed $10,000 for each day of noncompliance. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(iii) APPOINTMENT OF TEMPORARY MANAGEMENT.—In consultation with the State, the Secretary may appoint temporary management to oversee the operation of the facility and to assure the health and safety of the facility's residents, where there is a need for temporary management while—

(I) there is an orderly closure of the facility, or

(II) improvements are made in order to bring the facility into compliance with all the requirements of subsections (b), (c), and (d).

The temporary management under this clause shall not be terminated under subclause (II) until the Secretary has determined that the facility has the man-

agement capability to ensure continued compliance with all the requirements of subsections (b), (c), and (d).

The Secretary shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies. In addition, the Secretary may provide for other specified remedies, such as directed plans of correction.

(C) CONTINUATION OF PAYMENTS PENDING REMEDIATION.—The Secretary may continue payments, over a period of not longer than 6 months after the effective date of the findings, under this title with respect to a skilled nursing facility not in compliance with a requirement of subsection (b), (c), or (d), if—

(i) the State survey agency finds that it is more appropriate to take alternative action to assure compliance of the facility with the requirements than to terminate the certification of the facility,

(ii) 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

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

The Secretary shall establish guidelines for approval of corrective actions requested by States under this subparagraph.

(D) ASSURING PROMPT COMPLIANCE.—If a skilled nursing facility has not complied with any of the requirements of subsections (b), (c), and (d), within 3 months after the date the facility is found to be out of compliance with such requirements, the Secretary shall impose the remedy described in subparagraph (B)(i) for all individuals who are admitted to the facility after such date.

(E) REPEATED NONCOMPLIANCE.—In the case of a skilled nursing facility which, on 3 consecutive standard surveys conducted under subsection (g)(2), has been found to have provided substandard quality of care, the Secretary shall (regardless of what other remedies are provided)—

(i) impose the remedy described in subparagraph (B)(i), and

(ii) monitor the facility under subsection (g)(4)(B),

until the facility has demonstrated, to the satisfaction of the Secretary, that it is in compliance with the requirements of subsections (b), (c), and (d), and that it will remain in compliance with such requirements.

(3) EFFECTIVE PERIOD OF DENIAL OF PAYMENT.—A finding to deny payment under this subsection shall terminate when the Secretary finds that the facility is in substantial compliance with all the requirements of subsections (b), (c), and (d).

(4) IMMEDIATE TERMINATION OF PARTICIPATION FOR FACILITY WHERE SECRETARY FINDS NONCOMPLIANCE AND IMMEDIATE JEOPARDY.—If the Secretary finds that a skilled nursing facility has not met a requirement of subsection (b), (c), or (d), and finds that the failure immediately jeopardizes the health or safety of its residents, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(B)(iii), or the Secretary shall terminate the facility's participation under this title. If the facility's participation under this title is terminated, the State shall provide for the safe and orderly transfer of the residents eligible under this title consistent with the requirements of subsection (c)(2).

(5) CONSTRUCTION.—The remedies provided under this subsection are in addition to those otherwise available under State or Federal law and shall not be construed as limiting such other remedies, including any remedy available to an individual at common law. The remedies described in clauses (i), and (iii) of paragraph (2)(B) may be imposed during the pendency of any hearing.

(6) SHARING OF INFORMATION.—Notwithstanding any other provision of law, all information concerning skilled nursing facilities required by this section to be filed with the Secretary or a State agency shall be made available by such facilities to Federal or State employees for purposes consistent with the effective administration of programs established under this title and title XIX, including investigations by State medicaid fraud control units.

(i) CONSTRUCTION.—Where requirements or obligations under this section are identical to those provided under section 1919 of this Act, the fulfillment of those requirements or obligations under section 1919 shall be considered to be the fulfillment of the corresponding requirements or obligations under this section.

MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM

SEC. 1820. [42 U.S.C. 1395i–4] (a) ESTABLISHMENT.—Any State that submits an application in accordance with subsection (b) may establish a medicare rural hospital flexibility program described in subsection (c).

(b) APPLICATION.—A State may establish a medicare rural hospital flexibility program described in subsection (c) if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing—

(1) assurances that the State—

(A) has developed, or is in the process of developing, a State rural health care plan that—

(i) provides for the creation of 1 or more rural health networks (as defined in subsection (d)) in the State;

(ii) promotes regionalization of rural health services in the State; and

(iii) improves access to hospital and other health services for rural residents of the State; and

(B) has developed the rural health care plan described in subparagraph (A) in consultation with the hospital association of the State, rural hospitals located in the State,

and the State Office of Rural Health (or, in the case of a State in the process of developing such plan, that assures the Secretary that the State will consult with its State hospital association, rural hospitals located in the State, and the State Office of Rural Health in developing such plan);

(2) assurances that the State has designated (consistent with the rural health care plan described in paragraph (1)(A)), or is in the process of so designating, rural nonprofit or public hospitals or facilities located in the State as critical access hospitals; and

(3) such other information and assurances as the Secretary may require.

(c) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM DESCRIBED.—

(1) IN GENERAL.—A State that has submitted an application in accordance with subsection (b), may establish a medicare rural hospital flexibility program that provides that—

(A) the State shall develop at least 1 rural health network (as defined in subsection (d)) in the State; and

(B) at least 1 facility in the State shall be designated as a critical access hospital in accordance with paragraph (2).

(2) STATE DESIGNATION OF FACILITIES.—

(A) IN GENERAL.—A State may designate 1 or more facilities as a critical access hospital in accordance with subparagraphs (B), (C) and (D).

(B) CRITERIA FOR DESIGNATION AS CRITICAL ACCESS HOSPITAL.—A State may designate a facility as a critical access hospital if the facility—

(i) is a hospital that is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1886(d)(2)(D)) or is being treated as being located in a rural area pursuant to section 1886(d)(8)(E) and that—

(I) is located more than a 35–mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15–mile drive) from a hospital, or another facility described in this subsection; or

(II) is certified before January 1, 2006,[81] by the State as being a necessary provider of health care services to residents in the area;

(ii) makes available 24–hour emergency care services that a State determines are necessary for ensuring access to emergency care services in each area served by a critical access hospital;

(iii) provides not more than 25[82] acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient;

[81] P.L. 108–173, §405(h)(1), inserted "before January 1, 2006", effective December 8, 2003.

[82] P.L. 108–173, §405(e)(1), struck out "15 (or, in the case of a facility under an agreement described in subsection (f), 25)" and substituted "25", applicable to designations made before, on, or after January 1, 2004, but any election made pursuant to regulations promulgated to carry out such amendments shall only apply prospectively.

(iv) meets such staffing requirements as would apply under section 1861(e) to a hospital located in a rural area, except that—

(I) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open and fully staffed, except insofar as the facility is required to make available emergency care services as determined under clause (ii) and must have nursing services available on a 24–hour basis, but need not otherwise staff the facility except when an inpatient is present;

(II) the facility may provide any services otherwise required to be provided by a full–time, on site dietitian, pharmacist, laboratory technician, medical technologist, and radiological technologist on a part–time, off site basis under arrangements as defined in section 1861(w)(1); and

(III) the inpatient care described in clause (iii) may be provided by a physician assistant, nurse practitioner, or clinical nurse specialist subject to the oversight of a physician who need not be present in the facility; and

(v) meets the requirements of section 1861(aa)(2)(I).

(C) RECENTLY CLOSED FACILITIES.—A State may designate a facility as a critical access hospital if the facility—

(i) was a hospital that ceased operations on or after the date that is 10 years before the date of the enactment of this subparagraph; and

(ii) as of the effective date of such designation, meets the criteria for designation under subparagraph (B).

(D) DOWNSIZED FACILITIES.—A State may designate a health clinic or a health center (as defined by the State) as a critical access hospital if such clinic or center—

(i) is licensed by the State as a health clinic or a health center;

(ii) was a hospital that was downsized to a health clinic or health center; and

(iii) as of the effective date of such designation, meets the criteria for designation under subparagraph (B).

(E)[83] AUTHORITY TO ESTABLISH PSYCHIATRIC AND REHABILITATION DISTINCT PART UNITS.—

(i) IN GENERAL.—Subject to the succeeding provisions of this subparagraph, a critical access hospital may establish—

(I) a psychiatric unit of the hospital that is a distinct part of the hospital; and

(II) a rehabilitation unit of the hospital that is a distinct part of the hospital,

[83] P.L. 108–173, §405(g)(1), added subparagraph (E), applicable to cost reporting periods beginning on or after October 1, 2004.

if the distinct part meets the requirements (including conditions of participation) that would otherwise apply to the distinct part if the distinct part were established by a subsection (d) hospital in accordance with the matter following clause (v) of section 1886(d)(1)(B), including any regulations adopted by the Secretary under such section.

(ii) LIMITATION ON NUMBER OF BEDS.—The total number of beds that may be established under clause (i) for a distinct part unit may not exceed 10.

(iii) EXCLUSION OF BEDS FROM BED COUNT.—In determining the number of beds of a critical access hospital for purposes of applying the bed limitations referred to in subparagraph (B)(iii) and subsection (f), the Secretary shall not take into account any bed established under clause (i).

(iv) EFFECT OF FAILURE TO MEET REQUIREMENTS.—If a psychiatric or rehabilitation unit established under clause (i) does not meet the requirements described in such clause with respect to a cost reporting period, no payment may be made under this title to the hospital for services furnished in such unit during such period. Payment to the hospital for services furnished in the unit may resume only after the hospital has demonstrated to the Secretary that the unit meets such requirements.

(d) DEFINITION OF RURAL HEALTH NETWORK.—

(1) IN GENERAL.—In this section, the term rural health network means, with respect to a State, an organization consisting of—

(A) at least 1 facility that the State has designated or plans to designate as a critical access hospital; and

(B) at least 1 hospital that furnishes acute care services.

(2) AGREEMENTS.—

(A) IN GENERAL.—Each critical access hospital that is a member of a rural health network shall have an agreement with respect to each item described in subparagraph (B) with at least 1 hospital that is a member of the network.

(B) ITEMS DESCRIBED.—The items described in this subparagraph are the following:

(i) Patient referral and transfer.

(ii) The development and use of communications systems including (where feasible)—

(I) telemetry systems; and

(II) systems for electronic sharing of patient data.

(iii) The provision of emergency and non–emergency transportation among the facility and the hospital.

(C) CREDENTIALING AND QUALITY ASSURANCE.—Each critical access hospital that is a member of a rural health network shall have an agreement with respect to credentialing and quality assurance with at least—

(i) 1 hospital that is a member of the network;

(ii) 1 peer review organization or equivalent entity; or

(iii) 1 other appropriate and qualified entity identified in the State rural health care plan.

(e) CERTIFICATION BY THE SECRETARY.—The Secretary shall certify a facility as a critical access hospital if the facility—

(1) is located in a State that has established a medicare rural hospital flexibility program in accordance with subsection (c);

(2) is designated as a critical access hospital by the State in which it is located; and

(3) meets such other criteria as the Secretary may require.

(f) PERMITTING MAINTENANCE OF SWING BEDS.—Nothing in this section shall be construed to prohibit a State from designating or the Secretary from certifying a facility as a critical access hospital solely because, at the time the facility applies to the State for designation as a critical access hospital, there is in effect an agreement between the facility and the Secretary under section 1883 under which the facility's inpatient hospital facilities are used for the provision of extended care services, so long as the total number of beds that may be used at any time for the furnishing of either such services or acute care inpatient services does not exceed 25 beds[84]. For purposes of the previous sentence, any bed of a unit of the facility that is licensed as a distinct–part skilled nursing facility at the time the facility applies to the State for designation as a critical access hospital shall not be counted.

(g) GRANTS.—

(1) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.—The Secretary may award grants to States that have submitted applications in accordance with subsection (b) for—

(A) engaging in activities relating to planning and implementing a rural health care plan;

(B) engaging in activities relating to planning and implementing rural health networks; and

(C) designating facilities as critical access hospitals.

(2) RURAL EMERGENCY MEDICAL SERVICES.—

(A) IN GENERAL.—The Secretary may award grants to States that have submitted applications in accordance with subparagraph (B) for the establishment or expansion of a program for the provision of rural emergency medical services.

(B) APPLICATION.—An application is in accordance with this subparagraph if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing the assurances described in subparagraphs (A)(ii), (A)(iii), and (B) of subsection (b)(1) and paragraph (3) of that subsection.

(3) UPGRADING DATA SYSTEMS.—

(A) GRANTS TO HOSPITALS.—The Secretary may award grants to hospitals that have submitted applications in accordance with subparagraph (C) to assist eligible small rural hospitals in meeting the costs of implementing data systems required to meet requirements established under

[84] P.L. 108–173, §405(e)(2), struck out "and the number of beds used at any time for acute care inpatient services does not exceed 15 beds", applicable to designations made before, on, or after January 1, 2004, but any election made pursuant to regulations promulgated to carry out such amendments shall only apply prospectively.

the medicare program pursuant to amendments made by the Balanced Budget Act of 1997.

(B) ELIGIBLE SMALL RURAL HOSPITAL DEFINED.—For purposes of this paragraph, the term "eligible small rural hospital" means a non–Federal, short–term general acute care hospital that—

(i) is located in a rural area (as defined for purposes of section 1886(d)); and

(ii) has less than 50 beds.

(C) APPLICATION.—A hospital seeking a grant under this paragraph shall submit an application to the Secretary on or before such date and in such form and manner as the Secretary specifies.

(D) AMOUNT OF GRANT.—A grant to a hospital under this paragraph may not exceed $50,000.

(E) USE OF FUNDS.—A hospital receiving a grant under this paragraph may use the funds for the purchase of computer software and hardware, the education and training of hospital staff on computer information systems, and to offset costs related to the implementation of prospective payment systems.

(F) REPORTS.—

(i) INFORMATION.—A hospital receiving a grant under this section shall furnish the Secretary with such information as the Secretary may require to evaluate the project for which the grant is made and to ensure that the grant is expended for the purposes for which it is made.

(ii) TIMING OF SUBMISSION.—

(I) INTERIM REPORTS.—The Secretary shall report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate at least annually on the grant program established under this section, including in such report information on the number of grants made, the nature of the projects involved, the geographic distribution of grant recipients, and such other matters as the Secretary deems appropriate.

(II) FINAL REPORT.—The Secretary shall submit a final report to such committees not later than 180 days after the completion of all of the projects for which a grant is made under this section.

(4)[85] ADDITIONAL REQUIREMENTS WITH RESPECT TO FLEX GRANTS.—With respect to grants awarded under paragraph (1) or (2) from funds appropriated for fiscal year 2005 and subsequent fiscal years—

(A) CONSULTATION WITH THE STATE HOSPITAL ASSOCIATION AND RURAL HOSPITALS ON THE MOST APPROPRIATE WAYS TO USE GRANTS.—A State shall consult with the hospital association of such State and rural hospitals located in such State on the most appropriate ways to use the funds under such grant.

[85] P.L. 108–173, §405(f)(2), added paragraph (4), effective December 8, 2003.

(B) LIMITATION ON USE OF GRANT FUNDS FOR ADMINISTRATIVE EXPENSES.—A State may not expend more than the lesser of—

(i) 15 percent of the amount of the grant for administrative expenses; or

(ii) the State's federally negotiated indirect rate for administering the grant.

(5)[86] USE OF FUNDS FOR FEDERAL ADMINISTRATIVE EXPENSES.—Of the total amount appropriated for grants under paragraphs (1) and (2) for a fiscal year (beginning with fiscal year 2005), up to 5 percent of such amount shall be available to the Health Resources and Services Administration for purposes of administering such grants.

(h) GRANDFATHERING PROVISIONS[87].—

(1) IN GENERAL.—Any medical assistance facility operating in Montana and any critical access hospital designated by the Secretary under this section prior to the date of the enactment of the Balanced Budget Act of 1997 shall be deemed to have been certified by the Secretary under subsection (e) as a critical access hospital if such facility or hospital is otherwise eligible to be designated by the State as a critical access hospital under subsection (c).

(2) CONTINUATION OF MEDICAL ASSISTANCE FACILITY AND CRITICAL CARE HOSPITAL TERMS.—Notwithstanding any other provision of this title, with respect to any medical assistance facility or critical access hospital described in paragraph (1), any reference in this title to a critical access hospital shall be deemed to be a reference to a medical assistance facility or critical access hospital.

(3)[88] STATE AUTHORITY TO WAIVE 35-MILE RULE.—In the case of a facility that was designated as a critical access hospital before January 1, 2006, and was certified by the State as being a necessary provider of health care services to residents in the area under subsection (c)(2)(B)(i)(II), as in effect before such date, the authority under such subsection with respect to any redesignation of such facility shall continue to apply notwithstanding the amendment made by section 405(h)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(i) WAIVER OF CONFLICTING PART A PROVISIONS.—The Secretary is authorized to waive such provisions of this part and part D as are necessary to conduct the program established under this section.

(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund for making grants to all States under subsection (g), $25,000,000 in each of the fiscal years 1998 through 2002, and for making grants to all States under paragraphs (1) and (2) of subsection (g), $35,000,000 in each of fiscal years 2005 through 2008[89].

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[86] P.L. 108–173, §405(f)(2), added paragraph (5), effective December 8, 2003.

[87] P.L. 108–173, §405(h)(2)(A), struck out "of Certain Facilities" and substituted "Provisions".

[88] P.L. 108–173, §405(h)(2)(B), added paragraph (3), effective December 8, 2003.

[89] P.L. 108–173, §405(f)(1), added ", and for making grants to all States under paragraphs (1) and (2) of subsection (g), $35,000,000 in each of fiscal years 2005 through 2008" effective December 8, 2003.

CONDITIONS FOR COVERAGE OF RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTIONAL SERVICES

SEC. 1821. [42 U.S.C. 1395i–5] (a) IN GENERAL.—Subject to subsections (c) and (d), payment under this part may be made for inpatient hospital services or post–hospital extended care services furnished an individual in a religious nonmedical health care institution and for home health services furnished an individual by a religious nonmedical health care institution[90] only if—

(1) the individual has an election in effect for such benefits under subsection (b); and

(2) the individual has a condition such that the individual would qualify for benefits under this part for inpatient hospital services, extended care services, or home health services[91], respectively, if the individual were an inpatient or resident in a hospital or skilled nursing facility, or receiving services from a home health agency,[92] that was not such an institution.

(b) ELECTION.—

(1) IN GENERAL.—An individual may make an election under this subsection in a form and manner specified by the Secretary consistent with this subsection. Unless otherwise provided, such an election shall take effect immediately upon its execution. Such an election, once made, shall continue in effect until revoked.

(2) FORM.—The election form under this subsection shall include the following:

(A) A written statement, signed by the individual (or such individual's legal representative), that—

(i) the individual is conscientiously opposed to acceptance of nonexcepted medical treatment; and

(ii) the individual's acceptance of nonexcepted medical treatment would be inconsistent with the individual's sincere religious beliefs.

(B) A statement that the receipt of nonexcepted medical services shall constitute a revocation of the election and may limit further receipt of services described in subsection (a).

(3) REVOCATION.—An election under this subsection by an individual may be revoked by voluntarily notifying the Secretary in writing of such revocation and shall be deemed to be revoked if the individual receives nonexcepted medical treatment for which reimbursement is made under this title.

(4) LIMITATION ON SUBSEQUENT ELECTIONS.—Once an individual's election under this subsection has been made and revoked twice—

(A) the next election may not become effective until the date that is 1 year after the date of most recent previous revocation, and

(B) any succeeding election may not become effective until the date that is 5 years after the date of the most recent previous revocation.

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[90] P.L. 108–173, §706(a)(1), inserted "and for home health services furnished an individual by a religious nonmedical health care institution", effective December 8, 2003.

[91] P.L. 108–173, §706(a)(2)(A), struck out "or extended care services" and substituted ", extended care services, or home health services", effective December 8, 2003.

[92] P.L. 108–173, §706(a)(2)(B), inserted ", or receiving services from a home health agency," effective December 8, 2003.

(5) EXCEPTED MEDICAL TREATMENT.—For purposes of this subsection:

(A) EXCEPTED MEDICAL TREATMENT.—The term excepted medical treatment means medical care or treatment (including medical and other health services)—

(i) received involuntarily, or

(ii) required under Federal or State law or law of a political subdivision of a State.

(B) NONEXCEPTED MEDICAL TREATMENT.—The term nonexcepted medical treatment means medical care or treatment (including medical and other health services) other than excepted medical treatment.

(c) MONITORING AND SAFEGUARD AGAINST EXCESSIVE EXPENDITURES.—

(1) ESTIMATE OF EXPENDITURES.—Before the beginning of each fiscal year (beginning with fiscal year 2000), the Secretary shall estimate the level of expenditures under this part for services described in subsection (a) for that fiscal year.

(2) ADJUSTMENT IN PAYMENTS.—

(A) PROPORTIONAL ADJUSTMENT.—If the Secretary determines that the level estimated under paragraph (1) for a fiscal year will exceed the trigger level (as defined in subparagraph (C)) for that fiscal year, the Secretary shall, subject to subparagraph (B), provide for such a proportional reduction in payment amounts under this part for services described in subsection (a) for the fiscal year involved as will assure that such level (taking into account any adjustment under subparagraph (B)) does not exceed the trigger level for that fiscal year.

(B) ALTERNATIVE ADJUSTMENTS.—The Secretary may, instead of making some or all of the reduction described in subparagraph (A), impose such other conditions or limitations with respect to the coverage of covered services (including limitations on new elections of coverage and new facilities) as may be appropriate to reduce the level of expenditures described in paragraph (1) to the trigger level.

(C) TRIGGER LEVEL.—For purposes of this subsection—

(i) IN GENERAL.—Subject to adjustment under paragraph (3)(B), the trigger level for a year is the unadjusted trigger level described in clause (ii).

(ii) UNADJUSTED TRIGGER LEVEL.—The unadjusted trigger level for—

(I) fiscal year 1998, is $20,000,000, or

(II) a succeeding fiscal year is the amount specified under this clause for the previous fiscal year increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) for the 12–month period ending with July preceding the beginning of the fiscal year.

(D) PROHIBITION OF ADMINISTRATIVE AND JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of the estimation of expenditures under subparagraph (A) or the application of reduction amounts under subparagraph (B).

(E) EFFECT ON BILLING.—Notwithstanding any other provision of this title, in the case of a reduction in payment provided under this subsection for services of a religious nonmedical health care institution provided to an individual, the amount that the institution is otherwise permitted to charge the individual for such services is increased by the amount of such reduction.

(3) MONITORING EXPENDITURE LEVEL.—

(A) IN GENERAL.—The Secretary shall monitor the expenditure level described in paragraph (2)(A) for each fiscal year (beginning with fiscal year 1999).

(B) ADJUSTMENT IN TRIGGER LEVEL.—

(i) IN GENERAL.—If the Secretary determines that such level for a fiscal year exceeded, or was less than, the trigger level for that fiscal year, then, subject to clause (ii), the trigger level for the succeeding fiscal year shall be reduced, or increased, respectively, by the amount of such excess or deficit.

(ii) LIMITATION ON CARRYFORWARD.—In no case may the increase effected under clause (i) for a fiscal year exceed $50,000,000.

(d) SUNSET.—If the Secretary determines that the level of expenditures described in subsection (c)(1) for 3 consecutive fiscal years (with the first such year being not earlier than fiscal year 2002) exceeds the trigger level for such expenditures for such years (as determined under subsection (c)(2)), benefits shall be paid under this part for services described in subsection (a) and furnished on or after the first January 1 that occurs after such 3 consecutive years only with respect to an individual who has an election in effect under subsection (b) as of such January 1 and only during the duration of such election.

(e) ANNUAL REPORT.—At the beginning of each fiscal year (beginning with fiscal year 1999), the Secretary shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate an annual report on coverage and expenditures for services described in subsection (a) under this part and under State plans under title XIX. Such report shall include—

(1) level of expenditures described in subsection (c)(1) for the previous fiscal year and estimated for the fiscal year involved;

(2) trends in such level; and

(3) facts and circumstances of any significant change in such level from the level in previous fiscal years.

Part B—Supplementary Medical Insurance Benefits for the Aged and Disabled [93]

ESTABLISHMENT OF SUPPLEMENTARY MEDICAL INSURANCE PROGRAM FOR THE AGED AND THE DISABLED

SEC. 1831. **[**42 U.S.C. 1395j**]** There is hereby established a voluntary insurance program to provide medical insurance benefits in

[93] See Vol. II, P.L. 98–369, §2323(e), with respect to monitoring of hepatitis vaccine.
See Vol. II, P.L. 100–203, §4048(b), with respect to the development of a uniform relative value guide for making payment for physician anesthesia services;

accordance with the provisions of this part for aged and disabled individuals who elect to enroll under such program, to be financed from premium payments by enrollees together with contributions from funds appropriated by the Federal Government.

SCOPE OF BENEFITS

SEC. 1832. [42 U.S.C. 1395k] (a) The benefits provided to an individual by the insurance program established by this part shall consist of—

(1) entitlement to have payment made to him or on his behalf (subject to the provisions of this part) for medical and other health services, except those described in subparagraphs (B) and (D) of paragraph (2) and subparagraphs (E) and (F) of section 1842(b)(6); and

(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

(A) home health services (other than items described in subparagraph (G) or subparagraph (I));

(B) medical and other health services (other than items described in subparagraph (G) or subparagraph (I)) furnished by a provider of services or by others under arrangement with them made by a provider of services, excluding—

(i) physician services except where furnished by—

(I) a resident or intern of a hospital, or

(II) a physician to a patient in a hospital which has a teaching program approved as specified in paragraph (6) of section 1861(b) (including services in conjunction with the teaching programs of such hospital whether or not such patient is an inpatient of such hospital) where the conditions specified in paragraph (7) of such section are met,

(ii) services for which payment may be made pursuant to section 1835(b)(2),

(iii) services described by section 1861(s)(2)(K)(i), certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist;

(iv) services of a nurse practitioner or clinical nurse specialist but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services; and

(C) outpatient physical therapy services (other than services to which the second sentence of section 1861(p) applies) and outpatient occupational therapy services (other than services to which such sentence applies through the operation of section 1861(g));

See Vol. II, P.L. 101–239, §6112(b), with respect to rental payments for enteral and parenteral pumps; and §6113(c) and (e), with respect to the development of criteria regarding consultation with a physician.

See Vol. II, P.L. 101–508, §4164(c), with respect to the directory of unique physician identifier numbers.

See Vol. II, P.L. 103–66, §6134, with respect to a study of the costs of furnishing, and payments for, portable x-ray services; and §13515(b), with respect to budget neutrality adjustment.

See Vol. II, P.L. 105–33, §4513(c), with respect to no x–ray required for chiropractic services.

(D)(i) rural health clinic services and (ii) Federally qualified health center services;

(E) comprehensive outpatient rehabilitation facility services;

(F) facility services furnished in connection with surgical procedures specified by the Secretary—

(i) pursuant to section 1833(i)(1)(A) and performed in an ambulatory surgical center (which meets health, safety, and other standards specified by the Secretary in regulations) if the center has an agreement in effect with the Secretary by which the center agrees to accept the standard overhead amount determined under section 1833(i)(2)(A) as full payment for such services (including intraocular lens in cases described in section 1833(i)(2)(A)(iii)) and to accept an assignment described in section 1842(b)(3)(B)(ii) with respect to payment for all such services (including intraocular lens in cases described in section 1833(i)(2)(A)(iii)) furnished by the center to individuals enrolled under this part, or

(ii) pursuant to section 1833(i)(1)(B) and performed by a physician, described in paragraph (1), (2), or (3) of section 1861(r), in his office, if the Secretary has determined that—

(I) a quality control and peer review organization (having a contract with the Secretary under part B of title XI of this Act) is willing, able, and has agreed to carry out a review (on a sample or other reasonable basis) of the physician's performing such procedures in the physician's office,

(II) the particular physician involved has agreed to make available to such organization such records as the Secretary determines to be necessary to carry out the review, and

(III) the physician is authorized to perform the procedure in a hospital located in the area in which the office is located,

and if the physician agrees to accept the standard overhead amount determined under section 1833(i)(2)(B) as full payment for such services and to accept payment on an assignment-related basis with respect to payment for all services (including all pre- and post-operative services) described in paragraphs (1) and (2)(A) of section 1861(s) and furnished in connection with such surgical procedure to individuals enrolled under this part;

(G) covered items (described in section 1834(a)(13)) furnished by a provider of services or by others under arrangements with them made by a provider of services;

(H) outpatient critical access hospital services (as defined in section 1861(mm)(3));

(I) prosthetic devices and orthotics and prosthetics (described in section 1834(h)(4)) furnished by a provider of services or by others under arrangements with them made by a provider of services; and

(J) partial hospitalization services provided by a community mental health center (as described in section 1861(ff)(2)(B)).

(b) For definitions of "spell of illness", "medical and other health services", and other terms used in this part, see section 1861.

PAYMENT OF BENEFITS [94]

SEC. 1833. [42 U.S.C. 1395l] (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1832(a)(1)—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis (and either is sponsored by a union or employer, or does not provide, or arrange for the provision of, any inpatient hospital services) may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b), (B) with respect to items and services described in section 1861(s)(10)(A), the amounts paid shall be 100 percent of the reasonable charges for such items and services, (C) with respect to expenses incurred for those physicians' services for which payment may be made under this part that are described in section 1862(a)(4), the prosthetic devices and orthotics and prosthetics (as defined in section 1834(h)(4)), the amounts paid shall be the amounts described in section 1834(h)(1), the amounts paid shall be subject to such limitations as may be prescribed by regulations, (D) with respect to clinical diagnostic laboratory tests for which payment is made under this part (i) on the basis of a fee schedule under subsection (h)(1) or section 1834(d)(1), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment–related basis) of the lesser of the amount determined under such fee schedule, the limitation amount for that test determined under subsection (h)(4)(B), or the amount of the charges billed for the tests, or (ii) on the basis of a negotiated rate established under subsection (h)(6), the amount paid shall be equal to 100 percent of such negotiated rate, (E) with respect to services furnished to individuals who have been determined to have end stage renal disease, the amounts paid shall be determined sub-

[94] See Vol. II, P.L. 108–173, §305(b), with respect to a GAO study of medicare payment for inhalation therapy; §416, with respect to treatment of certain clinical diagnostic laboratory tests furnished to hospital outpatients in certain rural areas; §641, with respect to a demonstration project for coverage of certain prescription drugs and biologicals; and §733, with respect to payments for pancreatic islet cell investigational transplants for medicare beneficiaries in clinical trials.

ject to the provisions of section 1881, (F) with respect to clinical social worker services under section 1861(s)(2)(N), the amounts paid shall be 80 percent of the lesser of (i) the actual charge for the services or (ii) 75 percent of the amount determined for payment of a psychologist under clause (L), (G)[95] with respect to facility services furnished in connection with a surgical procedure specified pursuant to subsection (i)(1)(A) and furnished to an individual in an ambulatory surgical center described in such subsection, for services furnished beginning with the implementation date of a revised payment system for such services in such facilities specified in subsection (i)(2)(D), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by the Secretary under such revised payment system, (H) with respect to services of a certified registered nurse anesthetist under section 1861(s)(11), the amounts paid shall be 80 percent of the least of the actual charge, the prevailing charge that would be recognized (or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1848) if the services had been performed by an anesthesiologist, or the fee schedule for such services established by the Secretary in accordance with subsection (1), (I) with respect to covered items (described in section 1834(a)(13)), the amounts paid shall be the amounts described in section 1834(a)(1), and (J) with respect to expenses incurred for radiologist services (as defined in section 1834(b)(6)), subject to section 1848, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount provided under the fee schedule established under section 1834(b), (K) with respect to certified nurse–midwife services under section 1861(s)(2)(L), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph (but in no event shall such fee schedule exceed 65 percent of the prevailing charge that would be allowed for the same service performed by a physician, or, for services furnished on or after January 1, 1992, 65 percent of the fee schedule amount provided under section 1848 for the same service performed by a physician), (L) with respect to qualified psychologist services under section 1861(s)(2)(M), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph, (M) with respect to prosthetic devices and orthotics and (N) with respect to expenses incurred for physicians' services (as defined in section 1848(j)(3)), the amounts paid shall be 80 percent of the payment basis determined under section 1848(a)(1), (O) with respect to services described in section 1861(s)(2)(K) (relating to services furnished by physicians assistants, nurse practitioners, or clinical nurse specialists), the amounts paid shall be equal to 80 percent of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848, or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of

[95] P.L. 108-173, §626(c), added subparagraph (G), effective December 8, 2003.

the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery, (P) with respect to surgical dressings, the amounts paid shall be the amounts determined under section 1834(i), (Q) with respect to items or services for which fee schedules are established pursuant to section 1842(s), the amounts paid shall be 80 percent of the lesser of the actual charge or the fee schedule established in such section, (R) with respect to ambulance services, (i) the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary under section 1834(l) and (ii) with respect to ambulance services described in section 1834(l)(8), the amounts paid shall be the amounts determined under section 1834(g) for outpatient critical access hospital services , (S) with respect to drugs and biologicals (including intravenous immune globulin (as defined in section 1861(zz)))[96] not paid on a cost or prospective payment basis as otherwise provided in this part (other than items and services described in subparagraph (B)), the amounts paid shall be 80 percent of the lesser of the actual charge or the payment amount established in section 1842(o) (or, if applicable, under section 1847, 1847A, or 1847B)[97], (T) with respect to medical nutrition therapy services (as defined in section 1861(vv)), the amount paid shall be 80 percent of the lesser of the actual charge for the services or 85 percent of the amount determined under the fee schedule established under section 1848(b) for the same services if furnished by a physician, (U)[98] with respect to facility fees described in section 1834(m)(2)(B), the amounts paid shall be 80 percent of the lesser of the actual charge or the amounts specified in such section, and (V) notwithstanding subparagraphs (I) (relating to durable medical equipment), (M) (relating to prosthetic devices and orthotics and prosthetics), and (Q) (relating to 1842(s) items), with respect to competitively priced items and services (described in section 1847(a)(2)) that are furnished in a competitive area, the amounts paid shall be the amounts described in section 1847(b)(5)[99] ;

(2) in the case of services described in section 1832(a)(2) (except those services described in subparagraphs (C), (D), (E), (F), (G), (H), and (I) of such section and unless otherwise specified in section 1881)—

(A) with respect to home health services (other than a covered osteoporosis drug) (as defined in section 1861(kk)), the amount determined under the prospective payment system under section 1895;

(B) with respect to other items and services (except those described in subparagraph (C), (D), or (E) of this paragraph and except as may be provided in section 1886 or section 1888(e)(9))—

[96] P.L. 108–173, §642(b), inserted "(including intravenous immune globulin (as defined in section 1861(zz)))", applicable to items furnished administered on or after January 1, 2004.

[97] P.L. 108-173, §303(i)(3)(A), inserted "(or, if applicable, under section 1847, 1847A, or 1847B)".

[98] P.L. 108–173, §302(b)(2)(A), struck out "and (U)" and substituted "(U)".

[99] P.L. 108–173, §302(b)(2)(B), inserted ", and (V) notwithstanding subparagraphs (I) (relating to durable medical equipment), (M) (relating to prosthetic devices and orthotics and prosthetics), and (Q) (relating to 1842(s) items), with respect to competitively priced items and services (described in section 1847(a)(2)) that are furnished in a competitive area, the amounts paid shall be the amounts described in section 1847(b)(5)", effective December 8, 2003.

(i) furnished before January 1, 1999, the lesser of—

(I) the reasonable cost of such services, as determined under section 1861(v), or

(II) the customary charges with respect to such services,

less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such other services exceed 80 percent of such reasonable cost, or

(ii) if such services are furnished before January 1, 1999, by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this clause), free of charge or at nominal charges to the public, 80 percent of the amount determined in accordance with section 1814(b)(2), or

(iii) if such services are furnished on or after January 1, 1999, the amount determined under subsection (t), or

(iv) if (and for so long as) the conditions described in section 1814(b)(3) are met, the amounts determined under the reimbursement system described in such section;

(C) with respect to services described in the second sentence of section 1861(p), 80 percent of the reasonable charges for such services;

(D) with respect to clinical diagnostic laboratory tests for which payment is made under this part (i) on the basis of a fee schedule determined under subsection (h)(1) or section 1834(d)(1), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis or to a provider having an agreement under section 1866 of the lesser of the amount determined under such fee schedule, the limitation amount for that test determined under subsection (h)(4)(B), or the amount of the charges billed for the tests, (ii)[100] on the basis of a negotiated rate established under subsection (h)(6), the amount paid shall be equal to 100 percent of such negotiated rate for such tests; or (iii) on the basis of a rate established under a demonstration project under section 1847(e), the amount paid shall be equal to 100 percent of such rate,[101]

(E) with respect to—

(i) outpatient hospital radiology services (including diagnostic and therapeutic radiology, nuclear medicine and CAT scan procedures, magnetic resonance imaging, and ultrasound and other imaging services, but excluding screening mammography and, for services

[100] P.L. 108–173, §302(b)(2)(C)(i), struck out "or (ii)" and substituted "(ii)".

[101] P.L. 108–173, §302(b)(2)(C)(ii), inserted "or (iii) on the basis of a rate established under a demonstration project under section 1847(e), the amount paid shall be equal to 100 percent of such rate," effective December 8, 2003.

furnished on or after January 1, 2005, diagnostic mammography[102]), and

(ii) effective for procedures performed on or after October 1, 1989, diagnostic procedures (as defined by the Secretary) described in section 1861(s)(3) (other than diagnostic x-ray tests and diagnostic laboratory tests),

the amount determined under subsection (n) or, for services or procedures performed on or after January 1, 1999, subsection (t);

(F) with respect to a covered osteoporosis drug (as defined in section 1861(kk)) furnished by a home health agency, 80 percent of the reasonable cost of such service, as determined under section 1861(v); and

(G) with respect to items and services described in section 1861(s)(10)(A), the lesser of—

(i) the reasonable cost of such services, as determined under section 1861(v), or

(ii) the customary charges with respect to such services,

or, if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low–income (and requests that payment be made under this provision), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2);

(3)[103] in the case of services described in section 1832(a)(2)(D), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A)) exceed 80 percent of such costs;

(4) in the case of facility services described in section 1832(a)(2)(F), and outpatient hospital facility services furnished in connection with surgical procedures specified by the Secretary pursuant to section 1833(i)(1)(A), the applicable amount as determined under paragraph (2) or (3) of subsection (i) or subsection (t);

(5) in the case of covered items (described in section 1834(a)(13)) the amounts described in section 1834(a)(1);

(6) in the case of outpatient critical access hospital services, the amounts described in section 1834(g);

(7) in the case of prosthetic devices and orthotics and prosthetics (as described in section 1834(h)(4)), the amounts described in section 1834(h);

(8) in the case of—

[102] P.L. 108–173, §614(b), inserted "and, for services furnished on or after January 1, 2005, diagnostic mammography", applicable to services furnished on or after December 8, 2003, and applicable to services furnished on or after January 1, 2005.

[103] P.L. 108–173, §237(a), amends paragraph (3), applicable to services provided on or after January 1, 2006, and contract years beginning on or after January 1, 2006.

(A) outpatient physical therapy services (which includes outpatient speech–language pathology services) and outpatient occupational therapy services furnished—

(i) by a rehabilitation agency, public health agency, clinic, comprehensive outpatient rehabilitation facility, or skilled nursing facility,

(ii) by a home health agency to an individual who is not homebound, or

(iii) by another entity under an arrangement with an entity described in clause (i) or (ii); and

(B) outpatient physical therapy services (which includes outpatient speech–language pathology services) and outpatient occupational therapy services furnished—

(i) by a hospital to an outpatient or to a hospital inpatient who is entitled to benefits under part A but has exhausted benefits for inpatient hospital services during a spell of illness or is not so entitled to benefits under part A, or

(ii) by another entity under an arrangement with a hospital described in clause (i), the amounts described in section 1834(k); and

(9) in the case of services described in section 1832(a)(2)(E) that are not described in paragraph (8), the amounts described in section 1834(k).

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of $75 for calendar years before 1991, $100 for 1991 through 2004, $110 for 2005, and for a subsequent year the amount of such deductible for the previous year increased by the annual percentage increase in the monthly actuarial rate under section 1839(a)(1) ending with such subsequent year (rounded to the nearest $1)[104]; except that (1) such total amount shall not include expenses incurred for items and services described in section 1861(s)(10)(A), (2) such deductible shall not apply with respect to home health services (other than a covered osteoporosis drug (as defined in section 1861(kk)), (3) such deductible shall not apply with respect to clinical diagnostic laboratory tests for which payment is made under this part (A) under subsection (a)(1)(D)(i) or (a)(2)(D)(i) on an assignment-related basis, or to a provider having an agreement under section 1866, or (B) on the basis of a negotiated rate determined under subsection (h)(6), (4) such deductible shall not apply to Federally qualified health center services. The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the

[104] P.L. 108–173, §629, struck out "and $100 for 1991 and subsequent years" and substituted ", $100 for 1991 through 2004, $110 for 2005, and for a subsequent year the amount of such deductible for the previous year increased by the annual percentage increase in the monthly actuarial rate under section 1839(a)(1) ending with such subsequent year (rounded to the nearest $1)", effective December 8, 2003.

calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence. The deductible under the previous sentence for blood or blood cells furnished an individual in a year shall be reduced to the extent that a deductible has been imposed under section 1813(a)(2) to blood or blood cells furnished the individual in the year, (5) such deductible shall not apply with respect to screening mammography (as described in section 1861(jj)), and (6) such deductible shall not apply with respect to screening pap smear and screening pelvic exam (as described in section 1861(nn)).

(c) Notwithstanding any other provision of this part, with respect to expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time such expenses are incurred, there shall be considered as incurred expenses for purposes of subsections (a) and (b) only 62 ½ percent of such expenses.

For purposes of this subsection, the term "treatment" does not include brief office visits (as defined by the Secretary) for the sole purpose of monitoring or changing drug prescriptions used in the treatment of such disorders or partial hospitalization services that are not directly provided by a physician.

(d) No payment may be made under this part with respect to any services furnished an individual to the extent that such individual is entitled (or would be entitled except for section 1813) to have payment made with respect to such services under part A.

(e) No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period.

(f) In establishing limits under subsection (a) on payment for rural health clinic services provided by rural health clinics (other than such clinics in hospitals with less than 50 beds), the Secretary shall establish such limit, for services provided—

(1) in 1988, after March 31, at $46 per visit, and

(2) in a subsequent year, at the limit established under this subsection for the previous year 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)) furnished as of the first day of that year.

(g)(1)[105] Subject to paragraph 4, in the case of physical therapy services of the type described in section 1861(p), but not described in section 1833(a)(8)(B), and physical therapy services of such type which are furnished by a physician or as incident to physicians' services, with respect to expenses incurred in any calendar year, no more than the amount specified in paragraph (2) for the year shall be considered as incurred expenses for purposes of subsections (a) and (b).

(2) The amount specified in this paragraph—

(A) for 1999, 2000, and 2001, is $1,500, and

(B) for a subsequent year is the amount specified in this paragraph for the preceding year increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) for such subsequent year;

except that if an increase under subparagraph (B) for a year is not a multiple of $10, it shall be rounded to the nearest multiple of $10.

(3) Subject to paragraph 4, in the case of occupational therapy services (of the type that are described in section 1861(p) (but not described in section 1833(a)(8)(B)) through the operation of section 1861(g) and of such type which are furnished by a physician or as incident to physicians' services), with respect to expenses incurred in any calendar year, no more than the amount specified in paragraph (2) for the year shall be considered as incurred expenses for purposes of subsections (a) and (b).

(4) This subsection shall not apply to expenses incurred with respect to services furnished during 2000, 2001, 2002, 2004, and 2005[106].

(h)(1)(A) Subject to section 1834(d)(1), the Secretary shall establish fee schedules for clinical diagnostic laboratory tests (including prostate cancer screening tests under section 1861(oo) consisting of prostate–specific antigen blood tests) for which payment is made under this part, other than such tests performed by a provider of services for an inpatient of such provider.

(B) In the case of clinical diagnostic laboratory tests performed by a physician or by a laboratory (other than tests performed by a qualified hospital laboratory (as defined in subparagraph (D)) for outpatients of such hospital), the fee schedules established under subparagraph (A) shall be established on a regional, statewide, or carrier service area basis (as the Secretary may determine to be appropriate) for tests furnished on or after July 1, 1984.

(C) In the case of clinical diagnostic laboratory tests performed by a qualified hospital laboratory (as defined in subparagraph (D)) for outpatients of such hospital, the fee schedules established under subparagraph (A) shall be established on a regional, statewide, or carrier service area basis (as the Secretary may determine to be appropriate) for tests furnished on or after July 1, 1984.

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[105] See Vol. II, P.L. 108–173, §624(a)(2) and (b), with respect to a two-year moratorium on therapy caps and a GAO study and report identifying conditions and diseases justifying waiver of therapy cap.

[106] P.L. 108–173, §624(a)(1), struck out "and 2002" and substituted "2002, 2004, and 2005", effective December 8, 2003.

(D) In this subsection, the term "qualified hospital laboratory" means a hospital laboratory, in a sole community hospital (as defined in section 1886(d)(5)(D)(iii)), which provides some clinical diagnostic laboratory tests 24 hours a day in order to serve a hospital emergency room which is available to provide services 24 hours a day and 7 days a week.

(2)(A)(i) Except as provided in paragraph (4), the Secretary shall set the fee schedules at 60 percent (or, in the case of a test performed by a qualified hospital laboratory (as defined in paragraph (1)(D)) for outpatients of such hospital, 62 percent) of the prevailing charge level determined pursuant to the third and fourth sentences of section 1842(b)(3) for similar clinical diagnostic laboratory tests for the applicable region, State, or area for the 12-month period beginning July 1, 1984, adjusted annually (to become effective on January 1 of each year) by a percentage increase or decrease equal to the percentage increase or decrease in the Consumer Price Index for All Urban Consumers (United States city average), and subject to such other adjustments as the Secretary determines are justified by technological changes.

(ii) Notwithstanding clause (i)—

(I) any change in the fee schedules which would have become effective under this subsection for tests furnished on or after January 1, 1988, shall not be effective for tests furnished during the 3-month period beginning on January 1, 1988,

(II) the Secretary shall not adjust the fee schedules under clause (i) to take into account any increase in the consumer price index for 1988,

(III) the annual adjustment in the fee schedules determined under clause (i) for each of the years 1991, 1992, and 1993 shall be 2 percent, and

(IV) the annual adjustment in the fee schedules determined under clause (i) for each of the years 1994 and 1995, 1998 through 2002, and 2004 through 2008 [107] shall be 0 percent.

(iii) In establishing fee schedules under clause (i) with respect to automated tests and tests (other than cytopathology tests) which before July 1, 1984, the Secretary made subject to a limit based on lowest charge levels under the sixth sentence of section 1842(b)(3) performed after March 31, 1988, the Secretary shall reduce by 8.3 percent the fee schedules otherwise established for 1988, and such reduced fee schedules shall serve as the base for 1989 and subsequent years.

(B) The Secretary may make further adjustments or exceptions to the fee schedules to assure adequate reimbursement of (i) emergency laboratory tests needed for the provision of bona fide emergency services, and (ii) certain low volume high-cost tests where highly sophisticated

[107] P.L. 108–173, §628, struck out "and 1998 through 2002" and substituted ", 1998 through 2002, and 2004 through 2008", effective December 8, 2003.

equipment or extremely skilled personnel are necessary to assure quality.

(3) In addition to the amounts provided under the fee schedules, the Secretary shall provide for and establish (A) a nominal fee to cover the appropriate costs in collecting the sample on which a clinical diagnostic laboratory test was performed and for which payment is made under this part, except that not more than one such fee may be provided under this paragraph with respect to samples collected in the same encounter, and (B) a fee to cover the transportation and personnel expenses for trained personnel to travel to the location of an individual to collect the sample, except that such a fee may be provided only with respect to an individual who is homebound or an inpatient in an inpatient facility (other than a hospital). In establishing a fee to cover the transportation and personnel expenses for trained personnel to travel to the location of an individual to collect a sample, the Secretary shall provide a method for computing the fee based on the number of miles traveled and the personnel costs associated with the collection of each individual sample, but the Secretary shall only be required to apply such method in the case of tests furnished during the period beginning on April 1, 1989, and ending on December 31, 1990, by a laboratory that establishes to the satisfaction of the Secretary (based on data for the 12-month period ending June 30, 1988) that (i) the laboratory is dependent upon payments under this title for at least 80 percent of its collected revenues for clinical diagnostic laboratory tests, (ii) at least 85 percent of its gross revenues for such tests are attributable to tests performed with respect to individuals who are homebound or who are residents in a nursing facility, and (iii) the laboratory provided such tests for residents in nursing facilities representing at least 20 percent of the number of such facilities in the State in which the laboratory is located.

(4)(A) In establishing any fee schedule under this subsection, the Secretary may provide for an adjustment to take into account, with respect to the portion of the expenses of clinical diagnostic laboratory tests attributable to wages, the relative difference between a region's or local area's wage rates and the wage rate presumed in the data on which the schedule is based.

(B) For purposes of subsections (a)(1)(D)(i) and (a)(2)(D)(i), the limitation amount for a clinical diagnostic laboratory test performed—

(i) on or after July 1, 1986, and before April 1, 1988, is equal to 115 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1),

(ii) after March 31, 1988, and before January 1, 1990, is equal to the median of all the fee schedules established for that test for that laboratory setting under paragraph (1),

(iii) after December 31, 1989, and before January 1, 1991, is equal to 93 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1),

(iv) after December 31, 1990, and before January 1, 1994, is equal to 88 percent of such median,

(v) after December 31, 1993, and before January 1, 1995, is equal to 84 percent of such median,

(vi) after December 31, 1994, and before January 1, 1996, is equal to 80 percent of such median,

(vii) after December 31, 1995, and before January 1, 1998, is equal to 76 percent of such median, and

(viii) after December 31, 1997, is equal to 74 percent of such median (or 100 percent of such median in the case of a clinical diagnostic laboratory test performed on or after January 1, 2001, that the Secretary determines is a new test for which no limitation amount has previously been established under this subparagraph).

(5)(A) In the case of a bill or request for payment for a clinical diagnostic laboratory test for which payment may otherwise be made under this part on an assignment-related basis or under a provider agreement under section 1866, payment may be made only to the person or entity which performed or supervised the performance of such test; except that—

(i) if a physician performed or supervised the performance of such test, payment may be made to another physician with whom he shares his practice,

(ii) in the case of a test performed at the request of a laboratory by another laboratory, payment may be made to the referring laboratory but only if—

(I) the referring laboratory is located in, or is part of, a rural hospital,

(II) the referring laboratory is wholly owned by the entity performing such test, the referring laboratory wholly owns the entity performing such test, or both the referring laboratory and the entity performing such test are wholly-owned by a third entity, or

(III) not more than 30 percent of the clinical diagnostic laboratory tests for which such referring laboratory (but not including a laboratory described in subclause (II)), receives requests for testing during the year in which the test is performed are performed by another laboratory, and

(iii) in the case of a clinical diagnostic laboratory test provided under an arrangement (as defined in section 1861(w)(1)) made by a hospital, critical access hospital or skilled nursing facility, payment shall be made to the hospital or skilled nursing facility.

(B) In the case of such a bill or request for payment for a clinical diagnostic laboratory test for which payment may otherwise be made under this part, and which is not described in subparagraph (A), payment may be made to the beneficiary only on the basis of the itemized bill of the person or entity which performed or supervised the performance of the test.

(C) Payment for a clinical diagnostic laboratory test, including a test performed in a physician's office but exclud-

ing a test performed by a rural health clinic may only be made on an assignment-related basis or to a provider of services with an agreement in effect under section 1866.

(D) A person may not bill for a clinical diagnostic laboratory test, including a test performed in a physician's office but excluding a test performed by a rural health clinic,[108] other than on an assignment-related basis. If a person knowingly and willfully and on a repeated basis bills for a clinical diagnostic laboratory test in violation of the previous sentence, the Secretary may apply sanctions against the person in the same manner as the Secretary may apply sanctions against a physician in accordance with paragraph (2) of section 1842(j) in the same manner such paragraphs apply with respect to a physician. Paragraph (4) of such section shall apply in this subparagraph in the same manner as such paragraph applies to such section.

(6) In the case of any diagnostic laboratory test payment for which is not made on the basis of a fee schedule under paragraph (1), the Secretary may establish a payment rate which is acceptable to the person or entity performing the test and which would be considered the full charge for such tests. Such negotiated rate shall be limited to an amount not in excess of the total payment that would have been made for the services in the absence of such rate.

(7) Notwithstanding paragraphs (1) and (4), the Secretary shall establish a national minimum payment amount under this subsection for a diagnostic or screening pap smear laboratory test (including all cervical cancer screening technologies that have been approved by the Food and Drug Administration as a primary screening method for detection of cervical cancer) equal to $14.60 for tests furnished in 2000. For such tests furnished in subsequent years, such national minimum payment amount shall be adjusted annually as provided in paragraph (2).

(8)[109](A) The Secretary shall establish by regulation procedures for determining the basis for, and amount of, payment under this subsection for any clinical diagnostic laboratory test with respect to which a new or substantially revised HCPCS code is assigned on or after January 1, 2005 (in this paragraph referred to as "new tests").

(B) Determinations under subparagraph (A) shall be made only after the Secretary—

(i) makes available to the public (through an Internet website and other appropriate mechanisms) a list that includes any such test for which establishment of a payment amount under this subsection is being considered for a year;

(ii) on the same day such list is made available, causes to have published in the Federal Register notice of a meeting to receive comments and recommendations (and data on which recommendations are based) from the public on the appropriate basis

[108] P.L. 108–173, §736(b)(1), struck out "clinic,," and substituted "clinic,".
[109] P.L. 108–173, §942(b), added paragraph (8), effective December 8, 2003.

under this subsection for establishing payment amounts for the tests on such list;

(iii) not less than 30 days after publication of such notice convenes a meeting, that includes representatives of officials of the Centers for Medicare and Medicaid Services involved in determining payment amounts, to receive such comments and recommendations (and data on which the recommendations are based);

(iv) taking into account the comments and recommendations (and accompanying data) received at such meeting, develops and makes available to the public (through an Internet website and other appropriate mechanisms) a list of proposed determinations with respect to the appropriate basis for establishing a payment amount under this subsection for each such code, together with an explanation of the reasons for each such determination, the data on which the determinations are based, and a request for public written comments on the proposed determination; and

(v) taking into account the comments received during the public comment period, develops and makes available to the public (through an Internet website and other appropriate mechanisms) a list of final determinations of the payment amounts for such tests under this subsection, together with the rationale for each such determination, the data on which the determinations are based, and responses to comments and suggestions received from the public.

(C) Under the procedures established pursuant to subparagraph (A), the Secretary shall—

(i) set forth the criteria for making determinations under subparagraph (A); and

(ii) make available to the public the data (other than proprietary data) considered in making such determinations.

(D) The Secretary may convene such further public meetings to receive public comments on payment amounts for new tests under this subsection as the Secretary deems appropriate.

(E) For purposes of this paragraph:

(i) The term "HCPCS" refers to the Health Care Procedure Coding System.

(ii) A code shall be considered to be "substantially revised" if there is a substantive change to the definition of the test or procedure to which the code applies (such as a new analyte or a new methodology for measuring an existing analyte-specific test).

(i)(1) The Secretary shall, in consultation with appropriate medical organizations—

(A) specify those surgical procedures which are appropriately (when considered in terms of the proper utilization of hospital inpatient facilities) performed on an inpatient basis in a hospital but which also can be performed safely on an ambulatory basis in an ambulatory surgical center (meeting the standards specified under section

1832(a)(2)(F)(i)), critical access hospital, or hospital outpatient department, and

(B) specify those surgical procedures which are appropriately (when considered in terms of the proper utilization of hospital inpatient facilities) performed on an inpatient basis in a hospital but which also can be performed safely on an ambulatory basis in a physician's office.

The lists of procedures established under subparagraphs (A) and (B) shall be reviewed and updated not less often than every 2 years.

(2)(A) For services furnished prior to the implementation of the system described in subparagraph (D), the[110] amount of payment to be made for facility services furnished in connection with a surgical procedure specified pursuant to paragraph (1)(A) and furnished to an individual in an ambulatory surgical center described in such paragraph shall be equal to 80 percent of a standard overhead amount established by the Secretary (with respect to each such procedure) on the basis of the Secretary's estimate of a fair fee which—

(i) takes into account the costs incurred by such centers, or classes of centers, generally in providing services furnished in connection with the performance of such procedure as determined in accordance with a survey (based upon a representative sample of procedures and facilities)[111] of the actual audited costs incurred by such centers in providing such services,

(ii) takes such costs into account in such a manner as will assure that the performance of the procedure in such a center will result in substantially less amounts paid under this title than would have been paid if the procedure had been performed on an inpatient basis in a hospital, and

(iii) in the case of insertion of an intraocular lens during or subsequent to cataract surgery includes payment which is reasonable and related to the cost of acquiring the class of lens involved.

Each amount so established shall be reviewed and updated not later than July 1, 1987, and annually thereafter to take account of varying conditions in different areas.

(B) The amount of payment to be made under this part for facility services furnished, in connection with a surgical procedure specified pursuant to paragraph (1)(B), in a physician's office shall be equal to 80 percent of a standard overhead amount established by the Secretary (with respect to each such procedure) on the basis of the Secretary's estimate of a fair fee which—

(i) takes into account additional costs, not usually included in the professional fee, incurred by physicians in securing, maintaining, and staffing the facilities and ancillary services appropriate for the performance of such procedure in the physician's office, and

[110] P.L. 108–173, §626(b)(1)(A), struck out "The" and substituted "For services furnished prior to the implementation of the system described in subparagraph (D), the", effective December 8, 2003.

[111] P.L. 108–173, §626(b)(1)(B), struck out "taken not later than January 1, 1995, and every 5 years thereafter," effective December 8, 2003.

(ii) takes such items into account in such a manner which will assure that the performance of such procedure in the physician's office will result in substantially less amounts paid under this title than would have been paid if the services had been furnished on an inpatient basis in a hospital.

Each amount so established shall be reviewed and updated not later than July 1, 1987, and annually thereafter and may be adjusted by the Secretary, when appropriate, to take account of varying conditions in different areas.

(C)[112](i) Notwithstanding the second sentence of each of subparagraphs (A) and (B), except as otherwise specified in clauses (ii), (iii), and (iv), if the Secretary has not updated amounts established under such subparagraphs or under subparagraph (D), with respect to facility services furnished during a fiscal year (beginning with fiscal year 1986 or a calendar year (beginning with 2006)), such amounts shall be increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved.

(ii) In each of the fiscal years 1998 through 2002, the increase under this subparagraph shall be reduced (but not below zero) by 2.0 percentage points.

(iii) In fiscal year 2004, beginning with April 1, 2004, the increase under this subparagraph shall be the Consumer Price Index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with March 31, 2003, minus 3.0 percentage points.

(iv) In fiscal year 2005, the last quarter of calendar year 2005, and each of calendar years 2006 through 2009, the increase under this subparagraph shall be 0 percent.

(D)[113](i) Taking into account the recommendations in the report under section 626(d) of Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the Secretary shall implement a revised payment system for payment of surgical services furnished in ambulatory surgical centers.

(ii) In the year the system described in clause (i) is implemented, such system shall be designed to result in the same aggregate amount of expenditures for such services as would be made if this subparagraph did not apply, as estimated by the Secretary.

(iii) The Secretary shall implement the system described in clause (i) for periods in a manner so that it is first effective beginning on or after January 1, 2006, and not later than January 1, 2008.

(iv) There shall be no administrative or judicial review under section 1869, 1878, or otherwise, of the

[112] P.L. 108–173, §626(a), amended subparagraph (C) in its entirety, effective December 8, 2003. For subparagraph (C) as it formerly read, see Vol. II, Superseded Provisions, P.L. 108-173.

[113] P.L. 108–173, §626(b)(1)(2), added subparagraph (D), effective December 8, 2003.

classification system, the relative weights, payment amounts, and the geographic adjustment factor, if any, under this subparagraph.

(3)(A) The aggregate amount of the payments to be made under this part for outpatient hospital facility services or critical access hospital services furnished before January 1, 1999, in connection with surgical procedures specified under paragraph (1)(A) shall be equal to the lesser of—

(i) the amount determined with respect to such services under subsection (a)(2)(B); or

(ii) the blend amount (described in subparagraph (B)).

(B)(i) The blend amount for a cost reporting period is the sum of—

(I) the cost proportion (as defined in clause (ii)(I)) of the amount described in subparagraph (A)(i), and

(II) the ASC proportion (as defined in clause (ii)(II)) of the standard overhead amount payable with respect to the same surgical procedure as if it were provided in an ambulatory surgical center in the same area, as determined under paragraph (2)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).

(ii) Subject to paragraph (4), in this paragraph:

(I) The term "cost proportion" means 75 percent for cost reporting periods beginning in fiscal year 1988, 50 percent for portions of cost reporting periods beginning on or after October 1, 1988, and ending on or before December 31, 1990, and 42 percent for portions of cost reporting periods beginning on or after January 1, 1991.

(II) The term "ASC proportion" means 25 percent for cost reporting periods beginning in fiscal year 1988, 50 percent for portions of cost reporting periods beginning on or after October 1, 1988, and ending on or before December 31, 1990, and 58 percent for portions of cost reporting periods beginning on or after January 1, 1991.

(4)(A) In the case of a hospital that—

(i) makes application to the Secretary and demonstrates that it specializes in eye services or eye and ear services (as determined by the Secretary),

(ii) receives more than 30 percent of its total revenues from outpatient services, and

(iii) on October 1, 1987—

(I) was an eye specialty hospital or an eye and ear specialty hospital, or

(II) was operated as an eye or eye and ear unit (as defined in subparagraph (B)) of a general acute care hospital which, on the date of the application described in clause (i), operates less than 20 percent of the beds that the hospital operated on October 1, 1987, and has sold or otherwise disposed of a substantial portion of the hospital's other acute care operations,

the cost proportion and ASC proportion in effect under subclauses (I) and (II) of paragraph (3)(B)(ii) for cost reporting periods beginning in fiscal year 1988 shall remain in effect for cost reporting periods beginning on or after October 1, 1988, and before January 1, 1995.

(B) For purposes of this subparagraph (A)(iii)(II), the term "eye or eye and ear unit" means a physically separate or distinct unit containing separate surgical suites devoted solely to eye or eye and ear services.

(5)(A) The Secretary is authorized to provide by regulations that in the case of a surgical procedure, specified by the Secretary pursuant to paragraph (1)(A), performed in an ambulatory surgical center described in such paragraph, there shall be paid (in lieu of any amounts otherwise payable under this part) with respect to the facility services furnished by such center and with respect to all related services (including physicians' services, laboratory, X-ray, and diagnostic services) a single all-inclusive fee established pursuant to subparagraph (B), if all parties furnishing all such services agree to accept such fee (to be divided among the parties involved in such manner as they shall have previously agreed upon) as full payment for the services furnished.

(B) In implementing this paragraph, the Secretary shall establish with respect to each surgical procedure specified pursuant to paragraph (1)(A) the amount of the all-inclusive fee for such procedure, taking into account such factors as may be appropriate. The amount so established with respect to any surgical procedure shall be reviewed periodically and may be adjusted by the Secretary, when appropriate, to take account of varying conditions in different areas.

(6) Any person, including a facility having an agreement under section 1832(a)(2)(F)(i), who knowingly and willfully presents, or causes to be presented, a bill or request for payment, for an intraocular lens inserted during or subsequent to cataract surgery for which payment may be made under paragraph (2)(A)(iii), is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(j) Whenever a final determination is made that the amount of payment made under this part either to a provider of services or to another person pursuant to an assignment under section 1842(b)(3)(B)(ii) was in excess of or less than the amount of payment that is due, and payment of such excess or deficit is not made (or effected by offset) within 30 days of the date of the determination, interest shall accrue on the balance of such excess or deficit not paid or offset (to the extent that the balance is owed by or owing to the provider) at a rate determined in accordance with the regulations of the Secretary of the Treasury applicable to charges for late payments.

(k) With respect to services described in section 1861(s)(10)(B), the Secretary may provide, instead of the amount of payment otherwise provided under this part, for payment of such an amount or

amounts as reasonably reflects the general cost of efficiently providing such services.

(l)(1)(A) The Secretary shall establish a fee schedule for services of certified registered nurse anesthetists under section 1861(s)(11).

(B) In establishing the fee schedule under this paragraph the Secretary may utilize a system of time units, a system of base and time units, or any appropriate methodology.

(C) The provisions of this subsection shall not apply to certain services furnished in certain hospitals in rural areas under the provisions of section 9320(k) of the Omnibus Budget Reconciliation Act of 1986[114], as amended by section 6132 of the Omnibus Budget Reconciliation Act of 1989.[115]

(2) Except as provided in paragraph (3), the fee schedule established under paragraph (1) shall be initially based on audited data from cost reporting periods ending in fiscal year 1985 and such other data as the Secretary determines necessary.

(3)(A) In establishing the initial fee schedule for those services, the Secretary shall adjust the fee schedule to the extent necessary to ensure that the estimated total amount which will be paid under this title for those services plus applicable coinsurance in 1989 will equal the estimated total amount which would be paid under this title for those services in 1989 if the services were included as inpatient hospital services and payment for such services was made under part A in the same manner as payment was made in fiscal year 1987, adjusted to take into account changes in prices and technology relating to the administration of anesthesia.

(B) The Secretary shall also reduce the prevailing charge of physicians for medical direction of a certified registered nurse anesthetist, or the fee schedule for services of certified registered nurse anesthetists, or both, to the extent necessary to ensure that the estimated total amount which will be paid under this title plus applicable coinsurance for such medical direction and such services in 1989 and 1990 will not exceed the estimated total amount which would have been paid plus applicable coinsurance but for the enactment of the amendments made by section 9320 of the Omnibus Budget Reconciliation Act of 1986[116]. A reduced prevailing charge under this subparagraph shall become the prevailing charge but for subsequent years for purposes of applying the economic index under the fourth sentence of section 1842(b)(3).

(4)(A) Except as provided in subparagraphs (C) and (D), in determining the amount paid under the fee schedule under this subsection for services furnished on or after January 1, 1991, by a certified registered nurse anesthetist who is not medically directed—

(i) the conversion factor shall be—

(I) for services furnished in 1991, $15.50,

(II) for services furnished in 1992, $15.75,

[114] See Vol. II, P.L. 99–509.
[115] P.L. 101–239.
[116] P.L. 99–509.

(III) for services furnished in 1993, $16.00,
(IV) for services furnished in 1994, $16.25,
(V) for services furnished in 1995, $16.50,
(VI) for services furnished in 1996, $16.75, and
(VII) for services furnished in calendar years after 1996, the previous year's conversion factor increased by the update determined under section 1848(d) for physician anesthesia services for that year;

(ii) the payment areas to be used shall be the fee schedule areas used under section 1848 (or, in the case of services furnished during 1991, the localities used under section 1842(b)) for purposes of computing payments for physicians' services that are anesthesia services;

(iii) the geographic adjustment factors to be applied to the conversion factor under clause (i) for services in a fee schedule area or locality is—

(I) in the case of services furnished in 1991, the geographic work index value and the geographic practice cost index value specified in section 1842(q)(1)(B) for physicians' services that are anesthesia services furnished in the area or locality, and

(II) in the case of services furnished after 1991, the geographic work index value, the geographic practice cost index value, and the geographic malpractice index value used for determining payments for physicians' services that are anesthesia services under section 1848,

with 70 percent of the conversion factor treated as attributable to work and 30 percent as attributable to overhead for services furnished in 1991 (and the portions attributable to work, practice expenses, and malpractice expenses in 1992 and thereafter being the same as is applied under section 1848).

(B)(i) Except as provided in clause (ii) and subparagraph (D), in determining the amount paid under the fee schedule under this subsection for services furnished on or after January 1, 1991, and before January 1, 1994, by a certified registered nurse anesthetist who is medically directed, the Secretary shall apply the same methodology specified in subparagraph (A).

(ii) The conversion factor used under clause (i) shall be—

(I) for services furnished in 1991, $10.50,
(II) for services furnished in 1992, $10.75, and
(III) for services furnished in 1993, $11.00.

(iii) In the case of services of a certified registered nurse anesthetist who is medically directed or medically supervised by a physician which are furnished on or after January 1, 1994, the fee schedule amount shall be one-half of the amount described in section 1848(a)(5)(B) with respect to the physician.

(C) Notwithstanding subclauses (I) through (V) of subparagraph (A)(i)—

(i) in the case of a 1990 conversion factor that is greater than $16.50, the conversion factor for a calendar year after 1990 and before 1996 shall be the 1990 conversion factor reduced by the product of the last digit of the calendar year and one-fifth of the amount by which the 1990 conversion factor exceeds $16.50; and

(ii) in the case of a 1990 conversion factor that is greater than $15.49 but less than $16.51, the conversion factor for a calendar year after 1990 and before 1996 shall be the greater of—

(I) the 1990 conversion factor, or

(II) the conversion factor specified in subparagraph (A)(i) for the year involved.

(D) Notwithstanding subparagraph (C), in no case may the conversion factor used to determine payment for services in a fee schedule area or locality under this subsection, as adjusted by the adjustment factors specified in subparagraphs [117] (A)(iii), exceed the conversion factor used to determine the amount paid for physicians' services that are anesthesia services in the area or locality.

(5)(A) Payment for the services of a certified registered nurse anesthetist (for which payment may otherwise be made under this part) may be made on the basis of a claim or request for payment presented by the certified registered nurse anesthetist furnishing such services, or by a hospital, critical access hospital, physician, group practice, or ambulatory surgical center with which the certified registered nurse anesthetist furnishing such services has an employment or contractual relationship that provides for payment to be made under this part for such services to such hospital, critical access hospital, physician, group practice, or ambulatory surgical center.

(B) No hospital or critical access hospital that presents a claim or request for payment for services of a certified nurse anesthetist under this part may treat any uncollected coinsurance amount imposed under this part with respect to such services as a bad debt of such hospital or critical access hospital for purposes of this title.

(6) If an adjustment under paragraph (3)(B) results in a reduction in the reasonable charge for a physicians' service and a nonparticipating physician furnishes the service to an individual entitled to benefits under this part after the effective date of the reduction, the physician's actual charge is subject to a limit under section 1842(j)(1)(D).

(m)(1) [118] In the case of physicians' services furnished in a year [119] to an individual, who is covered under the insurance program established by this part and who incurs expenses for such services, in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act) as a health professional shortage area as identified by the Secretary prior to the beginning of such year [120], in addition to the amount otherwise paid under this part,

[117] Probably should be "subparagraph".

[118] P.L. 108–173, §413(b)(1)(A), added "(1)".

[119] P.L. 108–173, §413(b)(1)(B)(i), added "in a year", applicable to physicians' services furnished on or after January 1, 2005.

[120] P.L. 108–173, §413(b)(1)(B)(ii), added "as identified by the Secretary prior to the beginning of such year", applicable to physicians' services furnished on or after January 1, 2005.

there also shall be paid to the physician (or to an employer or facility in the cases described in clause (A) of section 1842(b)(6)) (on a monthly or quarterly basis) from the Federal Supplementary Medical Insurance Trust Fund an amount equal to 10 percent of the payment amount for the service under this part.

(2)[121] For each health professional shortage area identified in paragraph (1) that consists of an entire county, the Secretary shall provide for the additional payment under paragraph (1) without any requirement on the physician to identify the health professional shortage area involved. The Secretary may implement the previous sentence using the method specified in subsection (u)(4)(C).

(3)[122] The Secretary shall post on the Internet website of the Centers for Medicare and Medicaid Services a list of the health professional shortage areas identified in paragraph (1) that consist of a partial county to facilitate the additional payment under paragraph (1) in such areas.

(4)[123] There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, respecting—

(A) the identification of a county or area;

(B) the assignment of a specialty of any physician under this paragraph;

(C) the assignment of a physician to a county under this subsection; or

(D) the assignment of a postal ZIP Code to a county or other area under this subsection.

(n)(1)(A) The aggregate amount of the payments to be made for all or part of a cost reporting period for services described in subsection (a)(2)(E)(i) furnished under this part on or after October 1, 1988, and before January 1, 1999, and for services described in subsection (a)(2)(E)(ii) furnished under this part on or after October 1, 1989, and before January 1, 1999, shall be equal to the lesser of—

(i) the amount determined with respect to such services under subsection (a)(2)(B), or

(ii) the blend amount for radiology services and diagnostic procedures determined in accordance with subparagraph (B).

(B)(i) The blend amount for radiology services and diagnostic procedures for a cost reporting period is the sum of—

(I) the cost proportion (as defined in clause (ii)) of the amount described in subparagraph (A)(i); and

(II) the charge proportion (as defined in clause (ii)(II)) of 62 percent (for services described in subsection (a)(2)(E)(i)), or (for procedures described in subsection (a)(2)(E)(ii)), 42 percent or such other percent established by the Secretary (or carriers acting pursuant to guidelines issued by the Secretary) based on prevailing charges

[121] P.L. 108–173, §413(b)(1)(C), added paragraph (2), applicable to physicians' services furnished on or after January 1, 2005.

[122] P.L. 108–173, §413(b)(1)(C), added paragraph (3), applicable to physicians' services furnished on or after January 1, 2005.

[123] P.L. 108–173, §413(b)(1)(C), added paragraph (4), applicable to physicians' services furnished on or after January 1, 2005.

established with actual charge data, of the prevailing charge or (for services described in subsection (a)(2)(E)(i) furnished on or after April 1, 1989 and for services described in subsection (a)(2)(E)(ii) furnished on or after January 1, 1992) the fee schedule amount established for participating physicians for the same services as if they were furnished in a physician's office in the same locality as determined under section 1842(b) (or, in the case of services furnished on or after January 1, 1992, under section 1848), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).

(ii) In this subparagraph:

(I) The term "cost proportion" means 50 percent, except that such term means 65 percent in the case of outpatient radiology services for portions of cost reporting periods which occur in fiscal year 1989 and in the case of diagnostic procedures described in subsection (a)(2)(E)(ii) for portions of cost reporting periods which occur in fiscal year 1990, and such term means 42 percent in the case of outpatient radiology services for portions of cost reporting periods beginning on or after January 1, 1991.

(II) The term "charge proportion" means 100 percent minus the cost proportion.

(o)(1) In the case of shoes described in section 1861(s)(12)—

(A) no payment may be made under this part, with respect to any individual for any year, for the furnishing of—

(i) more than one pair of custom molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts for such shoes, or

(ii) more than one pair of extra-depth shoes (not including inserts provided with such shoes) and 3 pairs of inserts for such shoes, and

(B) with respect to expenses incurred in any calendar year, no more than the amount of payment applicable under paragraph (2)[124] shall be considered as incurred expenses for purposes of subsections (a) and (b).

Payment for shoes (or inserts) under this part shall be considered to include payment for any expenses for the fitting of such shoes (or inserts).

(2)[125](A) Except as provided by the Secretary under subparagraphs (B) and (C), the amount of payment under this paragraph for custom molded shoes, extra-depth shoes, and inserts shall be the amount determined for such items by the Secretary under section 1834(h).

(B) The Secretary may establish payment amounts for shoes and inserts that are lower than the amount established under section 1834(h) if the Secretary finds that

[124] P.L. 108–173, §627(a)(1), struck out "no more than the limits established under paragraph (2)" and substituted "no more than the amount of payment applicable under paragraph (2)", applicable to items furnished on or after January 1, 2005.

[125] P.L. 108–173, §627(a)(2), amended paragraph (2) in its entirety, applicable to items furnished on or after January 1, 2005. For paragraph (2) as it formerly read, see Vol. II, Superseded Provisions, P.L. 108-173.

shoes and inserts of an appropriate quality are readily available at or below the amount established under such section.

(C) In accordance with procedures established by the Secretary, an individual entitled to benefits with respect to shoes described in section 1861(s)(12) may substitute modification of such shoes instead of obtaining one (or more, as specified by the Secretary) pair of inserts (other than the original pair of inserts with respect to such shoes). In such case, the Secretary shall substitute, for the payment amount established under section 1834(h), a payment amount that the Secretary estimates will assure that there is no net increase in expenditures under this subsection as a result of this subparagraph.

(3) In this title, the term "shoes" includes, except for purposes of subparagraphs (A)(ii) and (B) of paragraph (2), inserts for extra-depth shoes.

(p) [Stricken.[126]]

(q)(1) Each request for payment, or bill submitted, for an item or service furnished by an entity for which payment may be made under this part and for which the entity knows or has reason to believe there has been a referral by a referring physician (within the meaning of section 1877) shall include the name and unique physician identification number for the referring physician.

(2)(A) In the case of a request for payment for an item or service furnished by an entity under this part on an assignment-related basis and for which information is required to be provided under paragraph (1) but not included, payment may be denied under this part.

(B) In the case of a request for payment for an item or service furnished by an entity under this part not submitted on an assignment-related basis and for which information is required to be provided under paragraph (1) but not included—

(i) if the entity knowingly and willfully fails to provide such information promptly upon request of the Secretary or a carrier, the entity may be subject to a civil money penalty in an amount not to exceed $2,000, and

(ii) if the entity knowingly, willfully, and in repeated cases fails, after being notified by the Secretary of the obligations and requirements of this subsection to provide the information required under paragraph (1), the entity may be subject to exclusion from participation in the programs under this Act for a period not to exceed 5 years, in accordance with the procedures of subsections (c), (f), and (g) of section 1128.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under clause (i) in the same manner as they apply to a penalty or proceeding under section 1128A(a).

(r)(1) With respect to services described in section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services), payment may be made on the basis of a claim or

[126] P.L. 103–432, §123(b)(2)(A)(ii); 108 Stat. 4411.

request for payment presented by the nurse practitioner or clinical nurse specialist furnishing such services, or by a hospital, critical access hospital, skilled nursing facility or nursing facility (as defined in section 1919(a)), physician, group practice or ambulatory surgical center with which the nurse practitioner or clinical nurse specialist has an employment or contractual relationship that provides for payment to be made under this part for such services to such hospital, physician, group practice, or ambulatory surgical center.

(2) No hospital or critical access hospital that presents a claim or request for payment under this part for services described in section 1861(s)(2)(K)(ii) may treat any uncollected coinsurance amount imposed under this part with respect to such services as a bad debt of such hospital for purposes of this title.

(s) The Secretary may not provide for payment under subsection (a)(1)(A) with respect to an organization unless the organization provides assurances satisfactory to the Secretary that the organization meets the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).

(t)[127] PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.—

(1) AMOUNT OF PAYMENT.—

(A) IN GENERAL.—With respect to covered OPD services (as defined in subparagraph (B)) furnished during a year beginning with 1999, the amount of payment under this part shall be determined under a prospective payment system established by the Secretary in accordance with this subsection.

(B) DEFINITION OF COVERED OPD SERVICES.—For purposes of this subsection, the term "covered OPD services"—

(i) means hospital outpatient services designated by the Secretary;

(ii) subject to clause (iv), includes inpatient hospital services designated by the Secretary that are covered under this part and furnished to a hospital inpatient who (I) is entitled to benefits under part A but has exhausted benefits for inpatient hospital services during a spell of illness, or (II) is not so entitled;

(iii) includes implantable items described in paragraph (3), (6), or (8) of section 1861(s); but

(iv) does not include any therapy services described in subsection (a)(8) or ambulance services, for which payment is made under a fee schedule described in section 1834(k) or section 1834(l) and does not include screening mammography (as defined in section 1861(jj)) and diagnostic mammography[128].

(2) SYSTEM REQUIREMENTS.—Under the payment system—

(A) the Secretary shall develop a classification system for covered OPD services;

[127] See Vol. II, P.L. 108–173, §626(d), with respect to a GAO study of ambulatory surgical center payments.

[128] P.L. 108–173, §614(a), added "and does not include screening mammography (as defined in section 1861(jj)) and diagnostic mammography", applicable to services furnished on or after December 8, 2003, and applicable to services furnished on or after January 1, 2005.

(B) the Secretary may establish groups of covered OPD services, within the classification system described in subparagraph (A), so that services classified within each group are comparable clinically and with respect to the use of resources and so that an implantable item is classified to the group that includes the service to which the item relates;

(C) the Secretary shall, using data on claims from 1996 and using data from the most recent available cost reports, establish relative payment weights for covered OPD services (and any groups of such services described in subparagraph (B)) based on median (or, at the election of the Secretary, mean) hospital costs and shall determine projections of the frequency of utilization of each such service (or group of services) in 1999;

(D) the Secretary shall determine a wage adjustment factor to adjust the portion of payment and coinsurance attributable to labor–related costs for relative differences in labor and labor–related costs across geographic regions in a budget neutral manner;

(E) the Secretary shall establish, in a budget neutral manner, outlier adjustments under paragraph (5) and transitional pass–through payments under paragraph (6) and other adjustments as determined to be necessary to ensure equitable payments, such as adjustments for certain classes of hospitals;

(F) the Secretary shall develop a method for controlling unnecessary increases in the volume of covered OPD services;[129]

(G) the Secretary shall create additional groups of covered OPD services that classify separately those procedures that utilize contrast agents from those that do not; and[130]

(H)[131] with respect to devices of brachytherapy consisting of a seed or seeds (or radioactive source), the Secretary shall create additional groups of covered OPD services that classify such devices separately from the other services (or group of services) paid for under this subsection in a manner reflecting the number, isotope, and radioactive intensity of such devices furnished, including separate groups for palladium-103 and iodine-125 devices.

For purposes of subparagraph (B), items and services within a group shall not be treated as "comparable with respect to the use of resources" if the highest median cost (or mean cost, if elected by the Secretary under subparagraph (C)) for an item or service within the group is more than 2 times greater than the lowest median cost (or mean cost, if so elected) for an item or service within the group; except that the Secretary may make exceptions in unusual cases, such as low volume items and services, but may not make such an exception in the case of a drug or biological that has been designated as an orphan drug under section 526 of the Federal Food, Drug and Cosmetic Act.

(3) CALCULATION OF BASE AMOUNTS.—

[129] P.L. 108–173, §621(b)(2)(A), struck out "and".
[130] P.L. 108–173, §621(b)(2)(B), struck out the period and substituted "; and".
[131] P.L. 108–173, §621(b)(2)(C), added subparagraph (H), effective December 8, 2003.

(A) AGGREGATE AMOUNTS THAT WOULD BE PAYABLE IF DEDUCTIBLES WERE DISREGARDED.—The Secretary shall estimate the sum of—

(i) the total amounts that would be payable from the Trust Fund under this part for covered OPD services in 1999, determined without regard to this subsection, as though the deductible under section 1833(b) did not apply, and

(ii) the total amounts of copayments estimated to be paid under this subsection by beneficiaries to hospitals for covered OPD services in 1999, as though the deductible under section 1833(b) did not apply.

(B) UNADJUSTED COPAYMENT AMOUNT.—

(i) IN GENERAL.—For purposes of this subsection, subject to clause (ii), the "unadjusted copayment amount" applicable to a covered OPD service (or group of such services) is 20 percent of the national median of the charges for the service (or services within the group) furnished during 1996, updated to 1999 using the Secretary's estimate of charge growth during the period.

(ii) ADJUSTED TO BE 20 PERCENT WHEN FULLY PHASED IN.—If the pre–deductible payment percentage for a covered OPD service (or group of such services) furnished in a year would be equal to or exceed 80 percent, then the unadjusted copayment amount shall be 20 percent of amount determined under subparagraph (D).

(iii) RULES FOR NEW SERVICES.—The Secretary shall establish rules for establishment of an unadjusted copayment amount for a covered OPD service not furnished during 1996, based upon its classification within a group of such services.

(C) CALCULATION OF CONVERSION FACTORS.—

(i) FOR 1999.—

(I) IN GENERAL.—The Secretary shall establish a 1999 conversion factor for determining the medicare OPD fee schedule amounts for each covered OPD service (or group of such services) furnished in 1999. Such conversion factor shall be established on the basis of the weights and frequencies described in paragraph (2)(C) and in such a manner that the sum for all services and groups of the products (described in subclause (II) for each such service or group) equals the total projected amount described in subparagraph (A).

(II) PRODUCT DESCRIBED.—The Secretary shall determine for each service or group the product of the medicare OPD fee schedule amounts (taking into account appropriate adjustments described in paragraphs (2)(D) and (2)(E)) and the estimated frequencies for such service or group.

(ii) SUBSEQUENT YEARS.—Subject to paragraph (8)(B), the Secretary shall establish a conversion factor for covered OPD services furnished in subsequent years in an amount equal to the conversion factor es-

tablished under this subparagraph and applicable to such services furnished in the previous year increased by the OPD fee schedule increase factor specified under clause (iv)[132] for the year involved.

(iii) ADJUSTMENT FOR SERVICE MIX CHANGES.—Insofar as the Secretary determines that the adjustments for service mix under paragraph (2) for a previous year (or estimates that such adjustments for a future year) did (or are likely to) result in a change in aggregate payments under this subsection during the year that are a result of changes in the coding or classification of covered OPD services that do not reflect real changes in service mix, the Secretary may adjust the conversion factor computed under this subparagraph for subsequent years so as to eliminate the effect of such coding or classification changes.

(iv) OPD FEE SCHEDULE INCREASE FACTOR.—For purposes of this subparagraph, the "OPD fee schedule increase factor" for services furnished in a year is equal to the market basket percentage increase applicable under section 1886(b)(3)(B)(iii) to hospital discharges occurring during the fiscal year ending in such year, reduced by 1 percentage point for such factor for services furnished in each of 2000 and 2002. In applying the previous sentence for years beginning with 2000, the Secretary may substitute for the market basket percentage increase an annual percentage increase that is computed and applied with respect to covered OPD services furnished in a year in the same manner as the market basket percentage increase is determined and applied to inpatient hospital services for discharges occurring in a fiscal year.

(D) CALCULATION OF MEDICARE OPD FEE SCHEDULE AMOUNTS.—The Secretary shall compute a medicare OPD fee schedule amount for each covered OPD service (or group of such services) furnished in a year, in an amount equal to the product of—

(i) the conversion factor computed under subparagraph (C) for the year, and

(ii) the relative payment weight (determined under paragraph (2)(C)) for the service or group.

(E) PRE–DEDUCTIBLE PAYMENT PERCENTAGE.—The pre–deductible payment percentage for a covered OPD service (or group of such services) furnished in a year is equal to the ratio of—

(i) the medicare OPD fee schedule amount established under subparagraph (D) for the year, minus the unadjusted copayment amount determined under subparagraph (B) for the service or group, to

(ii) the medicare OPD fee schedule amount determined under subparagraph (D) for the year for such service or group.

(4) MEDICARE PAYMENT AMOUNT.—The amount of payment made from the Trust Fund under this part for a covered OPD

[132] P.L. 108–173, §736(b)(2), struck out "clause (iii)" and substituted "clause (iv)".

service (and such services classified within a group) furnished in a year is determined, subject to paragraph (7) as follows:

(A) FEE SCHEDULE ADJUSTMENTS.—The medicare OPD fee schedule amount (computed under paragraph (3)(D)) for the service or group and year is adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under paragraphs (2)(D) and (2)(E).

(B) SUBTRACT APPLICABLE DEDUCTIBLE.—Reduce the adjusted amount determined under subparagraph (A) by the amount of the deductible under section 1833(b), to the extent applicable.

(C) APPLY PAYMENT PROPORTION TO REMAINDER.—The amount of payment is the amount so determined under subparagraph (B) multiplied by the pre–deductible payment percentage (as determined under paragraph (3)(E)) for the service or group and year involved, plus the amount of any reduction in the copayment amount attributable to paragraph (8)(C).

(5) OUTLIER ADJUSTMENT.—

(A) IN GENERAL.—Subject to subparagraph (D), the Secretary shall provide for an additional payment for each covered OPD service (or group of services) for which a hospital's charges, adjusted to cost, exceed—

(i) a fixed multiple of the sum of—

(I) the applicable medicare OPD fee schedule amount determined under paragraph (3)(D), as adjusted under paragraph (4)(A) (other than for adjustments under this paragraph or paragraph (6)); and

(II) any transitional pass–through payment under paragraph (6); and

(ii) at the option of the Secretary, such fixed dollar amount as the Secretary may establish.

(B) AMOUNT OF ADJUSTMENT.—The amount of the additional payment under subparagraph (A) shall be determined by the Secretary and shall approximate the marginal cost of care beyond the applicable cutoff point under such subparagraph.

(C) LIMIT ON AGGREGATE OUTLIER ADJUSTMENTS.—

(i) IN GENERAL.—The total of the additional payments made under this paragraph for covered OPD services furnished in a year (as estimated by the Secretary before the beginning of the year) may not exceed the applicable percentage (specified in clause (ii)) of the total program payments estimated to be made under this subsection for all covered OPD services furnished in that year. If this paragraph is first applied to less than a full year, the previous sentence shall apply only to the portion of such year.

(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the term "applicable percentage" means a percentage specified by the Secretary up to (but not to exceed)—

(I) for a year (or portion of a year) before 2004, 2.5 percent; and

(II) for 2004 and thereafter, 3.0 percent.

(D) TRANSITIONAL AUTHORITY.—In applying subparagraph (A) for covered OPD services furnished before January 1, 2002, the Secretary may—

(i) apply such subparagraph to a bill for such services related to an outpatient encounter (rather than for a specific service or group of services) using OPD fee schedule amounts and transitional pass–through payments covered under the bill; and

(ii) use an appropriate cost–to–charge ratio for the hospital involved (as determined by the Secretary), rather than for specific departments within the hospital.

(E)[133] EXCLUSION OF SEPARATE DRUG AND BIOLOGICAL APCS FROM OUTLIER PAYMENTS.—No additional payment shall be made under subparagraph (A) in the case of ambulatory payment classification groups established separately for drugs or biologicals.

(6) TRANSITIONAL PASS–THROUGH FOR ADDITIONAL COSTS OF INNOVATIVE MEDICAL DEVICES, DRUGS, AND BIOLOGICALS.—

(A) IN GENERAL.—The Secretary shall provide for an additional payment under this paragraph for any of the following that are provided as part of a covered OPD service (or group of services):

(i) CURRENT ORPHAN DRUGS.—A drug or biological that is used for a rare disease or condition with respect to which the drug or biological has been designated as an orphan drug under section 526 of the Federal Food, Drug and Cosmetic Act if payment for the drug or biological as an outpatient hospital service under this part was being made on the first date that the system under this subsection is implemented.

(ii) CURRENT CANCER THERAPY DRUGS AND BIOLOGICALS AND BRACHYTHERAPY.—A drug or biological that is used in cancer therapy, including (but not limited to) a chemotherapeutic agent, an antiemetic, a hematopoietic growth factor, a colony stimulating factor, a biological response modifier, a bisphosphonate, and a device of brachytherapy or temperature monitored cryoablation, if payment for such drug, biological, or device as an outpatient hospital service under this part was being made on such first date.

(iii) CURRENT RADIOPHARMACEUTICAL DRUGS AND BIOLOGICAL PRODUCTS.—A radiopharmaceutical drug or biological product used in diagnostic, monitoring, and therapeutic nuclear medicine procedures if payment for the drug or biological as an outpatient hospital service under this part was being made on such first date.

(iv) NEW MEDICAL DEVICES, DRUGS, AND BIOLOGICALS.—A medical device, drug, or biological not described in clause (i), (ii), or (iii) if—

[133] P.L. 108–173, §621(b)(3), added subparagraph (E), applicable to items and services furnished on or after January 1, 2004.

(I) payment for the device, drug, or biological as an outpatient hospital service under this part was not being made as of December 31, 1996; and

(II) the cost of the drug or biological or the average cost of the category of devices is not insignificant in relation to the OPD fee schedule amount (as calculated under paragraph (3)(D)) payable for the service (or group of services) involved.

(B) USE OF CATEGORIES IN DETERMINING ELIGIBILITY OF A DEVICE FOR PASS–THROUGH PAYMENTS.—The following provisions apply for purposes of determining whether a medical device qualifies for additional payments under clause (ii) or (iv) of subparagraph (A):

(i) ESTABLISHMENT OF INITIAL CATEGORIES.—

(I) IN GENERAL.—The Secretary shall initially establish under this clause categories of medical devices based on type of device by April 1, 2001. Such categories shall be established in a manner such that each medical device that meets the requirements of clause (ii) or (iv) of subparagraph (A) as of January 1, 2001, is included in such a category and no such device is included in more than one category. For purposes of the preceding sentence, whether a medical device meets such requirements as of such date shall be determined on the basis of the program memoranda issued before such date.

(II) AUTHORIZATION OF IMPLEMENTATION OTHER THAN THROUGH REGULATIONS.—The categories may be established under this clause by program memorandum or otherwise, after consultation with groups representing hospitals, manufacturers of medical devices, and other affected parties.

(ii) ESTABLISHING CRITERIA FOR ADDITIONAL CATEGORIES.—

(I) IN GENERAL.—The Secretary shall establish criteria that will be used for creation of additional categories (other than those established under clause (i)) through rulemaking (which may include use of an interim final rule with comment period).

(II) STANDARD.—Such categories shall be established under this clause in a manner such that no medical device is described by more than one category. Such criteria shall include a test of whether the average cost of devices that would be included in a category and are in use at the time the category is established is not insignificant, as described in subparagraph (A)(iv)(II).

(III) DEADLINE.—Criteria shall first be established under this clause by July 1, 2001. The Secretary may establish in compelling circumstances categories under this clause before the date such criteria are established.

(IV) ADDING CATEGORIES.—The Secretary shall promptly establish a new category of medical

devices under this clause for any medical device that meets the requirements of subparagraph (A)(iv) and for which none of the categories in effect (or that were previously in effect) is appropriate.

(iii) PERIOD FOR WHICH CATEGORY IS IN EFFECT.—A category of medical devices established under clause (i) or (ii) shall be in effect for a period of at least 2 years, but not more than 3 years, that begins—

(I) in the case of a category established under clause (i), on the first date on which payment was made under this paragraph for any device described by such category (including payments made during the period before April 1, 2001); and

(II) in the case of any other category, on the first date on which payment is made under this paragraph for any medical device that is described by such category.

(iv) REQUIREMENTS TREATED AS MET.—A medical device shall be treated as meeting the requirements of subparagraph (A)(iv), regardless of whether the device meets the requirement of subclause (I) of such subparagraph, if—

(I) the device is described by a category established and in effect under clause (i); or

(II) the device is described by a category established and in effect under clause (ii) and an application under section 515 of the Federal Food, Drug, and Cosmetic Act has been approved with respect to the device, or the device has been cleared for market under section 510(k) of such Act, or the device is exempt from the requirements of section 510(k) of such Act pursuant to subsection (l) or (m) of section 510 of such Act or section 520(g) of such Act.

Nothing in this clause shall be construed as requiring an application or prior approval (other than that described in subclause (II)) in order for a covered device described by a category to qualify for payment under this paragraph.

(C) LIMITED PERIOD OF PAYMENT.—

(i) DRUGS AND BIOLOGICALS.—The payment under this paragraph with respect to a drug or biological shall only apply during a period of at least 2 years, but not more than 3 years, that begins—

(I) on the first date this subsection is implemented in the case of a drug or biological described in clause (i), (ii), or (iii) of subparagraph (A) and in the case of a drug or biological described in subparagraph (A)(iv) and for which payment under this part is made as an outpatient hospital service before such first date; or

(II) in the case of a drug or biological described in subparagraph (A)(iv) not described in subclause (I), on the first date on which payment is made under this part for the drug or biological as an outpatient hospital service.

(ii) MEDICAL DEVICES.—Payment shall be made under this paragraph with respect to a medical device only if such device—

(I) is described by a category of medical devices established and in effect under subparagraph (B); and

(II) is provided as part of a service (or group of services) paid for under this subsection and provided during the period for which such category is in effect under such subparagraph.

(D) AMOUNT OF ADDITIONAL PAYMENT.—Subject to subparagraph (E)(iii), the amount of the payment under this paragraph with respect to a device, drug, or biological provided as part of a covered OPD service is—

(i) in the case of a drug or biological, the amount by which the amount determined under section 1842(o) (or if the drug or biological is covered under a competitive acquisition contract under section 1847B, an amount determined by the Secretary equal to the average price for the drug or biological for all competitive acquisition areas and year established under such section as calculated and adjusted by the Secretary for purposes of this paragraph)[134] for the drug or biological exceeds the portion of the otherwise applicable medicare OPD fee schedule that the Secretary determines is associated with the drug or biological; or

(ii) in the case of a medical device, the amount by which the hospital's charges for the device, adjusted to cost, exceeds the portion of the otherwise applicable medicare OPD fee schedule that the Secretary determines is associated with the device.

(E) LIMIT ON AGGREGATE ANNUAL ADJUSTMENT.—

(i) IN GENERAL.—The total of the additional payments made under this paragraph for covered OPD services furnished in a year (as estimated by the Secretary before the beginning of the year) may not exceed the applicable percentage (specified in clause (ii)) of the total program payments estimated to be made under this subsection for all covered OPD services furnished in that year. If this paragraph is first applied to less than a full year, the previous sentence shall apply only to the portion of such year.

(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the term "applicable percentage" means—

(I) for a year (or portion of a year) before 2004, 2.5 percent; and

(II) for 2004 and thereafter, a percentage specified by the Secretary up to (but not to exceed) 2.0 percent.

(iii) UNIFORM PROSPECTIVE REDUCTION IF AGGREGATE LIMIT PROJECTED TO BE EXCEEDED.—If the Secretary

[134] P.L. 108–173, §621(b)(4), inserted "(or if the drug or biological is covered under a competitive acquisition contract under section 1847B, an amount determined by the Secretary equal to the average price for the drug or biological for all competitive acquisition areas and year established under such section as calculated and adjusted by the Secretary for purposes of this paragraph)", applicable to items and services furnished on or after January 1, 2004.

estimates before the beginning of a year that the amount of the additional payments under this paragraph for the year (or portion thereof) as determined under clause (i) without regard to this clause will exceed the limit established under such clause, the Secretary shall reduce pro rata the amount of each of the additional payments under this paragraph for that year (or portion thereof) in order to ensure that the aggregate additional payments under this paragraph (as so estimated) do not exceed such limit.

(F)[135] LIMITATION OF APPLICATION OF FUNCTIONAL EQUIVALENCE STANDARD.—

(i) IN GENERAL.—The Secretary may not publish regulations that apply a functional equivalence standard to a drug or biological under this paragraph.

(ii) APPLICATION.—Clause (i) shall apply to the application of a functional equivalence standard to a drug or biological on or after the date of enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 unless—

(I) such application was being made to such drug or biological prior to such date of enactment; and

(II) the Secretary applies such standard to such drug or biological only for the purpose of determining eligibility of such drug or biological for additional payments under this paragraph and not for the purpose of any other payments under this title.

(iii) RULE OF CONSTRUCTION.—Nothing in this subparagraph shall be construed to effect the Secretary's authority to deem a particular drug to be identical to another drug if the 2 products are pharmaceutically equivalent and bioequivalent, as determined by the Commissioner of Food and Drugs.

(7) TRANSITIONAL ADJUSTMENT TO LIMIT DECLINE IN PAYMENT.—

(A) BEFORE 2002.—Subject to subparagraph (D), for covered OPD services furnished before January 1, 2002, for which the PPS amount (as defined in subparagraph (E)) is—

(i) at least 90 percent, but less than 100 percent, of the pre–BBA amount (as defined in subparagraph (F)), the amount of payment under this subsection shall be increased by 80 percent of the amount of such difference;

(ii) at least 80 percent, but less than 90 percent, of the pre–BBA amount, the amount of payment under this subsection shall be increased by the amount by which (I) the product of 0.71 and the pre–BBA amount, exceeds (II) the product of 0.70 and the PPS amount;

(iii) at least 70 percent, but less than 80 percent, of the pre–BBA amount, the amount of payment under

[135] P.L. 108–173, §622, added subparagraph (F), effective December 8, 2003.

this subsection shall be increased by the amount by which (I) the product of 0.63 and the pre–BBA amount, exceeds (II) the product of 0.60 and the PPS amount; or

(iv) less than 70 percent of the pre–BBA amount, the amount of payment under this subsection shall be increased by 21 percent of the pre–BBA amount.

(B) 2002.—Subject to subparagraph (D), for covered OPD services furnished during 2002, for which the PPS amount is—

(i) at least 90 percent, but less than 100 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by 70 percent of the amount of such difference;

(ii) at least 80 percent, but less than 90 percent, of the pre–BBA amount, the amount of payment under this subsection shall be increased by the amount by which (I) the product of 0.61 and the pre–BBA amount, exceeds (II) the product of 0.60 and the PPS amount; or

(iii) less than 80 percent of the pre–BBA amount, the amount of payment under this subsection shall be increased by 13 percent of the pre–BBA amount.

(C) 2003.—Subject to subparagraph (D), for covered OPD services furnished during 2003, for which the PPS amount is—

(i) at least 90 percent, but less than 100 percent, of the pre–BBA amount, the amount of payment under this subsection shall be increased by 60 percent of the amount of such difference; or

(ii) less than 90 percent of the pre–BBA amount, the amount of payment under this subsection shall be increased by 6 percent of the pre–BBA amount.

(D) HOLD HARMLESS PROVISIONS.—

(i) TEMPORARY TREATMENT FOR CERTAIN[136] rural hospitals.—In the case of a hospital located in a rural area and that has not more than 100 beds or a sole community hospital (as defined in section 1886(d)(5)(D)(iii)) located in a rural area[137], for covered OPD services furnished before January 1, 2006[138], for which the PPS amount is less than the pre–BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

(ii) PERMANENT TREATMENT FOR CANCER HOSPITALS AND CHILDREN'S HOSPITALS.—In the case of a hospital described in section clause (iii) or (v) of 1886(d)(1)(B), for covered OPD services for which the PPS amount is less than the pre–BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

[136] P.L. 108–173, §411(a)(1)(A), struck out "small" and substituted "certain".

[137] P.L. 108–173, §411(a)(1)(B), inserted "or a sole community hospital (as defined in section 1886(d)(5)(D)(iii)) located in a rural area", applicable with respect to cost reporting periods beginning on and after January 1, 2004.

[138] P.L. 108–173, §411(a)(1)(C), struck out "2004" and substituted "2006".

(E) PPS amount defined.—In this paragraph, the term "PPS amount" means, with respect to covered OPD services, the amount payable under this title for such services (determined without regard to this paragraph), including amounts payable as copayment under paragraph (8), coinsurance under section 1866(a)(2)(A)(ii), and the deductible under section 1833(b).

(F) PRE–BBA AMOUNT DEFINED.—

(i) IN GENERAL.—In this paragraph, the "pre–BBA amount" means, with respect to covered OPD services furnished by a hospital in a year, an amount equal to the product of the reasonable cost of the hospital for such services for the portions of the hospital's cost reporting period (or periods) occurring in the year and the base OPD payment–to–cost ratio for the hospital (as defined in clause (ii)).

(ii) BASE PAYMENT–TO–COST–RATIO DEFINED.—For purposes of this subparagraph, the "base payment–to–cost ratio" for a hospital means the ratio of—

(I) the hospital's reimbursement under this part for covered OPD services furnished during the cost reporting period ending in 1996 (or in the case of a hospital that did not submit a cost report for such period, during the first subsequent cost reporting period ending before 2001 for which the hospital submitted a cost report) , including any reimbursement for such services through cost–sharing described in subparagraph (E), to (II) the reasonable cost of such services for such period.

The Secretary shall determine such ratios as if the amendments made by section 4521 of the Balanced Budget Act of 1997 were in effect in 1996.

(G) INTERIM PAYMENTS.—The Secretary shall make payments under this paragraph to hospitals on an interim basis, subject to retrospective adjustments based on settled cost reports.

(H) NO EFFECT ON COPAYMENTS.—Nothing in this paragraph shall be construed to affect the unadjusted copayment amount described in paragraph (3)(B) or the copayment amount under paragraph (8).

(I) APPLICATION WITHOUT REGARD TO BUDGET NEUTRALITY.—The additional payments made under this paragraph—

(i) shall not be considered an adjustment under paragraph (2)(E); and

(ii) shall not be implemented in a budget neutral manner.

(8) COPAYMENT AMOUNT.—

(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the copayment amount under this subsection is the amount by which the amount described in paragraph (4)(B) exceeds the amount of payment determined under paragraph (4)(C).

(B) ELECTION TO OFFER REDUCED COPAYMENT AMOUNT.—The Secretary shall establish a procedure under which a hospital, before the beginning of a year (beginning with

1999), may elect to reduce the copayment amount otherwise established under subparagraph (A) for some or all covered OPD services to an amount that is not less than 20 percent of the medicare OPD fee schedule amount (computed under paragraph (3)(D)) for the service involved. Under such procedures, such reduced copayment amount may not be further reduced or increased during the year involved and the hospital may disseminate information on the reduction of copayment amount effected under this subparagraph.

(C) LIMITATION ON COPAYMENT AMOUNT.—

(i) TO INPATIENT HOSPITAL DEDUCTIBLE AMOUNT.—In no case shall the copayment amount for a procedure performed in a year exceed the amount of the inpatient hospital deductible established under section 1813(b) for that year.

(ii) TO SPECIFIED PERCENTAGE.—The Secretary shall reduce the national unadjusted copayment amount for a covered OPD service (or group of such services) furnished in a year in a manner so that the effective copayment rate (determined on a national unadjusted basis) for that service in the year does not exceed the following percentage:

(I) For procedures performed in 2001, on or after April 1, 2001, 57 percent.

(II) For procedures performed in 2002 or 2003, 55 percent.

(III) For procedures performed in 2004, 50 percent.

(IV) For procedures performed in 2005, 45 percent.

(V) For procedures performed in 2006 and thereafter, 40 percent.

(D) NO IMPACT ON DEDUCTIBLES.—Nothing in this paragraph shall be construed as affecting a hospital's authority to waive the charging of a deductible under section 1833(b).

(E) COMPUTATION IGNORING OUTLIER AND PASS–THROUGH ADJUSTMENTS.—The copayment amount shall be computed under subparagraph (A) as if the adjustments under paragraphs (5) and (6) (and any adjustment made under paragraph (2)(E) in relation to such adjustments) had not occurred.

(9) PERIODIC REVIEW AND ADJUSTMENTS COMPONENTS OF PROSPECTIVE PAYMENT SYSTEM.—

(A) PERIODIC REVIEW.—The Secretary shall review not less often than annually and revise the groups, the relative payment weights, and the wage and other adjustments described in paragraph (2) to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors. The Secretary shall consult with an expert outside advisory panel composed of an appropriate selection of representatives of providers to review (and advise the Secretary concerning) the clinical integrity of the groups and weights. Such panel may use data collected or

developed by entities and organizations (other than the Department of Health and Human Services) in conducting such review.

(B) BUDGET NEUTRALITY ADJUSTMENT.—If the Secretary makes adjustments under subparagraph (A), then the adjustments for a year may not cause the estimated amount of expenditures under this part for the year to increase or decrease from the estimated amount of expenditures under this part that would have been made if the adjustments had not been made. In determining adjustments under the preceding sentence for 2004 and 2005, the Secretary shall not take into account under this subparagraph or paragraph (2)(E) any expenditures that would not have been made but for the application of paragraph (14).[139]

(C) UPDATE FACTOR.—If the Secretary determines under methodologies described in paragraph (2)(F) that the volume of services paid for under this subsection increased beyond amounts established through those methodologies, the Secretary may appropriately adjust the update to the conversion factor otherwise applicable in a subsequent year.

(10) SPECIAL RULE FOR AMBULANCE SERVICES.—The Secretary shall pay for hospital outpatient services that are ambulance services on the basis described in section 1861(v)(1)(U), or, if applicable, the fee schedule established under section 1834(l).

(11) SPECIAL RULES FOR CERTAIN HOSPITALS.—In the case of hospitals described in clause (iii) or (v) of section 1886(d)(1)(B)—

(A) the system under this subsection shall not apply to covered OPD services furnished before January 1, 2000; and

(B) the Secretary may establish a separate conversion factor for such services in a manner that specifically takes into account the unique costs incurred by such hospitals by virtue of their patient population and service intensity.

(12) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

(A) the development of the classification system under paragraph (2), including the establishment of groups and relative payment weights for covered OPD services, of wage adjustment factors, other adjustments, and methods described in paragraph (2)(F);

(B) the calculation of base amounts under paragraph (3);

(C) periodic adjustments made under paragraph (6);

(D) the establishment of a separate conversion factor under paragraph (8)(B); and

(E) the determination of the fixed multiple, or a fixed dollar cutoff amount, the marginal cost of care, or applicable percentage under paragraph (5) or the determination of insignificance of cost, the duration of the additional payments, the determination and deletion of initial and new categories (consistent with subparagraphs (B) and (C) of

[139] P.L. 108–173, §621(a)(5) added this last sentence to subparagraph (B), applicable to items and services furnished on or after January 1, 2004.

paragraph (6)), the portion of the medicare OPD fee schedule amount associated with particular devices, drugs, or biologicals, and the application of any pro rata reduction under paragraph (6).

(13)[140] AUTHORIZATION OF ADJUSTMENT FOR RURAL HOSPITALS.—

(A) STUDY.—The Secretary shall conduct a study to determine if, under the system under this subsection, costs incurred by hospitals located in rural areas by ambulatory payment classification groups (APCs) exceed those costs incurred by hospitals located in urban areas.

(B) AUTHORIZATION OF ADJUSTMENT.—Insofar as the Secretary determines under subparagraph (A) that costs incurred by hospitals located in rural areas exceed those costs incurred by hospitals located in urban areas, the Secretary shall provide for an appropriate adjustment under paragraph (2)(E) to reflect those higher costs by January 1, 2006.

(14)[141] DRUG APC PAYMENT RATES.—

(A) IN GENERAL.—The amount of payment under this subsection for a specified covered outpatient drug (defined in subparagraph (B)) that is furnished as part of a covered OPD service (or group of services)—

(i) in 2004, in the case of—

(I) a sole source drug shall in no case be less than 88 percent, or exceed 95 percent, of the reference average wholesale price for the drug;

(II) an innovator multiple source drug shall in no case exceed 68 percent of the reference average wholesale price for the drug; or

(III) a noninnovator multiple source drug shall in no case exceed 46 percent of the reference average wholesale price for the drug;

(ii) in 2005, in the case of—

(I) a sole source drug shall in no case be less than 83 percent, or exceed 95 percent, of the reference average wholesale price for the drug;

(II) an innovator multiple source drug shall in no case exceed 68 percent of the reference average wholesale price for the drug; or

(III) a noninnovator multiple source drug shall in no case exceed 46 percent of the reference average wholesale price for the drug; or

(iii) in a subsequent year, shall be equal, subject to subparagraph (E)—

(I) to the average acquisition cost for the drug for that year (which, at the option of the Secretary, may vary by hospital group (as defined by the Secretary based on volume of covered OPD services or other relevant characteristics)), as determined by the Secretary taking into account

[140] P.L. 108–173, §411(b)(1), added paragraph (13), applicable with respect to cost reporting periods beginning on or after January 1, 2004.

[141] P.L. 108–173, §621(a)(1), added paragraph (14), applicable to items and services furnished on or after January 1, 2004.

the hospital acquisition cost survey data under subparagraph (D); or

(II) if hospital acquisition cost data are not available, the average price for the drug in the year established under section 1842(o), section 1847A, or section 1847B, as the case may be, as calculated and adjusted by the Secretary as necessary for purposes of this paragraph.

(B) SPECIFIED COVERED OUTPATIENT DRUG DEFINED.—

(i) IN GENERAL.—In this paragraph, the term "specified covered outpatient drug" means, subject to clause (ii), a covered outpatient drug (as defined in section 1927(k)(2)) for which a separate ambulatory payment classification group (APC) has been established and that is—

(I) a radiopharmaceutical; or

(II) a drug or biological for which payment was made under paragraph (6) (relating to pass-through payments) on or before December 31, 2002.

(ii) EXCEPTION.—Such term does not include—

(I) a drug or biological for which payment is first made on or after January 1, 2003, under paragraph (6);

(II) a drug or biological for which a temporary HCPCS code has not been assigned; or

(III) during 2004 and 2005, an orphan drug (as designated by the Secretary).

(C) PAYMENT FOR DESIGNATED ORPHAN DRUGS DURING 2004 AND 2005.—The amount of payment under this subsection for an orphan drug designated by the Secretary under subparagraph (B)(ii)(III) that is furnished as part of a covered OPD service (or group of services) during 2004 and 2005 shall equal such amount as the Secretary may specify.

(D) ACQUISITION COST SURVEY FOR HOSPITAL OUTPATIENT DRUGS.—

(i) Annual GAO surveys in 2004 and 2005.—

(I) IN GENERAL.—The Comptroller General of the United States shall conduct a survey in each of 2004 and 2005 to determine the hospital acquisition cost for each specified covered outpatient drug. Not later than April 1, 2005, the Comptroller General shall furnish data from such surveys to the Secretary for use in setting the payment rates under subparagraph (A) for 2006.

(II) RECOMMENDATIONS.—Upon the completion of such surveys, the Comptroller General shall recommend to the Secretary the frequency and methodology of subsequent surveys to be conducted by the Secretary under clause (ii).

(ii) SUBSEQUENT SECRETARIAL SURVEYS.—The Secretary, taking into account such recommendations, shall conduct periodic subsequent surveys to determine the hospital acquisition cost for each specified

covered outpatient drug for use in setting the payment rates under subparagraph (A).

(iii) SURVEY REQUIREMENTS.—The surveys conducted under clauses (i) and (ii) shall have a large sample of hospitals that is sufficient to generate a statistically significant estimate of the average hospital acquisition cost for each specified covered outpatient drug. With respect to the surveys conducted under clause (i), the Comptroller General shall report to Congress on the justification for the size of the sample used in order to assure the validity of such estimates.

(iv) DIFFERENTIATION IN COST.—In conducting surveys under clause (i), the Comptroller General shall determine and report to Congress if there is (and the extent of any) variation in hospital acquisition costs for drugs among hospitals based on the volume of covered OPD services performed by such hospitals or other relevant characteristics of such hospitals (as defined by the Comptroller General).

(v) COMMENT ON PROPOSED RATES.—Not later than 30 days after the date the Secretary promulgated proposed rules setting forth the payment rates under subparagraph (A) for 2006, the Comptroller General shall evaluate such proposed rates and submit to Congress a report regarding the appropriateness of such rates based on the surveys the Comptroller General has conducted under clause (i).

(E) ADJUSTMENT IN PAYMENT RATES FOR OVERHEAD COSTS.—

(i) MEDPAC REPORT ON DRUG APC DESIGN.—The Medicare Payment Advisory Commission shall submit to the Secretary, not later than July 1, 2005, a report on adjustment of payment for ambulatory payment classifications for specified covered outpatient drugs to take into account overhead and related expenses, such as pharmacy services and handling costs. Such report shall include—

(I) a description and analysis of the data available with regard to such expenses;

(II) a recommendation as to whether such a payment adjustment should be made; and

(III) if such adjustment should be made, a recommendation regarding the methodology for making such an adjustment.

(ii) ADJUSTMENT AUTHORIZED.—The Secretary may adjust the weights for ambulatory payment classifications for specified covered outpatient drugs to take into account the recommendations contained in the report submitted under clause (i).

(F) CLASSES OF DRUGS.—For purposes of this paragraph:

(i) SOLE SOURCE DRUGS.—The term "sole source drug" means—

(I) a biological product (as defined under section 1861(t)(1)); or

(II) a single source drug (as defined in section 1927(k)(7)(A)(iv)).

(ii) INNOVATOR MULTIPLE SOURCE DRUGS.—The term "innovator multiple source drug" has the meaning given such term in section 1927(k)(7)(A)(ii).

(iii) NONINNOVATOR MULTIPLE SOURCE DRUGS.—The term "noninnovator multiple source drug" has the meaning given such term in section 1927(k)(7)(A)(iii).

(G) REFERENCE AVERAGE WHOLESALE PRICE.—The term "reference average wholesale price" means, with respect to a specified covered outpatient drug, the average wholesale price for the drug as determined under section 1842(o) as of May 1, 2003.

(H) INAPPLICABILITY OF EXPENDITURES IN DETERMINING CONVERSION, WEIGHTING, AND OTHER ADJUSTMENT FACTORS.—Additional expenditures resulting from this paragraph shall not be taken into account in establishing the conversion, weighting, and other adjustment factors for 2004 and 2005 under paragraph (9), but shall be taken into account for subsequent years.

(15)[142] PAYMENT FOR NEW DRUGS AND BIOLOGICALS UNTIL HCPCS CODE ASSIGNED.—With respect to payment under this part for an outpatient drug or biological that is covered under this part and is furnished as part of covered OPD services for which a HCPCS code has not been assigned, the amount provided for payment for such drug or biological under this part shall be equal to 95 percent of the average wholesale price for the drug or biological.

(16)[143] MISCELLANEOUS PROVISIONS.—

(A) APPLICATION OF RECLASSIFICATION OF CERTAIN HOSPITALS.—If a hospital is being treated as being located in a rural area under section 1886(d)(8)(E), that hospital shall be treated under this subsection as being located in that rural area.

(B)[144] THRESHOLD FOR ESTABLISHMENT OF SEPARATE APCS FOR DRUGS.—The Secretary shall reduce the threshold for the establishment of separate ambulatory payment classification groups (APCs) with respect to drugs or biologicals to $50 per administration for drugs and biologicals furnished in 2005 and 2006.

(C)[145] PAYMENT FOR DEVICES OF BRACHYTHERAPY AT CHARGES ADJUSTED TO COST.—Notwithstanding the preceding provisions of this subsection, for a device of brachytherapy consisting of a seed or seeds (or radioactive source) furnished on or after January 1, 2004, and before January 1, 2007, the payment basis for the device under this subsection shall be equal to the hospital's charges for each device furnished, adjusted to cost. Charges for such devices shall not be included in determining any outlier payment under this subsection.

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[142] P.L. 108–173, §621(a)(1), added paragraph (15), applicable to items and services furnished on or after January 1, 2004.

[143] P.L. 108–173, §411(b)(1), redesignated the former paragraph (13) as paragraph (16).

[144] P.L. 108–173, §621(a)(2), added subparagraph (B), applicable to items and services furnished on or after January 1, 2004.

[145] P.L. 108–173, §621(b)(1), added subparagraph (C), effective December 8, 2003.

See Vol. II, P.L. 108–173, §621(b)(3), with respect to a GAO study and report regarding appropriate payment amounts for devices of brachytherapy.

(u)[146] INCENTIVE PAYMENTS FOR PHYSICIAN SCARCITY AREAS.—

(1) IN GENERAL.—In the case of physicians' services furnished on or after January 1, 2005, and before January 1, 2008—

(A) by a primary care physician in a primary care scarcity county (identified under paragraph (4)); or

(B) by a physician who is not a primary care physician in a specialist care scarcity county (as so identified),

in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid an amount equal to 5 percent of the payment amount for the service under this part.

(2) DETERMINATION OF RATIOS OF PHYSICIANS TO MEDICARE BENEFICIARIES IN AREA.—Based upon available data, the Secretary shall establish for each county or equivalent area in the United States, the following:

(A) NUMBER OF PHYSICIANS PRACTICING IN THE AREA.—The number of physicians who furnish physicians' services in the active practice of medicine or osteopathy in that county or area, other than physicians whose practice is exclusively for the Federal Government, physicians who are retired, or physicians who only provide administrative services. Of such number, the number of such physicians who are—

(i) primary care physicians; or

(ii) physicians who are not primary care physicians.

(B) NUMBER OF MEDICARE BENEFICIARIES RESIDING IN THE AREA.—The number of individuals who are residing in the county and are entitled to benefits under part A or enrolled under this part, or both (in this subsection referred to as "individuals").

(C) DETERMINATION OF RATIOS.—

(i) PRIMARY CARE RATIO.—The ratio (in this paragraph referred to as the "primary care ratio") of the number of primary care physicians (determined under subparagraph (A)(i)), to the number of individuals determined under subparagraph (B).

(ii) SPECIALIST CARE RATIO.—The ratio (in this paragraph referred to as the "specialist care ratio") of the number of other physicians (determined under subparagraph (A)(ii)), to the number of individuals determined under subparagraph (B).

(3) RANKING OF COUNTIES.—The Secretary shall rank each such county or area based separately on its primary care ratio and its specialist care ratio.

(4) IDENTIFICATION OF COUNTIES.—

(A) IN GENERAL.—The Secretary shall identify—

(i) those counties and areas (in this paragraph referred to as "primary care scarcity counties") with the lowest primary care ratios that represent, if each such county or area were weighted by the number of individuals determined under paragraph (2)(B), an aggregate total of 20 percent of the total of the individuals determined under such paragraph; and

[146] P.L. 108–173, §413(a), added subsection (u), effective December 8, 2003.

(ii) those counties and areas (in this subsection referred to as "specialist care scarcity counties") with the lowest specialist care ratios that represent, if each such county or area were weighted by the number of individuals determined under paragraph (2)(B), an aggregate total of 20 percent of the total of the individuals determined under such paragraph.

(B) PERIODIC REVISIONS.—The Secretary shall periodically revise the counties or areas identified in subparagraph (A) (but not less often than once every three years) unless the Secretary determines that there is no new data available on the number of physicians practicing in the county or area or the number of individuals residing in the county or area, as identified in paragraph (2).

(C) IDENTIFICATION OF COUNTIES WHERE SERVICE IS FURNISHED.—For purposes of paying the additional amount specified in paragraph (1), if the Secretary uses the 5-digit postal ZIP Code where the service is furnished, the dominant county of the postal ZIP Code (as determined by the United States Postal Service, or otherwise) shall be used to determine whether the postal ZIP Code is in a scarcity county identified in subparagraph (A) or revised in subparagraph (B).

(D) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting—

(i) the identification of a county or area;

(ii) the assignment of a specialty of any physician under this paragraph;

(iii) the assignment of a physician to a county under paragraph (2); or

(iv) the assignment of a postal ZIP Code to a county or other area under this subsection.

(5) RURAL CENSUS TRACTS.—To the extent feasible, the Secretary shall treat a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)), as an equivalent area for purposes of qualifying as a primary care scarcity county or specialist care scarcity county under this subsection.

(6) PHYSICIAN DEFINED.—For purposes of this paragraph, the term "physician" means a physician described in section 1861(r)(1) and the term "primary care physician" means a physician who is identified in the available data as a general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist.

(7) PUBLICATION OF LIST OF COUNTIES; POSTING ON WEBSITE.—With respect to a year for which a county or area is identified or revised under paragraph (4), the Secretary shall identify such counties or areas as part of the proposed and final rule to implement the physician fee schedule under section 1848 for the applicable year. The Secretary shall post the list of counties identified or revised under paragraph (4) on the Internet website of the Centers for Medicare and Medicaid Services.

SPECIAL PAYMENT RULES FOR PARTICULAR ITEMS AND SERVICES [147]

SEC. 1834. [42 U.S.C. 1395m] (a) PAYMENT FOR DURABLE MEDICAL EQUIPMENT.—

(1) GENERAL RULE FOR PAYMENT.—

(A) IN GENERAL.—With respect to a covered item (as defined in paragraph (13)) for which payment is determined under this subsection, payment shall be made in the frequency specified in paragraphs (2) through (7) and in an amount equal to 80 percent of the payment basis described in subparagraph (B).

(B) PAYMENT BASIS.—The payment basis described in this subparagraph is the lesser of—

(i) the actual charge for the item, or

(ii) the payment amount recognized under paragraphs (2) through (7) of this subsection for the item;

except that clause (i) shall not apply if the covered item is furnished by a public home health agency (or by another home health agency which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low income) free of charge or at nominal charges to the public.

(C) EXCLUSIVE PAYMENT RULE.—This subsection shall constitute the exclusive provision of this title for payment for covered items under this part or under part A to a home health agency.

(D) REDUCTION IN FEE SCHEDULES FOR CERTAIN ITEMS.—With respect to a seat-lift chair or transcutaneous electrical nerve stimulator furnished on or after April 1, 1990, the Secretary shall reduce the payment amount applied under subparagraph (B)(ii) for such an item by 15 percent, and, in the case of a transcutaneous electrical nerve stimulator furnished on or after January 1, 1991, the Secretary shall further reduce such payment amount (as previously reduced) by 45 percent.

(2) PAYMENT FOR INEXPENSIVE AND OTHER ROUTINELY PURCHASED DURABLE MEDICAL EQUIPMENT.—

(A) IN GENERAL.—Payment for an item of durable medical equipment (as defined in paragraph (13))—

(i) the purchase price of which does not exceed $150,

(ii) which the Secretary determines is acquired at least 75 percent of the time by purchase, or

(iii) which is an accessory used in conjunction with a nebulizer, aspirator, or a ventilator excluded under paragraph (3)(A),

shall be made on a rental basis or in a lump-sum amount for the purchase of the item. The payment amount recognized for purchase or rental of such equipment is the amount specified in subparagraph (B) for purchase or rental, except that the total amount of payments with respect to an item may not exceed the payment amount specified in subparagraph (B) with respect to the purchase of the item.

[147] See Vol. II, P.L. 108-173, §302(c)(1)(B), with respect to a GAO report on class III medical devices and §418, with respect to a report on a demonstration project permitting skilled nursing facilities to be originating telehealth sites; authority to implement.

(B) PAYMENT AMOUNT.—For purposes of subparagraph (A), the amount specified in this subparagraph, with respect to the purchase or rental of an item furnished in a carrier service area—

(i) in 1989 and in 1990 is the average reasonable charge in the area for the purchase or rental, respectively, of the item for the 12-month period ending on June 30, 1987, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987;

(ii) in 1991 is the sum of (I) 67 percent of the local payment amount for the item or device computed under subparagraph (C)(i)(I) for 1991, and (II) 33 percent of the national limited payment amount for the item or device computed under subparagraph (C)(ii) for 1991;

(iii) in 1992 is the sum of (I) 33 percent of the local payment amount for the item or device computed under subparagraph (C)(i)(II) for 1992, and (II) 67 percent of the national limited payment amount for the item or device computed under subparagraph (C)(ii) for 1992; and

(iv) in 1993 and each subsequent year is the national limited payment amount for the item or device computed under subparagraph (C)(ii) for that year (reduced by 10 percent, in the case of a blood glucose testing strip furnished after 1997 for an individual with diabetes).

(C) COMPUTATION OF LOCAL PAYMENT AMOUNT AND NATIONAL LIMITED PAYMENT AMOUNT.—For purposes of subparagraph (B)—

(i) the local payment amount for an item or device for a year is equal to—

(I) for 1991, the amount specified in subparagraph (B)(i) for 1990 increased by the covered item update for 1991, and

(II) for 1992, 1993, and 1994 the amount determined under this clause for the preceding year increased by the covered item update for the year; and

(ii) the national limited payment amount for an item or device for a year is equal to—

(I) for 1991, the local payment amount determined under clause (i) for such item or device for that year, except that the national limited payment amount may not exceed 100 percent of the weighted average of all local payment amounts determined under such clause for such item for that year and may not be less than 85 percent of the weighted average of all local payment amounts determined under such clause for such item,

(II) for 1992 and 1993, the amount determined under this clause for the preceding year increased

by the covered item update for such subsequent year,

(III) for 1994, the local payment amount determined under clause (i) for such item or device for that year, except that the national limited payment amount may not exceed 100 percent of the median of all local payment amounts determined under such clause for such item for that year and may not be less than 85 percent of the median of all local payment amounts determined under such clause for such item or device for that year, and

(IV) for each subsequent year, the amount determined under this clause for the preceding year increased by the covered item update for such subsequent year.

(3) PAYMENT FOR ITEMS REQUIRING FREQUENT AND SUBSTANTIAL SERVICING.—

(A) IN GENERAL.—Payment for a covered item (such as IPPB machines and ventilators, excluding ventilators that are either continuous airway pressure devices or intermittent assist devices with continuous airway pressure devices) for which there must be frequent and substantial servicing in order to avoid risk to the patient's health shall be made on a monthly basis for the rental of the item and the amount recognized is the amount specified in subparagraph (B).

(B) PAYMENT AMOUNT.—For purposes of subparagraph (A), the amount specified in this subparagraph, with respect to an item or device furnished in a carrier service area—

(i) in 1989 and in 1990 is the average reasonable charge in the area for the rental of the item or device for the 12-month period ending with June 1987, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987;

(ii) in 1991 is the sum of (I) 67 percent of the local payment amount for the item or device computed under subparagraph (C)(i)(I) for 1991, and (II) 33 percent of the national limited payment amount for the item or device computed under subparagraph (C)(ii) for 1991;

(iii) in 1992 is the sum of (I) 33 percent of the local payment amount for the item or device computed under subparagraph (C)(i)(II) for 1992, and (II) 67 percent of the national limited payment amount for the item or device computed under subparagraph (C)(ii) for 1992; and

(iv) in 1993 and each subsequent year is the national limited payment amount for the item or device computed under subparagraph (C)(ii) for that year.

(C) COMPUTATION OF LOCAL PAYMENT AMOUNT AND NATIONAL LIMITED PAYMENT AMOUNT.—For purposes of subparagraph (B)—

(i) the local payment amount for an item or device for a year is equal to—

(I) for 1991, the amount specified in subparagraph (B)(i) for 1990 increased by the covered item update for 1991, and

(II) for 1992, 1993, and 1994 the amount determined under this clause for the preceding year increased by the covered item update for the year; and

(ii) the national limited payment amount for an item or device for a year is equal to—

(I) for 1991, the local payment amount determined under clause (i) for such item or device for that year, except that the national limited payment amount may not exeed 100 percent of the weighted average of all local payment amounts determined under such clause for such item for that year and may not be less than 85 percent of the weighted average of all local payment amounts determined under such clause for such item,

(II) for 1992 and 1993, the amount determined under this clause for the preceding year increased by the covered item update for such subsequent year,

(III) for 1994, the local payment amount determined under clause (i) for such item or device for that year, except that the national limited payment amount may not exceed 100 percent of the median of all local payment amounts determined under such clause for such item for that year and may not be less than 85 percent of the median of all local payment amounts determined under such clause for such item or device for that year, and

(IV) for each subsequent year, the amount determined under this clause for the preceding year increased by the covered item update for such subsequent year.

(4) PAYMENT FOR CERTAIN CUSTOMIZED ITEMS.—Payment with respect to a covered item that is uniquely constructed or substantially modified to meet the specific needs of an individual patient, and for that reason cannot be grouped with similar items for purposes of payment under this title, shall be made in a lump–sum amount (A) for the purchase of the item in a payment amount based upon the carrier's individual consideration for that item, and (B) for the reasonable and necessary maintenance and servicing for parts and labor not covered by the supplier's or manufacturer's warranty, when necessary during the period of medical need, and the amount recognized for such maintenance and servicing shall be paid on a lump-sum, as needed basis based upon the carrier's individual consideration for that item. In the case of a wheelchair furnished on or after January 1, 1992, the wheelchair shall be treated as a customized item for purposes of this paragraph if the wheelchair has been measured, fitted, or adapted in consideration of

the patient's body size, disability, period of need, or intended use, and has been assembled by a supplier or ordered from a manufacturer who makes available customized features, modifications, or components for wheelchairs that are intended for an individual patient's use in accordance with instructions from the patient's physician.

(5) PAYMENT FOR OXYGEN AND OXYGEN EQUIPMENT.—

(A) IN GENERAL.—Payment for oxygen and oxygen equipment shall be made on a monthly basis in the monthly payment amount recognized under paragraph (9) for oxygen and oxygen equipment (other than portable oxygen equipment), subject to subparagraphs (B), (C), and (E).

(B) ADD–ON FOR PORTABLE OXYGEN EQUIPMENT.—When portable oxygen equipment is used, but subject to subparagraph (D), the payment amount recognized under subparagraph (A) shall be increased by the monthly payment amount recognized under paragraph (9) for portable oxygen equipment.

(C) VOLUME ADJUSTMENT.—When the attending physician prescribes an oxygen flow rate—

(i) exceeding 4 liters per minute, the payment amount recognized under subparagraph (A), subject to subparagraph (D), shall be increased by 50 percent, or

(ii) of less than 1 liter per minute, the payment amount recognized under subparagraph (A) shall be decreased by 50 percent.

(D) LIMIT ON ADJUSTMENT.—When portable oxygen equipment is used and the attending physician prescribes an oxygen flow rate exceeding 4 liters per minute, there shall only be an increase under either subparagraph (B) or (C), whichever increase is larger, and not under both such subparagraphs.

(E) RECERTIFICATION FOR PATIENTS RECEIVING HOME OXYGEN THERAPY.—In the case of a patient receiving home oxygen therapy services who, at the time such services are initiated, has an initial arterial blood gas value at or above a partial pressure of 56 or an arterial oxygen saturation at or above 89 percent (or such other values, pressures, or criteria as the Secretary may specify) no payment may be made under this part for such services after the expiration of the 90-day period that begins on the date the patient first receives such services unless the patient's attending physician certifies that, on the basis of a follow-up test of the patient's arterial blood gas value or arterial oxygen saturation conducted during the final 30 days of such 90-day period, there is a medical need for the patient to continue to receive such services.

(6) PAYMENT FOR OTHER COVERED ITEMS (OTHER THAN DURABLE MEDICAL EQUIPMENT).—Payment for other covered items (other than durable medical equipment and other covered items described in paragraph (3), (4), or (5)) shall be made in a lump-sum amount for the purchase of the item in the amount of the purchase price recognized under paragraph (8).

(7) PAYMENT FOR OTHER ITEMS OF DURABLE MEDICAL EQUIPMENT.—

(A) IN GENERAL.—In the case of an item of durable medical equipment not described in paragraphs (2) through (6)—

(i) payment shall be made on a monthly basis for the rental of such item during the period of medical need (but payments under this clause may not extend over a period of continuous use of longer than 15 months, or, in the case of an item for which a purchase agreement has been entered into under clause (iii), a period of continuous use of longer than 13 months), and, subject to subparagraph (B), the amount recognized for each of the first 3 months of such period is 10 percent of the purchase price recognized under paragraph (8) with respect to the item, and for each of the remaining months of such period is 7.5 percent of such purchase price;

(ii) in the case of a power-driven wheelchair, at the time the supplier furnishes the item, the supplier shall offer the individual patient the option to purchase the item, and payment for such item shall be made on a lump-sum basis if the patient exercises such option;

(iii) during the 10th continuous month during which payment is made for the rental of an item under clause (i), the supplier of such item shall offer the individual patient the option to enter into a purchase agreement under which, if the patient notifies the supplier not later than 1 month after the supplier makes such offer that the patient agrees to accept such offer and exercise such option—

(I) the supplier shall transfer title to the item to the individual patient on the first day that begins after the 13th continuous month during which payment is made for the rental of the item under clause (i),

(II) after the supplier transfers title to the item under subclause (I), maintenance and servicing payments shall be made in accordance with clause (vi);

(iv) in the case of an item for which a purchase agreement has not been entered into under clause (ii) or clause (iii), during the first 6-month period of medical need that follows the period of medical need during which payment is made under clause (i), no payment shall be made for rental or maintenance and servicing of the item;

(v) in the case of an item for which a purchase agreement has not been entered into under clause (ii) or clause (iii), during the first month of each succeeding 6-month period of medical need, a maintenance and servicing payment may be made (for parts and labor not covered by the supplier's or manufacturer's warranty, as determined by the Secretary to be appropriate for the particular type of durable medical equipment) and the amount recognized for each such 6-month period is the lower of (I) a reasonable and nec-

essary maintenance and servicing fee or fees established by the Secretary, or (II) 10 percent of the total of the purchase price recognized under paragraph (8) with respect to the item; and

(vi) in the case of an item for which a purchase agreement has been entered into under clause (ii) or clause (iii), maintenance and servicing payments may be made (for parts and labor not covered by the supplier's or manufacturer's warranty, as determined by the Secretary to be appropriate for the particular type of durable medical equipment), and such payments shall be in an amount established by the Secretary on the basis of reasonable charges in the locality for maintenance and servicing.

The Secretary shall determine the meaning of the term "continuous" in subparagraph (A).

(B) RANGE FOR RENTAL AMOUNTS.—

(i) FOR 1989.—For items furnished during 1989, the payment amount recognized under subparagraph (A)(i) shall not be more than 115 percent, and shall not be less than 85 percent, of the prevailing charge established for rental of the item in January 1987, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6–month period ending with December 1987.

(ii) FOR 1990.—For items furnished during 1990, clause (i) shall apply in the same manner as it applies to items furnished during 1989.

(C) REPLACEMENT OF ITEMS.—

(i) ESTABLISHMENT OF REASONABLE USEFUL LIFETIME.—In accordance with clause (iii), the Secretary shall determine and establish a reasonable useful lifetime for items of durable medical equipment for which payment may be made under this paragraph.

(ii) PAYMENT FOR REPLACEMENT ITEMS.—If the reasonable lifetime of such an item, as so established, has been reached during a continuous period of medical need, or the carrier determines that the item is lost or irreparably damaged, the patient may elect to have payment for an item serving as a replacement for such item made—

(I) on a monthly basis for the rental of the replacement item in accordance with subparagraph (A); or

(II) in the case of an item for which a purchase agreement has been entered into under subparagraph (A)(ii) or (A)(iii), in a lump-sum amount for the purchase of the item.

(iii) LENGTH OF REASONABLE USEFUL LIFETIME.—The reasonable useful lifetime of an item of durable medical equipment under this subparagraph shall be equal to 5 years, except that, if the Secretary determines that, on the basis of prior experience in making payments for such an item under this title, a reasonable useful lifetime of 5 years is not appropriate with re-

spect to a particular item, the Secretary shall establish an alternative reasonable lifetime for such item.

(8) PURCHASE PRICE RECOGNIZED FOR MISCELLANEOUS DEVICES AND ITEMS.—For purposes of paragraphs (6) and (7), the amount that is recognized under this paragraph as the purchase price for a covered item is the amount described in subparagraph (C) of this paragraph, determined as follows:

(A) COMPUTATION OF LOCAL PURCHASE PRICE.—Each carrier under section 1842 shall compute a base local purchase price for the item as follows:

(i) The carrier shall compute a base local purchase price, for each item described—

(I) in paragraph (6) equal to the average reasonable charge in the locality for the purchase of the item for the 12-month period ending with June 1987, or

(II) in paragraph (7) equal to the average of the purchase prices on the claims submitted on an assignment-related basis for the unused item supplied during the 6-month period ending with December 1986.

(ii) The carrier shall compute a local purchase price, with respect to the furnishing of each particular item—

(I) in 1989 and 1990, equal to the base local purchase price computed under clause (i) increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987,

(II) in 1991, equal to the local purchase price computed under this clause for the previous year, increased by the covered item update for 1991, and decreased by the percentage by which the average of the reasonable charges for claims paid for all items described in paragraph (7) is lower than the average of the purchase prices submitted for such items during the final 9 months of 1988; or

(III) in 1992, 1993, and 1994 equal to the local purchase price computed under this clause for the previous year increased by the covered item update for the year.

(B) COMPUTATION OF NATIONAL LIMITED PURCHASE PRICE.—With respect to the furnishing of a particular item in a year, the Secretary shall compute a national limited purchase price—

(i) for 1991, equal to the local purchase price computed under subparagraph (A)(ii) for the item for the year, except that such national limited purchase price may not exceed 100 percent of the weighted average of all local purchase prices for the item computed under such subparagraph for the year, and may not be less than 85 percent of the weighted average of all local purchase prices for the item computed under such subparagraph for the year;

(ii) for 1992 and 1993, the amount determined under this subparagraph for the preceding year increased by the covered item update for such subsequent year;

(iii) for 1994, the local purchase price computed under subparagraph (A)(ii) for the item for the year, except that such national limited purchase price may not exceed 100 percent of the median of all local purchase prices computed for the item under such subparagraph for the year and may not be less than 85 percent of the median of all local purchase prices computed under such subparagraph for the item for the year;

(iv) for 1995, 1996, and 1997, equal to the amount determined under this subparagraph for the preceding year increased by the covered item update for such subsequent year;

(v) for 1998, 75 percent of the amount determined under this subparagraph for 1997; and

(vi) for 1999 and each subsequent year, 70 percent of the amount determined under this subparagraph for 1997.

(C) PURCHASE PRICE RECOGNIZED.—For purposes of paragraphs (6) and (7), the amount that is recognized under this paragraph as the purchase price for each item furnished—

(i) in 1989 or 1990, is 100 percent of the local purchase price computed under subparagraph (A)(ii)(I);

(ii) in 1991, is the sum of (I) 67 percent of the local purchase price computed under subparagraph (A)(ii)(II) for 1991, and (II) 33 percent of the national limited purchase price computed under subparagraph (B) for 1991;

(iii) in 1992, is the sum of (I) 33 percent of the local purchase price computed under subparagraph (A)(ii)(III) for 1992, and (II) 67 percent of the national limited purchase price computed under subparagraph (B) for 1992; and

(iv) in 1993 or a subsequent year, is the national limited purchase price computed under subparagraph (B) for that year.

(9) MONTHLY PAYMENT AMOUNT RECOGNIZED WITH RESPECT TO OXYGEN AND OXYGEN EQUIPMENT.—For purposes of paragraph (5), the amount that is recognized under this paragraph for payment for oxygen and oxygen equipment is the monthly payment amount described in subparagraph (C) of this paragraph. Such amount shall be computed separately (i) for all items of oxygen and oxygen equipment (other than portable oxygen equipment) and (ii) for portable oxygen equipment (each such group referred to in this paragraph as an "item").

(A) COMPUTATION OF LOCAL MONTHLY PAYMENT RATE.—Each carrier under this section shall compute a base local payment rate for each item as follows:

(i) The carrier shall compute a base local average monthly payment rate per beneficiary as an amount equal to (I) the total reasonable charges for the item during the 12-month period ending with December

1986, divided by (II) the total number of months for all beneficiaries receiving the item in the area during the 12-month period for which the carrier made payment for the item under this title.

(ii) The carrier shall compute a local average monthly payment rate for the item applicable—

(I) to 1989 and 1990, equal to 95 percent of the base local average monthly payment rate computed under clause (i) for the item increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987, or

(II) to 1991, 1992, 1993, and 1994 equal to the local average monthly payment rate computed under this clause for the item for the previous year increased by the covered item increase for the year.

(B) COMPUTATION OF NATIONAL LIMITED MONTHLY PAYMENT RATE.—With respect to the furnishing of an item in a year, the Secretary shall compute a national limited monthly payment rate equal to—

(i) for 1991, the local monthly payment rate computed under subparagraph (A)(ii)(II) for the item for the year, except that such national limited monthly payment rate may not exceed 100 percent of the weighted average of all local monthly payment rates computed for the item under such subparagraph for the year, and may not be less than 85 percent of the weighted average of all local monthly payment rates computed for the item under such subparagraph for the year;

(ii) for 1992 and 1993, the amount determined under this subparagraph for the preceding year increased by the covered item update for such subsequent year;

(iii) for 1994, the local monthly payment rate computed under subparagraph (A)(ii) for the item for the year, except that such national limited monthly payment rate may not exceed 100 percent of the median of all local monthly payment rates computed for the item under such subparagraph for the year and may not be less than 85 percent of the median of all local monthly payment rates computed for the item under such subparagraph for the year;

(iv) for 1995, 1996, and 1997, equal to the amount determined under this subparagraph for the preceding year increased by the covered item update for such subsequent year;

(v) for 1998, 75 percent of the amount determined under this subparagraph for 1997; and

(vi) for 1999 and each subsequent year, 70 percent of the amount determined under this subparagraph for 1997.

(C) MONTHLY PAYMENT AMOUNT RECOGNIZED.—For purposes of paragraph (5), the amount that is recognized

under this paragraph as the base monthly payment amount for each item furnished—

(i) in 1989 and in 1990, is 100 percent of the local average monthly payment rate computed under subparagraph (A)(ii) for the item;

(ii) in 1991, is the sum of (I) 67 percent of the local average monthly payment rate computed under subparagraph (A)(ii)(II) for the item for 1991, and (II) 33 percent of the national limited monthly payment rate computed under subparagraph (B)(i) for the item for 1991;

(iii) in 1992, is the sum of (I) 33 percent of the local average monthly payment rate computed under subparagraph (A)(ii)(II) for the item for 1992, and (II) 67 percent of the national limited monthly payment rate computed under subparagraph (B)(ii) for the item for 1992; and

(iv) in a subsequent year, is the national limited monthly payment rate computed under subparagraph (B) for the item for that year.

(D) AUTHORITY TO CREATE CLASSES.—

(i) IN GENERAL.—Subject to clause (ii), the Secretary may establish separate classes for any item of oxygen and oxygen equipment and separate national limited monthly payment rates for each of such classes.

(ii) BUDGET NEUTRALITY.—The Secretary may take actions under clause (i) only to the extent such actions do not result in expenditures for any year to be more or less than the expenditures which would have been made if such actions had not been taken.

(10) EXCEPTIONS AND ADJUSTMENTS.—

(A) AREAS OUTSIDE CONTINENTAL UNITED STATES.—Exceptions to the amounts recognized under the previous provisions of this subsection shall be made to take into account the unique circumstances of covered items furnished in Alaska, Hawaii, or Puerto Rico.

(B) ADJUSTMENT FOR INHERENT REASONABLENESS.—The Secretary is authorized to apply the provisions of paragraphs (8) and (9) of section 1842(b) to covered items and suppliers of such items and payments under this subsection.

(C) TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR (TENS).—In order to permit an attending physician time to determine whether the purchase of a transcutaneous electrical nerve stimulator is medically appropriate for a particular patient, the Secretary may determine an appropriate payment amount for the initial rental of such item for a period of not more than 2 months. If such item is subsequently purchased, the payment amount with respect to such purchase is the payment amount determined under paragraph (2).

(11) IMPROPER BILLING AND REQUIREMENT OF PHYSICIAN ORDER.—

(A) IMPROPER BILLING FOR CERTAIN RENTAL ITEMS.—Notwithstanding any other provision of this title, a supplier of a covered item for which payment is made under this sub-

section and which is furnished on a rental basis shall continue to supply the item without charge (other than a charge provided under this subsection for the maintenance and servicing of the item) after rental payments may no longer be made under this subsection. If a supplier knowingly and willfully violates the previous sentence, the Secretary may apply sanctions against the supplier under section 1842(j)(2) in the same manner such sanctions may apply with respect to a physician.

(B) REQUIREMENT OF PHYSICIAN ORDER.—The Secretary is authorized to require, for specified covered items, that payment may be made under this subsection with respect to the item only if a physician has communicated to the supplier, before delivery of the item, a written order for the item.

(12) REGIONAL CARRIERS.—The Secretary may designate, by regulation under section 1842, one carrier for one or more entire regions to process all claims within the region for covered items under this section.

(13) COVERED ITEM.—In this subsection, the term "covered item" means durable medical equipment (as defined in section 1861(n)), including such equipment described in section 1861(m)(5), but not including implantable items for which payment may be made under section 1833(t).

(14) COVERED ITEM UPDATE.—In this subsection, the term "covered item update" means, with respect to a year—

(A) for 1991 and 1992, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for 12-month period ending with June of the previous year reduced by 1 percentage point;

(B) for 1993, 1994, 1995, 1996, and 1997, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year;

(C) for each of the years 1998 through 2000, 0 percentage points;

(D) for 2001, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12–month period ending with June 2000;

(E) for 2002, 0 percentage points;[148]

(F) for 2003[149], the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12–month period ending with June of 2002;[150]

(G)[151] for 2004 through 2006—

(i) subject to clause (ii), in the case of class III medical devices described in section 513(a)(1)(C) of the Federal Food, Drug, and Cosmetic Act[152] (21 U.S.C. 360(c)(1)(C)), the percentage increase described in subparagraph (B) for the year involved; and

(ii) in the case of covered items not described in clause (i), 0 percentage points;

[148] P.L. 108–173, §302(c)(1)(A)(i), struck out "and".
[149] P.L. 108–173, §302(c)(1)(A)(ii)(I), struck out "a subsequent year" and substituted "2003".
[150] P.L. 108–173, §302(c)(1)(A)(ii)(II), struck out "the previous year." and substituted "2002;".
[151] P.L. 108–173, §302(c)(1)(A)(iii), added subparagraph (G), effective December 8, 2003.
[152] See Vol. II, P.L. 75-717, §513(a)(1)(C).

(H)[153] for 2007—

(i) subject to clause (ii), in the case of class III medical devices described in section 513(a)(1)(C) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(c)(1)(C)), the percentage change determined by the Secretary to be appropriate taking into account recommendations contained in the report of the Comptroller General of the United States under section 302(c)(1)(B) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003; and

(ii) in the case of covered items not described in clause (i), 0 percentage points; and

(I)[154] for 2008—

(i) subject to clause (ii), in the case of class III medical devices described in section 513(a)(1)(C) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(c)(1)(C)), the percentage increase described in subparagraph (B) (as applied to the payment amount for 2007 determined after the application of the percentage change under subparagraph (H)(i)); and

(ii) in the case of covered items not described in clause (i), 0 percentage points; and

(J)[155] for a subsequent year, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.

(15) ADVANCE DETERMINATIONS OF COVERAGE FOR CERTAIN ITEMS.—

(A) DEVELOPMENT OF LIST OF ITEMS BY SECRETARY.—The Secretary may develop and periodically update a list of items for which payment may be made under this subsection that the Secretary determines, on the basis of prior payment experience, are frequently subject to unnecessary utilization throughout a carrier's entire service area or a portion of such area.

(B) DEVELOPMENT OF LISTS OF SUPPLIERS BY SECRETARY.—The Secretary may develop and periodically update a list of suppliers of items for which payment may be made under this subsection with respect to whom—

(i) the Secretary has found that a substantial number of claims for payment under this part for items furnished by the supplier have been denied on the basis of the application of section 1862(a)(1); or

(ii) the Secretary has identified a pattern of overutilization resulting from the business practice of the supplier.

(C) DETERMINATIONS OF COVERAGE IN ADVANCE.—A carrier shall determine in advance of delivery of an item whether payment for the item may not be made because the item is not covered or because of the application of section 1862(a)(1) if—

(i) the item is included on the list developed by the Secretary under subparagraph (A);

[153] P.L. 108–173, §302(c)(1)(A)(iii), added subparagraph (H), effective December 8, 2003.
[154] P.L. 108–173, §302(c)(1)(A)(iii), added subparagraph (I), effective December 8, 2003.
[155] P.L. 108–173, §302(c)(1)(A)(iii), added subparagraph (J), effective December 8, 2003.

(ii) the item is furnished by a supplier included on the list developed by the Secretary under subparagraph (B); or

(iii) the item is a customized item (other than inexpensive items specified by the Secretary) and the patient to whom the item is to be furnished or the supplier requests that such advance determination be made.

(16) DISCLOSURE OF INFORMATION AND SURETY BOND.—The Secretary shall not provide for the issuance (or renewal) of a provider number for a supplier of durable medical equipment, for purposes of payment under this part for durable medical equipment furnished by the supplier, unless the supplier provides the Secretary on a continuing basis—

(A) with—

(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) with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000.

The Secretary may waive the requirement of a bond under subparagraph (B) in the case of a supplier that provides a comparable surety bond under State law. The Secretary, at the Secretary's discretion, may impose the requirements of the first sentence with respect to some or all providers of items or services under part A or some or all suppliers or other persons (other than physicians or other practitioners, as defined in section 1842(b)(18)(C)) who furnish items or services under this part.

(17) PROHIBITION AGAINST UNSOLICITED TELEPHONE CONTACTS BY SUPPLIERS.—

(A) IN GENERAL.—A supplier of a covered item under this subsection may not contact an individual enrolled under this part by telephone regarding the furnishing of a covered item to the individual unless 1 of the following applies:

(i) The individual has given written permission to the supplier to make contact by telephone regarding the furnishing of a covered item.

(ii) The supplier has furnished a covered item to the individual and the supplier is contacting the individual only regarding the furnishing of such covered item.

(iii) If the contact is regarding the furnishing of a covered item other than a covered item already furnished to the individual, the supplier has furnished at least 1 covered item to the individual during the 15-

month period preceding the date on which the supplier makes such contact.

(B) PROHIBITING PAYMENT FOR ITEMS FURNISHED SUBSEQUENT TO UNSOLICITED CONTACTS.—If a supplier knowingly contacts an individual in violation of subparagraph (A), no payment may be made under this part for any item subsequently furnished to the individual by the supplier.

(C) EXCLUSION FROM PROGRAM FOR SUPPLIERS ENGAGING IN PATTERN OF UNSOLICITED CONTACTS.—If a supplier knowingly contacts individuals in violation of subparagraph (A) to such an extent that the supplier's conduct establishes a pattern of contacts in violation of such subparagraph, the Secretary shall exclude the supplier from participation in the programs under this Act, in accordance with the procedures set forth in subsections (c), (f), and (g) of section 1128.

(18) REFUND OF AMOUNTS COLLECTED FOR CERTAIN DISALLOWED ITEMS.—

(A) IN GENERAL.—If a nonparticipating supplier furnishes to an individual enrolled under this part a covered item for which no payment may be made under this part by reason of paragraph (17)(B), the supplier shall refund on a timely basis to the patient (and shall be liable to the patient for) any amounts collected from the patient for the item, unless—

(i) the supplier establishes that the supplier did not know and could not reasonably have been expected to know that payment may not be made for the item by reason of paragraph (17)(B), or

(ii) before the item was furnished, the patient was informed that payment under this part may not be made for that item and the patient has agreed to pay for that item.

(B) SANCTIONS.—If a supplier knowingly and willfully fails to make refunds in violation of subparagraph (A), the Secretary may apply sanctions against the supplier in accordance with section 1842(j)(2).

(C) NOTICE.—Each carrier with a contract in effect under this part with respect to suppliers of covered items shall send any notice of denial of payment for covered items by reason of paragraph (17)(B) and for which payment is not requested on an assignment-related basis to the supplier and the patient involved.

(D) TIMELY BASIS DEFINED.—A refund under subparagraph (A) is considered to be on a timely basis only if—

(i) in the case of a supplier who does not request reconsideration or seek appeal on a timely basis, the refund is made within 30 days after the date the supplier receives a denial notice under subparagraph (C), or

(ii) in the case in which such a reconsideration or appeal is taken, the refund is made within 15 days after the date the supplier receives notice of an adverse determination on reconsideration or appeal.

(19)[156] CERTAIN UPGRADED ITEMS.—

(A) INDIVIDUAL'S RIGHT TO CHOOSE UPGRADED ITEM.—Notwithstanding any other provision of this title, the Secretary may issue regulations under which an individual may purchase or rent from a supplier an item of upgraded durable medical equipment for which payment would be made under this subsection if the item were a standard item.

(B) PAYMENTS TO SUPPLIER.—In the case of the purchase or rental of an upgraded item under subparagraph (A)—

(i) the supplier shall receive payment under this subsection with respect to such item as if such item were a standard item; and

(ii) the individual purchasing or renting the item shall pay the supplier an amount equal to the difference between the supplier's charge and the amount under clause (i).

In no event may the supplier's charge for an upgraded item exceed the applicable fee schedule amount (if any) for such item.

(C) CONSUMER PROTECTION SAFEGUARDS.—Any regulations under subparagraph (A) shall provide for consumer protection standards with respect to the furnishing of upgraded equipment under subparagraph (A). Such regulations shall provide for—

(i) determination of fair market prices with respect to an upgraded item;

(ii) full disclosure of the availability and price of standard items and proof of receipt of such disclosure information by the beneficiary before the furnishing of the upgraded item;

(iii) conditions of participation for suppliers in the billing arrangement;

(iv) sanctions of suppliers who are determined to engage in coercive or abusive practices, including exclusion; and

(v) such other safeguards as the Secretary determines are necessary.

(20)[157] IDENTIFICATION OF QUALITY STANDARDS.—

(A) IN GENERAL.—Subject to subparagraph (C), the Secretary shall establish and implement quality standards for suppliers of items and services described in subparagraph (D) to be applied by recognized independent accreditation organizations (as designated under subparagraph (B)) and with which such suppliers shall be required to comply in order to—

(i) furnish any such item or service for which payment is made under this part; and

(ii) receive or retain a provider or supplier number used to submit claims for reimbursement for any such item or service for which payment may be made under this title.

(B) DESIGNATION OF INDEPENDENT ACCREDITATION ORGANIZATIONS.—Not later than the date that is 1 year after the

[156] P.L. 108–173, §302(a)(1)(A), transferred the former paragraph (17) to the end of the section and redesignated it as paragraph (19).

[157] P.L. 108–173, §302(a)(1)(B), added paragraph (20), effective December 8, 2003.

date on which the Secretary implements the quality standards under subparagraph (A), notwithstanding section 1865(b), the Secretary shall designate and approve one or more independent accreditation organizations for purposes of such subparagraph.

(C) QUALITY STANDARDS.—The quality standards described in subparagraph (A) may not be less stringent than the quality standards that would otherwise apply if this paragraph did not apply and shall include consumer services standards.

(D) ITEMS AND SERVICES DESCRIBED.—The items and services described in this subparagraph are the following items and services, as the Secretary determines appropriate:

(i) Covered items (as defined in paragraph (13)) for which payment may otherwise be made under this subsection.

(ii) Prosthetic devices and orthotics and prosthetics described in section 1834(h)(4).

(iii) Items and services described in section 1842(s)(2).

(E) IMPLEMENTATION.—The Secretary may establish by program instruction or otherwise the quality standards under this paragraph, after consultation with representatives of relevant parties. Such standards shall be applied prospectively and shall be published on the Internet website of the Centers for Medicare and Medicaid Services.

(21)[158] SPECIAL PAYMENT RULE FOR SPECIFIED ITEMS AND SUPPLIES.—

(A) IN GENERAL.—Notwithstanding the preceding provisions of this subsection, for specified items and supplies (described in subparagraph (B)) furnished during 2005, the payment amount otherwise determined under this subsection for such specified items and supplies shall be reduced by the percentage difference between—

(i) the amount of payment otherwise determined for the specified item or supply under this subsection for 2002, and

(ii) the amount of payment for the specified item or supply under chapter 89 of title 5, United States Code, as identified in the column entitled "Median FEHP Price" in the table entitled "SUMMARY OF MEDICARE PRICES COMPARED TO VA, MEDICAID, RETAIL, AND FEHP PRICES FOR 16 ITEMS" included in the Testimony of the Inspector General before the Senate Committee on Appropriations, June 12, 2002, or any subsequent report by the Inspector General.

(B) SPECIFIED ITEM OR SUPPLY DESCRIBED.—For purposes of subparagraph (A), a specified item or supply means oxygen and oxygen equipment, standard wheelchairs (including standard power wheelchairs), nebulizers, diabetic supplies consisting of lancets and testing strips, hospital beds, and air mattresses, but only if the HCPCS code for the

[158] P.L. 108–173, §302(c)(2), added paragraph (21), effective December 8, 2003.

item or supply is identified in a table referred to in subparagraph (A)(ii).

(C) APPLICATION OF UPDATE TO SPECIAL PAYMENT AMOUNT.—The covered item update under paragraph (14) for specified items and supplies for 2006 and each subsequent year shall be applied to the payment amount under subparagraph (A) unless payment is made for such items and supplies under section 1847.

(b) FEE SCHEDULES FOR RADIOLOGIST SERVICES.—

(1) DEVELOPMENT.—The Secretary shall develop—

(A) a relative value scale to serve as the basis for the payment for radiologist services under this part, and

(B) using such scale and appropriate conversion factors and subject to subsection (c)(1)(A), fee schedules (on a regional, statewide, locality, or carrier service area basis) for payment for radiologist services under this part, to be implemented for such services furnished during 1989.

(2) CONSULTATION.—In carrying out paragraph (1), the Secretary shall regularly consult closely with the Physician Payment Review Commission, the American College of Radiology, and other organizations representing physicians or suppliers who furnish radiologist services and shall share with them the data and data analysis being used to make the determinations under paragraph (1), including data on variations in current medicare payments by geographic area, and by service and physician specialty.

(3) CONSIDERATIONS.—In developing the relative value scale and fee schedules under paragraph (1), the Secretary—

(A) shall take into consideration variations in the cost of furnishing such services among geographic areas and among different sites where services are furnished, and

(B) may also take into consideration such other factors respecting the manner in which physicians in different specialties furnish such services as may be appropriate to assure that payment amounts are equitable and designed to promote effective and efficient provision of radiologist services by physicians in the different specialties.

(4) SAVINGS.—

(A) BUDGET NEUTRAL FEE SCHEDULES.—The Secretary shall develop preliminary fee schedules for 1989, which are designed to result in the same amount of aggregate payments (net of any coinsurance and deductibles under sections 1833(a)(1)(J) and 1833(b)) for radiologist services furnished in 1989 as would have been made if this subsection had not been enacted.

(B) INITIAL SAVINGS.—The fee schedules established for payment purposes under this subsection for services furnished in 1989 shall be 97 percent of the amounts permitted under these preliminary fee schedules developed under subparagraph (A).

(C) 1990 FEE SCHEDULES.—For radiologist services (other than portable X-ray services) furnished under this part during 1990, after March 31 of such year, the conversion factors used under this subsection shall be 96 percent of the conversion factors that applied under this subsection as of December 31, 1989.

(D) 1991 FEE SCHEDULES.—For radiologist services (other than portable X–ray services) furnished under this part during 1991, the conversion factors used in a locality under this subsection shall, subject to clause (vii), be reduced to the adjusted conversion factor for the locality determined as follows:

(i) NATIONAL WEIGHTED AVERAGE CONVERSION FACTOR.—The Secretary shall estimate the national weighted average of the conversion factors used under this subsection for services furnished during 1990 beginning on April 1, using the best available data.

(ii) REDUCED NATIONAL WEIGHTED AVERAGE.—The national weighted average estimated under clause (i) shall be reduced by 13 percent.

(iii) COMPUTATION OF 1990 LOCALITY INDEX RELATIVE TO NATIONAL AVERAGE.—The Secretary shall establish an index which reflects, for each locality, the ratio of the conversion factor used in the locality under this subsection to the national weighted average estimated under clause (i).

(iv) ADJUSTED CONVERSION FACTOR.—The adjusted conversion factor for the professional or technical component of a service in a locality is the sum of ½ of the locally-adjusted amount determined under clause (v) and ½ of the GPCI-adjusted amount determined under clause (vi) [159].

(v) LOCALLY-ADJUSTED AMOUNT.—For purposes of clause (iv), the locally adjusted amount determined under this clause is the product of (I) the national weighted average conversion factor computed under clause (ii), and (II) the index value established under clause (iii) for the locality.

(vi) GPCI-ADJUSTED AMOUNT.—For purposes of clause (iv), the GPCI-adjusted amount determined under this clause is the sum of—

(I) the product of (a) the portion of the reduced national weighted average conversion factor computed under clause (ii) which is attributable to physician work and (b) the geographic work index value for the locality (specified in Addendum C to the Model Fee Schedule for Physician Services (published on September 4, 1990, 55 Federal Register pp. 36238–36243)); and

(II) the product of (a) the remaining portion of the reduced national weighted average conversion factor computed under clause (ii), and (b) the geographic practice cost index value specified in section 1842(b)(14)(C)(iv) for the locality.

In applying this clause with respect to the professional component of a service, 80 percent of the conversion factor shall be considered to be attributable to physician work and with respect to the technical component of the service, 0 percent shall be considered to be attributable to physician work.

[159] P.L. 108–173, §736(b)(4), struck out "clauses (vi)" and substituted "clause (vi)".

(vii) LIMITS ON CONVERSION FACTOR.—The conversion factor to be applied to a locality to the professional or technical component of a service shall not be reduced under this subparagraph by more than 9.5 percent below the conversion factor applied in the locality under subparagraph (C) to such component, but in no case shall the conversion factor be less than 60 percent of the national weighted average of the conversion factors (computed under clause (i)).

(viii) RULE FOR CERTAIN SCANNING SERVICES.—

(E) In the case of the technical components of magnetic resonance imaging (MRI) services and computer assisted tomography (CAT) services furnished after December 31, 1990, the amount otherwise payable shall be reduced by 10 percent.

(F) SUBSEQUENT UPDATING.—For radiologist services furnished in subsequent years, the fee schedules shall be the schedules for the previous year updated by the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year.

(G) NONPARTICIPATING PHYSICIANS AND SUPPLIERS.—Each fee schedule so established shall provide that the payment rate recognized for nonparticipating physicians and suppliers is equal to the appropriate percent (as defined in section 1842(b)(4)(A)(iv)) of the payment rate recognized for participating physicians and suppliers.

(5) LIMITING CHARGES OF NONPARTICIPATING PHYSICIANS AND SUPPLIERS.—

(A) IN GENERAL.—In the case of radiologist services furnished after January 1, 1989, for which payment is made under a fee schedule under this subsection, if a nonparticipating physician or supplier furnishes the service to an individual entitled to benefits under this part, the physician or supplier may not charge the individual more than the limiting charge (as defined in subparagraph (B)).

(B) LIMITING CHARGE DEFINED.—In subparagraph (A), the term "limiting charge" means, with respect to a service furnished—

(i) in 1989, 125 percent of the amount specified for the service in the appropriate fee schedule established under paragraph (1),

(ii) in 1990, 120 percent of the amount specified for the service in the appropriate fee schedule established under paragraph (1), and

(iii) after 1990, 115 percent of the amount specified for the service in the appropriate fee schedule established under paragraph (1).

(C) ENFORCEMENT.—If a physician or supplier knowingly and willfully bills in violation of subparagraph (A), the Secretary may apply sanctions against such physician or supplier in accordance with section 1842(j)(2) in the same manner as such sanctions may apply to a physician.

(6) RADIOLOGIST SERVICES DEFINED.—For the purposes of this subsection and section 1833(a)(1)(J), the term "radiologist services" only includes radiology services performed by, or under the direction or supervision of, a physician—

(A) who is certified, or eligible to be certified, by the American Board of Radiology, or

(B) for whom radiology services account for at least 50 percent of the total amount of charges made under this part.

(c)[160] PAYMENT AND STANDARDS FOR SCREENING MAMMOGRAPHY.—

(1) IN GENERAL.—With respect to expenses incurred for screening mammography (as defined in section 1861(jj)), payment may be made only—

(A) for screening mammography conducted consistent with the frequency permitted under paragraph (2); and

(B) if the screening mammography is conducted by a facility that has a certificate (or provisional certificate) issued under section 354 of the Public Health Service Act.

(2) Frequency covered.—

(A) IN GENERAL.—Subject to revision by the Secretary under subparagraph (B)—

(i) no payment may be made under this part for screening mammography performed on a woman under 35 years of age;

(ii) payment may be made under this part for only one screening mammography performed on a woman over 34 years of age, but under 40 years of age; and

(iii) in the case of a woman over 39 years of age, payment may not be made under this part for screening mammography performed within 11 months following the month in which a previous screening mammography was performed.

(B) REVISION OF FREQUENCY.—

(i) REVIEW.—The Secretary, in consultation with the Director of the National Cancer Institute, shall review periodically the appropriate frequency for performing screening mammography, based on age and such other factors as the Secretary believes to be pertinent.

(ii) REVISION OF FREQUENCY.—The Secretary, taking into consideration the review made under clause (i), may revise from time to time the frequency with which screening mammography may be paid for under this subsection.

(d) FREQUENCY LIMITS AND PAYMENT FOR COLORECTAL CANCER SCREENING TESTS.—

(1) SCREENING FECAL–OCCULT BLOOD TESTS.—

(A) PAYMENT AMOUNT.—The payment amount for colorectal cancer screening tests consisting of screening fecal–occult blood tests is equal to the payment amount established for diagnostic fecal–occult blood tests under section 1833(h).

(B) FREQUENCY LIMIT.—No payment may be made under this part for a colorectal cancer screening test consisting of a screening fecal–occult blood test—

(i) if the individual is under 50 years of age; or

[160] See Vol. II, P.L. 106–554, §1(a)(6) [104(d)], with respect to payment for new technologies for mammographies.

(ii) if the test is performed within the 11 months after a previous screening fecal–occult blood test.

(2) SCREENING FLEXIBLE SIGMOIDOSCOPIES.—

(A) FEE SCHEDULE.—With respect to colorectal cancer screening tests consisting of screening flexible sigmoidoscopies, payment under section 1848 shall be consistent with payment under such section for similar or related services.

(B) PAYMENT LIMIT.—In the case of screening flexible sigmoidoscopy services, payment under this part shall not exceed such amount as the Secretary specifies, based upon the rates recognized for diagnostic flexible sigmoidoscopy services.

(C) FACILITY PAYMENT LIMIT.—

(i) IN GENERAL.—Notwithstanding subsections (i)(2)(A) and (t) of section 1833, in the case of screening flexible sigmoidoscopy services furnished on or after January 1, 1999, that—

(I) in accordance with regulations, may be performed in an ambulatory surgical center and for which the Secretary permits ambulatory surgical center payments under this part,

(II) are performed in an ambulatory surgical center or hospital outpatient department, payment under this part shall be based on the lesser of the amount under the fee schedule that would apply to such services if they were performed in a hospital outpatient department in an area or the amount under the fee schedule that would apply to such services if they were performed in an ambulatory surgical center in the same area.

(ii) LIMITATION ON DEDUCTIBLE AND COINSURANCE.—Notwithstanding any other provision of this title, in the case of a beneficiary who receives the services described in clause (i)—

(I) in computing the amount of any applicable deductible or copayment, the computation of such deductible or coinsurance shall be based upon the fee schedule under which payment is made for the services, and

(II) the amount of such coinsurance is equal to 25 percent of the payment amount under the fee schedule described in subclause (I).

(D) SPECIAL RULE FOR DETECTED LESIONS.—If during the course of such screening flexible sigmoidoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening flexible sigmoidoscopy but shall be made for the procedure classified as a flexible sigmoidoscopy with such biopsy or removal.

(E) FREQUENCY LIMIT.—No payment may be made under this part for a colorectal cancer screening test consisting of a screening flexible sigmoidoscopy—

(i) if the individual is under 50 years of age; or

(ii) if the procedure is performed within the 47 months after a previous screening flexible

sigmoidoscopy or, in the case of an individual who is not at high risk for colorectal cancer, if the procedure is performed within the 119 months after a previous screening colonoscopy.

(3) SCREENING COLONOSCOPY.—

(A) FEE SCHEDULE.—With respect to colorectal cancer screening test consisting of a screening colonoscopy, payment under section 1848 shall be consistent with payment amounts under such section for similar or related services.

(B) PAYMENT LIMIT.—In the case of screening colonoscopy services, payment under this part shall not exceed such amount as the Secretary specifies, based upon the rates recognized for diagnostic colonoscopy services.

(C) FACILITY PAYMENT LIMIT.—

(i) IN GENERAL.—Notwithstanding subsections (i)(2)(A) and (t) of section 1833, in the case of screening colonoscopy services furnished on or after January 1, 1999, that are performed in an ambulatory surgical center or a hospital outpatient department, payment under this part shall be based on the lesser of the amount under the fee schedule that would apply to such services if they were performed in a hospital outpatient department in an area or the amount under the fee schedule that would apply to such services if they were performed in an ambulatory surgical center in the same area.

(ii) LIMITATION ON DEDUCTIBLE AND COINSURANCE.—Notwithstanding any other provision of this title, in the case of a beneficiary who receives the services described in clause (i)—

(I) in computing the amount of any applicable deductible or coinsurance, the computation of such deductible or coinsurance shall be based upon the fee schedule under which payment is made for the services, and

(II) the amount of such coinsurance is equal to 25 percent of the payment amount under the fee schedule described in subclause (I).

(D) SPECIAL RULE FOR DETECTED LESIONS.—If during the course of such screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening colonoscopy but shall be made for the procedure classified as a colonoscopy with such biopsy or removal.

(E) FREQUENCY LIMIT.—No payment may be made under this part for a colorectal cancer screening test consisting of a screening colonoscopy for individuals at high risk for colorectal cancer if the procedure is performed within the 23 months after a previous screening colonoscopy or for other individuals if the procedure is performed within the 119 months after a previous screening colonoscopy or within 47 months after a previous screening flexible sigmoidoscopy.

(e) [Repealed.[161]]

(f) REDUCTION IN PAYMENTS FOR PHYSICIAN PATHOLOGY SERVICES DURING 1991.—

(1) IN GENERAL.—For physician pathology services furnished under this part during 1991, the prevailing charges used in a locality under this part shall be 7 percent below the prevailing charges used in the locality under this part in 1990 after March 31.

(2) LIMITATION.—The prevailing charge for the technical and professional components of an[162] physician pathology service furnished by a physician through an independent laboratory shall not be reduced pursuant to paragraph (1) to the extent that such reduction would reduce such prevailing charge below 115 percent of the prevailing charge for the professional component of such service when furnished by a hospital-based physician in the same locality. For purposes of the preceding sentence, an independent laboratory is a laboratory that is independent of a hospital and separate from the attending or consulting physicians' office.

(g) PAYMENT FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—

(1) IN GENERAL.—The amount of payment for outpatient critical access hospital services of a critical access hospital is equal to 101 percent of[163] the reasonable costs of the hospital in providing such services, unless the hospital makes the election under paragraph (2).

(2) ELECTION OF COST–BASED HOSPITAL OUTPATIENT SERVICE PAYMENT PLUS FEE SCHEDULE FOR PROFESSIONAL SERVICES.—A critical access hospital may elect to be paid for outpatient critical access hospital services amounts equal to the sum of the following, less the amount that such hospital may charge as described in section 1866(a)(2)(A):

(A) FACILITY FEE.—With respect to facility services, not including any services for which payment may be made under subparagraph (B), the reasonable costs of the critical access hospital in providing such services.

(B) FEE SCHEDULE FOR PROFESSIONAL SERVICES.—With respect to professional services otherwise included within outpatient critical access hospital services, 115 percent of such amounts as would otherwise be paid under this part if such services were not included in outpatient critical access hospital services.

The Secretary may not require, as a condition for applying subparagraph (B) with respect to a critical access hospital, that each physician or other practitioner providing professional services in the hospital must assign billing rights with respect to such services, except that such subparagraph shall not apply to those physicians and practitioners who have not assigned such billing rights.[164]

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[161] P.L. 101–234, §201(a)(1); 103 Stat. 1981.

[162] As in original; possibly should be "a".

[163] P.L. 108–173, §405(a)(1), added "equal to 101 percent of", applicable to payments for services furnished during cost reporting periods beginning on or after January 1, 2004.

[164] P.L. 108–173, §405(d)(1), added this sentence, applicable to cost reporting periods beginning on or after July 1, 2004, in the case of a critical access hospital that made an election before November 1, 2003, applicable to cost reporting periods beginning on or after July 1, 2001.

(3) DISREGARDING CHARGES.—The payment amounts under this subsection shall be determined without regard to the amount of the customary or other charge.

(4) NO BENEFICIARY COST–SHARING FOR CLINICAL DIAGNOSTIC LABORATORY SERVICES.—No coinsurance, deductible, copayment, or other cost–sharing otherwise applicable under this part shall apply with respect to clinical diagnostic laboratory services furnished as an outpatient critical access hospital service. Nothing in this title shall be construed as providing for payment for clinical diagnostic laboratory services furnished as part of outpatient critical access hospital services, other than on the basis described in this subsection.

(5) COVERAGE OF COSTS FOR CERTAIN [165] emergency room on–call providers [166].—In determining the reasonable costs of outpatient critical access hospital services under paragraphs (1) and (2)(A), the Secretary shall recognize as allowable costs, amounts (as defined by the Secretary) for reasonable compensation and related costs for physicians, physician assistants, nurse practitioners, and clinical nurse specialists who are on-call (as defined by the Secretary) to provide emergency services [167] but who are not present on the premises of the critical access hospital involved, and are not otherwise furnishing services covered under this title [168] and are not on–call at any other provider or facility.

(h) [169] PAYMENT FOR PROSTHETIC DEVICES AND ORTHOTICS AND PROSTHETICS.—

(1) GENERAL RULE FOR PAYMENT.—

(A) IN GENERAL.—Payment under this subsection for prosthetic devices and orthotics and prosthetics shall be made in a lump-sum amount for the purchase of the item in an amount equal to 80 percent of the payment basis described in subparagraph (B).

(B) PAYMENT BASIS.—Except as provided in subparagraphs (C), (E), and (H)(i) [170], the payment basis described in this subparagraph is the lesser of—

(i) the actual charge for the item; or

(ii) the amount recognized under paragraph (2) as the purchase price for the item.

(C) EXCEPTION FOR CERTAIN PUBLIC HOME HEALTH AGENCIES.—Subparagraph (B)(i) shall not apply to an item furnished by a public home health agency (or by another home health agency which demonstrates to the satisfaction of the Secretary that a significant portion of its patients

[165] P.L. 108–173, §405(b)(1)(A)(i), inserted "certain".

[166] P.L. 108–173, §405(b)(1)(A)(ii), struck out "physicians" and substituted "providers", effective December 8, 2003.

[167] P.L. 108–173, §405(b)(1)(B), struck out "emergency room physicians who are on-call (as defined by the Secretary)" and substituted "physicians, physician assistants, nurse practitioners, and clinical nurse specialists who are on-call (as defined by the Secretary) to provide emergency services", applicable with respect to costs incurred for services furnished on or after January 1, 2005.

[168] P.L. 108–173, §405(b)(1)(C), struck out "physicians' services" and substituted "services covered under this title", applicable with respect to costs incurred for services furnished on or after January 1, 2005.

[169] See Vol. II, P.L. 106–554, §1(a)(6) [426(b)], with respect to a special rule payment for prosthetic devices and orthotics for 2001; [427(b)], with respect to revised regulations; and [428(b)], with respect to preemption of rules regarding prosthetic devices under §1834(h)(1)(G).

[170] P.L. 108–173, §302(d)(2)(A), struck out "and (E)" and substituted ", (E), and (H)(i)".

are low income) free of charge or at nominal charges to the public.

(D) EXCLUSIVE PAYMENT RULE.—Subject to subparagraph (H)(ii), this subsection [171] shall constitute the exclusive provision of this title for payment for prosthetic devices, orthotics, and prosthetics under this part or under part A to a home health agency.

(E) EXCEPTION FOR CERTAIN ITEMS.—Payment for ostomy supplies, tracheostomy supplies, and urologicals shall be made in accordance with subparagraphs (B) and (C) of section 1834(a)(2).

(F) SPECIAL PAYMENT RULES FOR CERTAIN PROSTHETICS AND CUSTOM–FABRICATED ORTHOTICS.—

(i) IN GENERAL.—No payment shall be made under this subsection for an item of custom– fabricated orthotics described in clause (ii) or for an item of prosthetics unless such item is—

(I) furnished by a qualified practitioner; and

(II) fabricated by a qualified practitioner or a qualified supplier at a facility that meets such criteria as the Secretary determines appropriate.

(ii) Description of custom–fabricated item.—

(I) IN GENERAL.—An item described in this clause is an item of custom– fabricated orthotics that requires education, training, and experience to custom–fabricate and that is included in a list established by the Secretary in subclause (II). Such an item does not include shoes and shoe inserts.

(II) LIST OF ITEMS.—The Secretary, in consultation with appropriate experts in orthotics (including national organizations representing manufacturers of orthotics), shall establish and update as appropriate a list of items to which this subparagraph applies. No item may be included in such list unless the item is individually fabricated for the patient over a positive model of the patient.

(iii) QUALIFIED PRACTITIONER DEFINED.—In this subparagraph, the term "qualified practitioner" means a physician or other individual who—

(I) is a qualified physical therapist or a qualified occupational therapist;

(II) in the case of a State that provides for the licensing of orthotics and prosthetics, is licensed in orthotics or prosthetics by the State in which the item is supplied; or

(III) in the case of a State that does not provide for the licensing of orthotics and prosthetics, is specifically trained and educated to provide or manage the provision of prosthetics and custom–designed or – fabricated orthotics, and is certified by the American Board for Certification in

[171] P.L. 108–173, §302(d)(2)(B), struck out "This subsection" and substituted "Subject to subparagraph (H)(ii), this subsection".

Orthotics and Prosthetics, Inc. or by the Board for Orthotist/Prosthetist Certification, or is credentialed and approved by a program that the Secretary determines, in consultation with appropriate experts in orthotics and prosthetics, has training and education standards that are necessary to provide such prosthetics and orthotics.

(iv) QUALIFIED SUPPLIER DEFINED.—In this subparagraph, the term "qualified supplier" means any entity that is accredited by the American Board for Certification in Orthotics and Prosthetics, Inc. or by the Board for Orthotist/ Prosthetist Certification, or accredited and approved by a program that the Secretary determines has accreditation and approval standards that are essentially equivalent to those of such Board.

(G) REPLACEMENT OF PROSTHETIC DEVICES AND PARTS.—

(i) IN GENERAL.—Payment shall be made for the replacement of prosthetic devices which are artificial limbs, or for the replacement of any part of such devices, without regard to continuous use or useful lifetime restrictions if an ordering physician determines that the provision of a replacement device, or a replacement part of such a device, is necessary because of any of the following:

(I) A change in the physiological condition of the patient.

(II) An irreparable change in the condition of the device, or in a part of the device.

(III) The condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost of a replacement device, or, as the case may be, of the part being replaced.

(ii) CONFIRMATION MAY BE REQUIRED IF DEVICE OR PART BEING REPLACED IS LESS THAN 3 YEARS OLD.— If a physician determines that a replacement device, or a replacement part, is necessary pursuant to clause (i)—

(I) such determination shall be controlling; and

(II) such replacement device or part shall be deemed to be reasonable and necessary for purposes of section 1862(a)(1)(A);

except that if the device, or part, being replaced is less than 3 years old (calculated from the date on which the beneficiary began to use the device or part), the Secretary may also require confirmation of necessity of the replacement device or replacement part, as the case may be.

(H)[172] Application of competitive acquisition to orthotics; limitation of inherent reasonableness authority.--In the case of orthotics described in paragraph (2)(C) of section 1847(a) furnished on or after January 1, 2009, that are in-

[172] P.L. 108–173, §302(d)(2)(C), added subparagraph (H), effective December 8, 2003.

cluded in a competitive acquisition program in a competitive acquisition area under such section--

(i) the payment basis under this subsection for such orthotics furnished in such area shall be the payment basis determined under such competitive acquisition program; and

(ii) the Secretary may use information on the payment determined under such competitive acquisition programs to adjust the payment amount otherwise recognized under subparagraph (B)(ii) for an area that is not a competitive acquisition area under section 1847, and in the case of such adjustment, paragraphs (8) and (9) of section 1842(b) shall not be applied.

(2) PURCHASE PRICE RECOGNIZED.—For purposes of paragraph (1), the amount that is recognized under this paragraph as the purchase price for prosthetic devices, orthotics, and prosthetics is the amount described in subparagraph (C) of this paragraph, determined as follows:

(A) COMPUTATION OF LOCAL PURCHASE PRICE.—Each carrier under section 1842 shall compute a base local purchase price for the item as follows:

(i) The carrier shall compute a base local purchase price for each item equal to the average reasonable charge in the locality for the purchase of the item for the 12-month period ending with June 1987.

(ii) The carrier shall compute a local purchase price, with respect to the furnishing of each particular item—

(I) in 1989 and 1990, equal to the base local purchase price computed under clause (i) increased by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 6-month period ending with December 1987, or

(II) in 1991, 1992 or 1993, equal to the local purchase price computed under this clause for the previous year increased by the applicable percentage increase for the year.

(B) COMPUTATION OF REGIONAL PURCHASE PRICE.—With respect to the furnishing of a particular item in each region (as defined by the Secretary), the Secretary shall compute a regional purchase price—

(i) for 1992, equal to the average (weighted by relative volume of all claims among carriers) of the local purchase prices for the carriers in the region computed under subparagraph (A)(ii)(II) for the year, and

(ii) for each subsequent year, equal to the regional purchase price computed under this subparagraph for the previous year increased by the applicable percentage increase for the year.

(C) PURCHASE PRICE RECOGNIZED.—For purposes of paragraph (1) and subject to subparagraph (D), the amount that is recognized under this paragraph as the purchase price for each item furnished—

(i) in 1989, 1990, or 1991, is 100 percent of the local purchase price computed under subparagraph (A)(ii);

(ii) in 1992, is the sum of (I) 75 percent of the local purchase price computed under subparagraph (A)(ii)(II) for 1992, and (II) 25 percent of the regional purchase price computed under subparagraph (B) for 1992;

(iii) in 1993, is the sum of (I) 50 percent of the local purchase price computed under subparagraph (A)(ii)(II) for 1993, and (II) 50 percent of the regional purchase price computed under subparagraph (B) for 1993; and

(iv) in 1994 or a subsequent year, is the regional purchase price computed under subparagraph (B) for that year.

(D) RANGE ON AMOUNT RECOGNIZED.—The amount that is recognized under subparagraph (C) as the purchase price for an item furnished—

(i) in 1992, may not exceed 125 percent, and may not be lower than 85 percent, of the average of the purchase prices recognized under such subparagraph for all the carrier service areas in the United States in that year; and

(ii) in a subsequent year, may not exceed 120 percent, and may not be lower than 90 percent, of the average of the purchase prices recognized under such subparagraph for all the carrier service areas in the United States in that year.

(3) APPLICABILITY OF CERTAIN PROVISIONS RELATING TO DURABLE MEDICAL EQUIPMENT.—Paragraphs (12), (15), and (17) and subparagraphs (A) and (B) of paragraph (10) and paragraph (11) of subsection (a) shall apply to prosthetic devices, orthotics, and prosthetics in the same manner as such provisions apply to covered items under such subsection.

(4) DEFINITIONS.—In this subsection—

(A) the term "applicable percentage increase" means—

(i) for 1991, 0 percent;

(ii) for 1992 and 1993, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;

(iii) for 1994 and 1995, 0 percent;

(iv) for 1996 and 1997, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;

(v) for each of the years 1998 through 2000, 1 percent;

(vi) for 2001, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12–month period ending with June 2000;

(vii) for 2002, 1 percent; and

(viii) for a subsequent year, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12–month period ending with June of the previous year;

(B) the term "prosthetic devices" has the meaning given such term in section 1861(s)(8), except that such term does not include parenteral and enteral nutrition nutrients, supplies, and equipment and does not include an implantable item for which payment may be made under section 1833(t); and

(C) the term "orthotics and prosthetics" has the meaning given such term in section 1861(s)(9) (and includes shoes described in section 1861(s)(12))[173], but does not include intraocular lenses or medical supplies (including catheters, catheter supplies, ostomy bags, and supplies related to ostomy care) furnished by a home health agency under section 1861(m)(5).

(i) PAYMENT FOR SURGICAL DRESSINGS.—

(1) IN GENERAL.—Payment under this subsection for surgical dressings (described in section 1861(s)(5)) shall be made in a lump sum amount for the purchase of the item in an amount equal to 80 percent of the lesser of—

(A) the actual charge for the item; or

(B) a payment amount determined in accordance with the methodology described in subparagraphs (B) and (C) of subsection (a)(2) (except that in applying such methodology, the national limited payment amount referred to in such subparagraphs shall be initially computed based on local payment amounts using average reasonable charges for the 12-month period ending December 31, 1992, increased by the covered item updates described in such subsection for 1993 and 1994).

(2) EXCEPTIONS.—Paragraph (1) shall not apply to surgical dressings that are—

(A) furnished as an incident to a physician's professional service; or

(B) furnished by a home health agency.

(j) REQUIREMENTS FOR SUPPLIERS OF MEDICAL EQUIPMENT AND SUPPLIES.—

(1) ISSUANCE AND RENEWAL OF SUPPLIER NUMBER.—

(A) PAYMENT.—Except as provided in subparagraph (C), no payment may be made under this part after the date of the enactment of the Social Security Act Amendments of 1994 for items furnished by a supplier of medical equipment and supplies unless such supplier obtains (and renews at such intervals as the Secretary may require) a supplier number.

(B) STANDARDS FOR POSSESSING A SUPPLIER NUMBER.—A supplier may not obtain a supplier number unless—

(i) for medical equipment and supplies furnished on or after the date of the enactment of the Social Security Act Amendments of 1994 and before January 1, 1996, the supplier meets standards prescribed by the Secretary in regulations issued on June 18, 1992; and

(ii) for medical equipment and supplies furnished on or after January 1, 1996, the supplier meets revised standards prescribed by the Secretary (in consultation

[173] P.L. 108–173, §627(b)(1), inserted "(and includes shoes described in section 1861(s)(12))", applicable to items furnished on or after January 1, 2005.

with representatives of suppliers of medical equipment and supplies, carriers, and consumers) that shall include requirements that the supplier—

(I) comply with all applicable State and Federal licensure and regulatory requirements;

(II) maintain a physical facility on appropriate site;

(III) have proof of appropriate liability insurance; and

(IV) meet such other requirements as the Secretary may specify.

(C) EXCEPTION FOR ITEMS FURNISHED AS INCIDENT TO A PHYSICIAN'S SERVICE.—Subparagraph (A) shall not apply with respect to medical equipment and supplies furnished incident to a physician's service.

(D) PROHIBITION AGAINST MULTIPLE SUPPLIER NUMBERS.—The Secretary may not issue more than one supplier number to any supplier of medical equipment and supplies unless the issuance of more than one number is appropriate to identify subsidiary or regional entities under the supplier's ownership or control.

(E) PROHIBITION AGAINST DELEGATION OF SUPPLIER DETERMINATIONS.—The Secretary may not delegate (other than by contract under section 1842) the responsibility to determine whether suppliers meet the standards necessary to obtain a supplier number.

(2) CERTIFICATES OF MEDICAL NECESSITY.—

(A) LIMITATION ON INFORMATION PROVIDED BY SUPPLIERS ON CERTIFICATES OF MEDICAL NECESSITY.—

(i) IN GENERAL.—Effective 60 days after the date of the enactment of the Social Security Act Amendments of 1994, a supplier of medical equipment and supplies may distribute to physicians, or to individuals entitled to benefits under this part, a certificate of medical necessity for commercial purposes which contains no more than the following information completed by the supplier:

(I) An identification of the supplier and the beneficiary to whom such medical equipment and supplies are furnished.

(II) A description of such medical equipment and supplies.

(III) Any product code identifying such medical equipment and supplies.

(IV) Any other administrative information (other than information relating to the beneficiary's medical condition) identified by the Secretary.

(ii) INFORMATION ON PAYMENT AMOUNT AND CHARGES.—If a supplier distributes a certificate of medical necessity containing any of the information permitted to be supplied under clause (i), the supplier shall also list on the certificate of medical necessity the fee schedule amount and the supplier's charge for the medical equipment or supplies being furnished

prior to distribution of such certificate to the physician.

(iii) PENALTY.—Any supplier of medical equipment and supplies who knowingly and willfully distributes a certificate of medical necessity in violation of clause (i) or fails to provide the information required under clause (ii) is subject to a civil money penalty in an amount not to exceed $1,000 for each such certificate of medical necessity so distributed. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under this subparagraph in the same manner as they apply to a penalty or proceeding under section 1128A(a).

(B) DEFINITION.—For purposes of this paragraph, the term "certificate of medical necessity" means a form or other document containing information required by the carrier to be submitted to show that an item is reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

(3) COVERAGE AND REVIEW CRITERIA.—The Secretary shall annually review the coverage and utilization of items of medical equipment and supplies to determine whether such items should be made subject to coverage and utilization review criteria, and if appropriate, shall develop and apply such criteria to such items.

(4) LIMITATION ON PATIENT LIABILITY.—If a supplier of medical equipment and supplies (as defined in paragraph (5))—

(A) furnishes an item or service to a beneficiary for which no payment may be made by reason of paragraph (1);

(B) furnishes an item or service to a beneficiary for which payment is denied in advance under subsection (a)(15); or

(C) furnishes an item or service to a beneficiary for which payment is denied under section 1862(a)(1);

any expenses incurred for items and services furnished to an individual by such a supplier not on an assigned basis shall be the responsibility of such supplier. The individual shall have no financial responsibility for such expenses and the supplier shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts collected from the individual for such items or services. The provisions of subsection (a)(18) shall apply to refunds required under the previous sentence in the same manner as such provisions apply to refunds under such subsection.

(5) DEFINITION.—The term "medical equipment and supplies" means—

(A) durable medical equipment (as defined in section 1861(n));

(B) prosthetic devices (as described in section 1861(s)(8));

(C) orthotics and prosthetics (as described in section 1861(s)(9));

(D) surgical dressings (as described in section 1861(s)(5));

(E) such other items as the Secretary may determine; and

(F) for purposes of paragraphs (1) and (3)—

(i) home dialysis supplies and equipment (as described in section 1861(s)(2)(F)),

(ii) immunosuppressive drugs (as described in section 1861(s)(2)(J)),

(iii) therapeutic shoes for diabetics (as described in section 1861(s)(12)),

(iv) oral drugs prescribed for use as an anticancer therapeutic agent (as described in section 1861(s)(2)(Q)), and

(v) self-administered erythropoetin (as described in section 1861(s)(2)(P)).

(k) PAYMENT FOR OUTPATIENT THERAPY SERVICES AND COMPREHENSIVE OUTPATIENT REHABILITATION SERVICES.—

(1) IN GENERAL.—With respect to services described in section 1833(a)(8) or 1833(a)(9) for which payment is determined under this subsection, the payment basis shall be—

(A) for services furnished during 1998, the amount determined under paragraph (2); or

(B) for services furnished during a subsequent year, 80 percent of the lesser of—

(i) the actual charge for the services, or

(ii) the applicable fee schedule amount (as defined in paragraph (3)) for the services.

(2) PAYMENT IN 1998 BASED UPON ADJUSTED REASONABLE COSTS.—The amount under this paragraph for services is the lesser of—

(A) the charges imposed for the services, or

(B) the adjusted reasonable costs (as defined in paragraph (4)) for the services, less 20 percent of the amount of the charges imposed for such services.

(3) APPLICABLE FEE SCHEDULE AMOUNT.—In this subsection, the term "applicable fee schedule amount" means, with respect to services furnished in a year, the amount determined under the fee schedule established under section 1848 for such services furnished during the year or, if there is no such fee schedule established for such services, the amount determined under the fee schedule established for such comparable services as the Secretary specifies.

(4) ADJUSTED REASONABLE COSTS.—In paragraph (2), the term "adjusted reasonable costs" means, with respect to any services, reasonable costs determined for such services, reduced by 10 percent. The 10–percent reduction shall not apply to services described in section 1833(a)(8)(B) (relating to services provided by hospitals).

(5) UNIFORM CODING.—For claims for services submitted on or after April 1, 1998, for which the amount of payment is determined under this subsection, the claim shall include a code (or codes) under a uniform coding system specified by the Secretary that identifies the services furnished.

(6) RESTRAINT ON BILLING.—The provisions of subparagraphs (A) and (B) of section 1842(b)(18) shall apply to therapy services for which payment is made under this subsection in the

same manner as they apply to services provided by a practitioner described in section 1842(b)(18)(C).

(l)[174] ESTABLISHMENT OF FEE SCHEDULE FOR AMBULANCE SERVICES.—

(1) IN GENERAL.—The Secretary shall establish a fee schedule for payment for ambulance services whether provided directly by a supplier or provider or under arrangement with a provider under this part through a negotiated rulemaking process described in title 5, United States Code, and in accordance with the requirements of this subsection.

(2) CONSIDERATIONS.—In establishing such fee schedule, the Secretary shall—

(A) establish mechanisms to control increases in expenditures for ambulance services under this part;

(B) establish definitions for ambulance services which link payments to the type of services provided;

(C) consider appropriate regional and operational differences;

(D) consider adjustments to payment rates to account for inflation and other relevant factors; and

(E) phase in the application of the payment rates under the fee schedule in an efficient and fair manner consistent with paragraph (11)[175], except that such phase–in shall provide for full payment of any national mileage rate for ambulance services provided by suppliers that are paid by carriers in any of the 50 States where payment by a carrier for such services for all such suppliers in such State did not, prior to the implementation of the fee schedule, include a separate amount for all mileage within the county from which the beneficiary is transported.

(3) SAVINGS.—In establishing such fee schedule, the Secretary shall—

(A) ensure that the aggregate amount of payments made for ambulance services under this part during 2000 does not exceed the aggregate amount of payments which would have been made for such services under this part during such year if the amendments made by section 4531(a) of the Balanced Budget Act of 1997 continued in effect, except that in making such determination the Secretary shall assume an update in such payments for 2002 equal to percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12–month period ending with June of the previous year reduced in the case of 2002 by 1.0 percentage points; and

(B) set the payment amounts provided under the fee schedule for services furnished in 2001 and each subsequent year at amounts equal to the payment amounts under the fee schedule for services furnished during the previous year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12–month period ending with June of the

[174] See Vol. II, P.L. 108-173, §414(e) and (f), with respect to implementation of §414 amendments and GAO report on cost and access.

[175] P.L. 108–173, §414(a)(1), inserted "consistent with paragraph (11)", effective December 8, 2003; P.L. 100-173, §414(c)(2), provides that "In order to promptly implement section 1834(l)(12) of the Social Security Act, as added by paragraph (1), the Secretary may use data furnished by the Comptroller General of the United States."

previous year reduced in the case of 2002 by 1.0 percentage points.

(4) CONSULTATION.—In establishing the fee schedule for ambulance services under this subsection, the Secretary shall consult with various national organizations representing individuals and entities who furnish and regulate ambulance services and share with such organizations relevant data in establishing such schedule.

(5) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869 or otherwise of the amounts established under the fee schedule for ambulance services under this subsection, including matters described in paragraph (2).

(6) RESTRAINT ON BILLING.—The provisions of subparagraphs (A) and (B) of section 1842(b)(18) shall apply to ambulance services for which payment is made under this subsection in the same manner as they apply to services provided by a practitioner described in section 1842(b)(18)(C).

(7) CODING SYSTEM.—The Secretary may require the claim for any services for which the amount of payment is determined under this subsection to include a code (or codes) under a uniform coding system specified by the Secretary that identifies the services furnished.

(8) SERVICES FURNISHED BY CRITICAL ACCESS HOSPITALS.—Notwithstanding any other provision of this subsection, the Secretary shall pay the reasonable costs incurred in furnishing ambulance services if such services are furnished—

(A) by a critical access hospital (as defined in section 1861(mm)(1)), or

(B) by an entity that is owned and operated by a critical access hospital, but only if the critical access hospital or entity is the only provider or supplier of ambulance services that is located within a 35–mile drive of such critical access hospital.

(9)[176] TRANSITIONAL ASSISTANCE FOR RURAL PROVIDERS.—In the case of ground ambulance services furnished on or after July 1, 2001, and before January 1, 2004, for which the transportation originates in a rural area (as defined in section 1886(d)(2)(D)) or in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)), the fee schedule established under this subsection shall provide that, with respect to the payment rate for mileage for a trip above 17 miles, and up to 50 miles, the rate otherwise established shall be increased by not less than ½ of the additional payment per mile established for the first 17 miles of such a trip originating in a rural area.

(10)[177] PHASE-IN PROVIDING FLOOR USING BLEND OF FEE SCHEDULE AND REGIONAL FEE SCHEDULES.—In carrying out the phase-in under paragraph (2)(E) for each level of ground service furnished in a year, the portion of the payment amount that is based on the fee schedule shall be the greater of the

[176] P.L. 108–173, §414(a)(2), redesignated this former paragraph (8) as paragraph (9).
[177] P.L. 108–173, §414(a)(3), added paragraph (10), effective December 8, 2003.

amount determined under such fee schedule (without regard to this paragraph) or the following blended rate of the fee schedule under paragraph (1) and of a regional fee schedule for the region involved:

(A) For 2004 (for services furnished on or after July 1, 2004), the blended rate shall be based 20 percent on the fee schedule under paragraph (1) and 80 percent on the regional fee schedule.

(B) For 2005, the blended rate shall be based 40 percent on the fee schedule under paragraph (1) and 60 percent on the regional fee schedule.

(C) For 2006, the blended rate shall be based 60 percent on the fee schedule under paragraph (1) and 40 percent on the regional fee schedule.

(D) For 2007, 2008, and 2009, the blended rate shall be based 80 percent on the fee schedule under paragraph (1) and 20 percent on the regional fee schedule.

(E) For 2010 and each succeeding year, the blended rate shall be based 100 percent on the fee schedule under paragraph (1).

For purposes of this paragraph, the Secretary shall establish a regional fee schedule for each of the nine census divisions (referred to in section 1886(d)(2)) using the methodology (used in establishing the fee schedule under paragraph (1)) to calculate a regional conversion factor and a regional mileage payment rate and using the same payment adjustments and the same relative value units as used in the fee schedule under such paragraph.

(11)[178] ADJUSTMENT IN PAYMENT FOR CERTAIN LONG TRIPS.—In the case of ground ambulance services furnished on or after July 1, 2004, and before January 1, 2009, regardless of where the transportation originates, the fee schedule established under this subsection shall provide that, with respect to the payment rate for mileage for a trip above 50 miles the per mile rate otherwise established shall be increased by ¼ of the payment per mile otherwise applicable to miles in excess of 50 miles in such trip.

(12)[179] ASSISTANCE FOR RURAL PROVIDERS FURNISHING SERVICES IN LOW POPULATION DENSITY AREAS.—

(A) IN GENERAL.—In the case of ground ambulance services furnished on or after July 1, 2004, and before January 1, 2010, for which the transportation originates in a qualified rural area (identified under subparagraph (B)(iii)), the Secretary shall provide for a percent increase in the base rate of the fee schedule for a trip established under this subsection. In establishing such percent increase, the Secretary shall estimate the average cost per trip for such services (not taking into account mileage) in the lowest quartile as compared to the average cost per trip for such services (not taking into account mileage) in the highest quartile of all rural county populations.

(B) IDENTIFICATION OF QUALIFIED RURAL AREAS.—

[178] P.L. 108–173, §414(b), added paragraph (11), effective December 8, 2003.
[179] P.L. 108–173, §414(c)(1), added paragraph (12), effective December 8, 2003.

(i) DETERMINATION OF POPULATION DENSITY IN AREA.—Based upon data from the United States decennial census for the year 2000, the Secretary shall determine, for each rural area, the population density for that area.

(ii) RANKING OF AREAS.—The Secretary shall rank each such area based on such population density.

(iii) IDENTIFICATION OF QUALIFIED RURAL AREAS.—The Secretary shall identify those areas (in subparagraph (A) referred to as "qualified rural areas") with the lowest population densities that represent, if each such area were weighted by the population of such area (as used in computing such population densities), an aggregate total of 25 percent of the total of the population of all such areas.

(iv) RURAL AREA.—For purposes of this paragraph, the term "rural area" has the meaning given such term in section 1886(d)(2)(D). If feasible, the Secretary shall treat a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725) as a rural area for purposes of this paragraph.

(v) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting the identification of an area under this subparagraph.

(13)[180] TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.

(A) IN GENERAL.—After computing the rates with respect to ground ambulance services under the other applicable provisions of this subsection, in the case of such services furnished on or after July 1, 2004, and before January 1, 2007, for which the transportation originates in—

(i) a rural area described in paragraph (9) or in a rural census tract described in such paragraph, the fee schedule established under this section shall provide that the rate for the service otherwise established, after the application of any increase under paragraphs (11) and (12), shall be increased by 2 percent; and

(ii) an area not described in clause (i), the fee schedule established under this subsection shall provide that the rate for the service otherwise established, after the application of any increase under paragraph (11), shall be increased by 1 percent.

(B) APPLICATION OF INCREASED PAYMENTS AFTER 2006.—The increased payments under subparagraph (A) shall not be taken into account in calculating payments for services furnished after the period specified in such subparagraph.

(14)[181] PROVIDING APPROPRIATE COVERAGE OF RURAL AIR AMBULANCE SERVICES.—

[180] P.L. 108–173, §414(d), added paragraph (13), effective December 8, 2003.

[181] P.L. 108–173, §415(a), added paragraph (14), applicable to services furnished on or after January 1, 2005, effective December 8, 2003.

(A) IN GENERAL.—The regulations described in section 1861(s)(7) shall provide, to the extent that any ambulance services (whether ground or air) may be covered under such section, that a rural air ambulance service (as defined in subparagraph (C)) is reimbursed under this subsection at the air ambulance rate if the air ambulance service—

(i) is reasonable and necessary based on the health condition of the individual being transported at or immediately prior to the time of the transport; and

(ii) complies with equipment and crew requirements established by the Secretary.

(B) SATISFACTION OF REQUIREMENT OF MEDICALLY NECESSARY.—The requirement of subparagraph (A)(i) is deemed to be met for a rural air ambulance service if—

(i) subject to subparagraph (D), such service is requested by a physician or other qualified medical personnel (as specified by the Secretary) who reasonably determines or certifies that the individual's condition is such that the time needed to transport the individual by land or the instability of transportation by land poses a threat to the individual's survival or seriously endangers the individual's health; or

(ii) such service is furnished pursuant to a protocol that is established by a State or regional emergency medical service (EMS) agency and recognized or approved by the Secretary under which the use of an air ambulance is recommended, if such agency does not have an ownership interest in the entity furnishing such service.

(C) RURAL AIR AMBULANCE SERVICE DEFINED.—For purposes of this paragraph, the term "rural air ambulance service" means fixed wing and rotary wing air ambulance service in which the point of pick up of the individual occurs in a rural area (as defined in section 1886(d)(2)(D)) or in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).

(D) LIMITATION.—

(i) IN GENERAL.—Subparagraph (B)(i) shall not apply if there is a financial or employment relationship between the person requesting the rural air ambulance service and the entity furnishing the ambulance service, or an entity under common ownership with the entity furnishing the air ambulance service, or a financial relationship between an immediate family member of such requester and such an entity.

(ii) EXCEPTION.—Where a hospital and the entity furnishing rural air ambulance services are under common ownership, clause (i) shall not apply to remuneration (through employment or other relationship) by the hospital of the requester or immediate family member if the remuneration is for provider-based physician services furnished in a hospital (as described in section 1887) which are reimbursed under part A and the amount of the remuneration is unrelated directly

or indirectly to the provision of rural air ambulance services.

(m) PAYMENT FOR TELEHEALTH SERVICES.—

(1) IN GENERAL.—The Secretary shall pay for telehealth services that are furnished via a telecommunications system by a physician (as defined in section 1861(r)) or a practitioner (described in section 1842(b)(18)(C)) to an eligible telehealth individual enrolled under this part notwithstanding that the individual physician or practitioner providing the telehealth service is not at the same location as the beneficiary. For purposes of the preceding sentence, in the case of any Federal telemedicine demonstration program conducted in Alaska or Hawaii, the term "telecommunications system" includes store–and–forward technologies that provide for the asynchronous transmission of health care information in single or multimedia formats.

(2) PAYMENT AMOUNT.—

(A) DISTANT SITE.—The Secretary shall pay to a physician or practitioner located at a distant site that furnishes a telehealth service to an eligible telehealth individual an amount equal to the amount that such physician or practitioner would have been paid under this title had such service been furnished without the use of a telecommunications system.

(B) FACILITY FEE FOR ORIGINATING SITE.—With respect to a telehealth service, subject to section 1833(a)(1)(U), there shall be paid to the originating site a facility fee equal to—

(i) for the period beginning on October 1, 2001, and ending on December 31, 2001, and for 2002, $20; and

(ii) for a subsequent year, the facility fee specified in clause (i) or this clause for the preceding year increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) for such subsequent year.

(C) TELEPRESENTER NOT REQUIRED.—Nothing in this subsection shall be construed as requiring an eligible telehealth individual to be presented by a physician or practitioner at the originating site for the furnishing of a service via a telecommunications system, unless it is medically necessary (as determined by the physician or practitioner at the distant site).

(3) LIMITATION ON BENEFICIARY CHARGES.—

(A) PHYSICIAN AND PRACTITIONER.—The provisions of section 1848(g) and subparagraphs (A) and (B) of section 1842(b)(18) shall apply to a physician or practitioner receiving payment under this subsection in the same manner as they apply to physicians or practitioners under such sections.

(B) ORIGINATING SITE.—The provisions of section 1842(b)(18) shall apply to originating sites receiving a facility fee in the same manner as they apply to practitioners under such section.

(4) DEFINITIONS.—For purposes of this subsection:

(A) DISTANT SITE.—The term "distant site" means the site at which the physician or practitioner is located at the time the service is provided via a telecommunications system.

(B) ELIGIBLE TELEHEALTH INDIVIDUAL.—The term "eligible telehealth individual" means an individual enrolled under this part who receives a telehealth service furnished at an originating site.

(C) ORIGINATING SITE.—

(i) IN GENERAL.—The term "originating site" means only those sites described in clause (ii) at which the eligible telehealth individual is located at the time the service is furnished via a telecommunications system and only if such site is located—

(I) in an area that is designated as a rural health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A));

(II) in a county that is not included in a Metropolitan Statistical Area; or

(III) from an entity that participates in a Federal telemedicine demonstration project that has been approved by (or receives funding from) the Secretary of Health and Human Services as of December 31, 2000.

(ii) SITES DESCRIBED.—The sites referred to in clause (i) are the following sites:

(I) The office of a physician or practitioner.

(II) A critical access hospital (as defined in section 1861(mm)(1)).

(III) A rural health clinic (as defined in section 1861(aa)(2)[182]).

(IV) A Federally qualified health center (as defined in section 1861(aa)(4)).

(V) A hospital (as defined in section 1861(e)).

(D) PHYSICIAN.—The term "physician" has the meaning given that term in section 1861(r).

(E) PRACTITIONER.—The term "practitioner" has the meaning given that term in section 1842(b)(18)(C).

(F) TELEHEALTH SERVICE.—

(i) IN GENERAL.—The term "telehealth service" means professional consultations, office visits, and office psychiatry services (identified as of July 1, 2000, by HCPCS codes 99241–99275, 99201–99215, 90804–90809, and 90862 (and as subsequently modified by the Secretary)), and any additional service specified by the Secretary.

(ii) YEARLY UPDATE.—The Secretary shall establish a process that provides, on an annual basis, for the addition or deletion of services (and HCPCS codes), as appropriate, to those specified in clause (i) for authorized payment under paragraph (1).

[182] P.L. 108–173, §736(b)(5), struck out "1861(aa)(s)" and substituted "1861(aa)(2)".

PROCEDURE FOR PAYMENT OF CLAIMS OF PROVIDERS OF SERVICES [183]

SEC. 1835. [42 U.S.C. 1395n] (a) Except as provided in subsections (b), (c), and (e), payment for services described in section 1832(a)(2) furnished an individual may be made only to providers of services which are eligible therefor under section 1866(a), and only if—

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that, where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year; and

(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations) that—

(A) in the case of home health services (i) such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needs or needed skilled nursing care (other than solely venipuncture for the purpose of obtaining a blood sample) on an intermittent basis or physical or speech therapy or, in the case of an individual who has been furnished home health services based on such a need and who no longer has such a need for such care or therapy, continues or continued to need occupational therapy, (ii) a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;

(B) in the case of medical and other health services, except services described in subparagraphs (B), (C), and (D) of section 1861(s)(2), such services are or were medically required;

(C) in the case of outpatient physical therapy services or outpatient occupational therapy services, (i) such services are or were required because the individual needed physical therapy services or occupational therapy services, respectively, (ii) a plan for furnishing such services has been established by a physician or by the qualified physical therapist or qualified occupational therapist, respectively, providing such services and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;

[183] See Vol. II, P.L. 108-173, §647, with respect to a MEDPAC study on direct access to physical therapy services.

(D) in the case of outpatient speech pathology services, (i) such services are or were required because the individual needed speech pathology services, (ii) a plan for furnishing such services has been established by a physician or by the speech pathologist providing such services and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;

(E) in the case of comprehensive outpatient rehabilitation facility services, (i) such services are or were required because the individual needed skilled rehabilitation services, (ii) a plan for furnishing such services has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician; and

(F) in the case of partial hospitalization services, (i) the individual would require inpatient psychiatric care in the absence of such services, (ii) an individualized, written plan for furnishing such services has been established by a physician and is reviewed periodically by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician.

For purposes of this section, the term "provider of services" shall include a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A) (or meets the requirements of such section through the operation of section 1861(g)), or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B) (or meets the requirements of such section through the operation of section 1861(g)), but only with respect to the furnishing of outpatient physical therapy services (as therein defined) or (through the operation of section 1861(g)) with respect to the furnishing of outpatient occupational therapy services.

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician makes a certification of the kind provided in subparagraph (A) or (B) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than July 1, 1981, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan, except that such prohibition shall not apply with respect to a home health agency which is a sole community home health agency (as determined by the Secretary). For purposes of the preceding sentence, service by a physician as an uncompensated officer or director of a home health agency shall not constitute having a significant ownership interest in,

or a significant financial or contractual relationship with, such agency. For purposes of paragraph (2)(A), an individual shall be considered to be "confined to his home" if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered "confined to his home", the condition of the individual should be such that there exists a normal inability to leave home and [184] that leaving home requires a considerable and taxing effort by the individual. Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day–care program that is licensed or certified by a State, or accredited, to furnish adult day–care services in the State shall not disqualify an individual from being considered to be "confined to his home". Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration.

(b)(1) Payment may also be made to any hospital for services described in section 1861(s) furnished as an outpatient service by a hospital or by others under arrangements made by it to an individual entitled to benefits under this part even though such hospital does not have an agreement in effect under this title if (A) such services were emergency services, (B) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder, and (C) such hospital has made an election pursuant to section 1814(d)(1)(C) with respect to the calendar year in which such emergency services are provided. Such payments shall be made only in the amounts provided under section 1833(a)(2) and then only if such hospital agrees to comply, with respect to the emergency services provided, with the provisions of section 1866(a).

(2) Payment may also be made on the basis of an itemized bill to an individual for services described in paragraph (1) of this subsection if (A) payment cannot be made under such paragraph (1) solely because the hospital does not elect, in accordance with section 1814(d)(1)(C), to claim such payments and (B) such individual files application (submitted within such time and in such form and manner, and containing and supported by such information as the Secretary shall by regulations prescribe) for reimbursement. The amounts payable under this paragraph shall, subject to the provisions of section 1833, be equal to 80 percent of the hospital's reasonable charges for such services.

(c) Notwithstanding the provisions of this section and sections 1832, 1833, and 1866(a)(1)(A), a hospital or a critical access hospital may, subject to such limitations as may be prescribed by regulations, collect from an individual the customary charges for services specified in section 1861(s) and furnished to him by such hos-

[184] P.L. 108–173, §736(c)(2)(B), struck out "leave home," and substituted "leave home and".

pital as an outpatient, but only if such charges for such services do not exceed the applicable supplementary medical insurance deductible, and such customary charges shall be regarded as expenses incurred by such individual with respect to which benefits are payable in accordance with section 1833(a)(1). Payments under this title to hospitals which have elected to make collections from individuals in accordance with the preceding sentence shall be adjusted periodically to place the hospital in the same position it would have been had it instead been reimbursed in accordance with section 1833(a)(2) (or, in the case of a critical access hospital, in accordance with section 1833(a)(6)).

(d) Subject to section 1880, no payment may be made under this part to any Federal provider of services or other Federal agency, except a provider of services which the Secretary determines is providing services to the public generally as a community institution or agency; and no such payment may be made to any provider of services or other person for any item or service which such provider or person is obligated by a law of, or a contract with, the United States to render at public expense.

(e) For purposes of services (1) which are inpatient hospital services by reason of paragraph (7) of section 1861(b) or for which entitlement exists by reason of clause (II) of section 1832(a)(2)(B)(i), and (2) for which the reasonable cost thereof is determined under section 1861(v)(1)(D) (or would be if section 1886 did not apply), payment under this part shall be made to such fund as may be designated by the organized medical staff of the hospital in which such services were furnished or, if such services were furnished in such hospital by the faculty of a medical school, to such fund as may be designated by such faculty, but only if—

(A) such hospital has an agreement with the Secretary under section 1866, and

(B) the Secretary has received written assurances that (i) such payment will be used by such fund solely for the improvement of care to patients in such hospital or for educational or charitable purposes and (ii) the individuals who were furnished such services or any other persons will not be charged for such services (or if charged provision will be made for return of any moneys incorrectly collected).

ELIGIBLE INDIVIDUALS

SEC. 1836. [42 U.S.C. 1395o] Every individual who—

(1) is entitled to hospital insurance benefits under part A, or

(2) has attained age 65 and is a resident of the United States, and is either (A) a citizen or (B) an alien lawfully admitted for permanent residence who has resided in the United States continuously during the 5 years immediately preceding the month in which he applies for enrollment under this part,

is eligible to enroll in the insurance program established by this part.

ENROLLMENT PERIODS [185]

SEC. 1837. [42 U.S.C. 1395p] (a) An individual may enroll in the insurance program established by this part only in such manner and form as may be prescribed by regulations, and only during an enrollment period prescribed in or under this section.

(b) [Repealed. [186]]

(c) In the case of individuals who first satisfy paragraph (1) or (2) of section 1836 before March 1, 1966, the initial general enrollment period shall begin on the first day of the second month [187] which begins after the date of enactment of this title [188] and shall end on May 31, 1966. For purposes of this subsection and subsection (d), an individual who has attained age 65 and who satisfies paragraph (1) of section 1836 but not paragraph (2) of such section shall be treated as satisfying such paragraph (1) on the first day on which he is (or on filing application would have been) entitled to hospital insurance benefits under part A.

(d) In the case of an individual who first satisfies paragraph (1) or (2) of section 1836 on or after March 1, 1966, his initial enrollment period shall begin on the first day of the third month before the month in which he first satisfies such paragraphs and shall end seven months later. Where the Secretary finds that an individual who has attained age 65 failed to enroll under this part during his initial enrollment period (based on a determination by the Secretary of the month in which such individual attained age 65), because such individual (relying on documentary evidence) was mistaken as to his correct date of birth, the Secretary shall establish for such individual an initial enrollment period based on his attaining age 65 at the time shown in such documentary evidence (with a coverage period determined under section 1838 as though he had attained such age at that time).

(e) There shall be a general enrollment period during the period beginning on January 1 and ending on March 31 of each year.

(f) Any individual—

(1) who is eligible under section 1836 to enroll in the medical insurance program by reason of entitlement to hospital insurance benefits as described in paragraph (1) of such section, and

(2) whose initial enrollment period under subsection (d) begins after March 31, 1973, and

(3) who is residing in the United States, exclusive of Puerto Rico,

shall be deemed to have enrolled in the medical insurance program established by this part.

(g) All of the provisions of this section shall apply to individuals satisfying subsection (f), except that—

(1) in the case of an individual who satisfies subsection (f) by reason of entitlement to disability insurance benefits described in section 226(b), his initial enrollment period shall begin on the first day of the later of (A) April 1973 or (B) the third month before the 25th month of such entitlement, and

[185] See Vol. II, P.L. 108-173, §625(b), with respect to a Medicare Part B special enrollment period.

[186] P.L. 96–499, §945(a); 94 Stat. 2642.

[187] September 1, 1965.

[188] July 30, 1965, is the date of enactment of P.L. 89–97 (79 Stat. 286) which added title XVIII to the Act.

shall reoccur with each continuous period of eligibility (as defined in section 1839(d)) and upon attainment of age 65;

(2)(A) in the case of an individual who is entitled to monthly benefits under section 202 or 223 on the first day of his initial enrollment period or becomes entitled to monthly benefits under section 202 during the first 3 months of such period, his enrollment shall be deemed to have occurred in the third month of his initial enrollment period, and

(B) in the case of an individual who is not entitled to benefits under section 202 on the first day of his initial enrollment period and does not become so entitled during the first 3 months of such period, his enrollment shall be deemed to have occurred in the month in which he files the application establishing his entitlement to hospital insurance benefits provided such filing occurs during the last 4 months of his initial enrollment period; and

(3) in the case of an individual who would otherwise satisfy subsection (f) but does not establish his entitlement to hospital insurance benefits until after the last day of his initial enrollment period (as defined in subsection (d) of this section), his enrollment shall be deemed to have occurred on the first day of the earlier of the then current or immediately succeeding general enrollment period (as defined in subsection (e) of this section).

(h) In any case where the Secretary finds that an individual's enrollment or nonenrollment in the insurance program established by this part or part A pursuant to section 1818 is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Federal Government, or its instrumentalities, the Secretary may take such action (including the designation for such individual of a special initial or subsequent enrollment period, with a coverage period determined on the basis thereof and with appropriate adjustments of premiums) as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.

(i)(1) In the case of an individual who—

(A) at the time the individual first satisfies paragraph (1) or (2) of section 1836, is enrolled in a group health plan described in section 1862(b)(1)(A)(v) by reason of the individual's (or the individual's spouse's) current employment status, and

(B) has elected not to enroll (or to be deemed enrolled) under this section during the individual's initial enrollment period,

there shall be a special enrollment period described in paragraph (3). In the case of an individual not described in the previous sentence who has not attained the age of 65, at the time the individual first satisfies paragraph (1) of section 1836, is enrolled in a large group health plan (as that term is defined in section 1862(b)(1)(B)(iii)) by reason of the individual's current employment status (or the current employment status of a family member of the individual) active individual (as those terms are defined in section 1862(b)(1)(B)(iii)), and has elected not to enroll (or to be deemed enrolled) under this section during the individual's initial enrollment period, there shall be a special enrollment period described in paragraph (3)(B).

(2) In the case of an individual who—

(A)(i) has enrolled (or has been deemed to have enrolled) in the medical insurance program established under this part during the individual's initial enrollment period, or (ii) is an individual described in paragraph (1)(A);

(B) has enrolled in such program during any subsequent special enrollment period under this subsection during which the individual was not enrolled in a group health plan described in section 1862(b)(1)(A)(v) by reason of the individual's (or individual's spouse's) current employment status; and

(C) has not terminated enrollment under this section at any time at which the individual is not enrolled in such a group health plan by reason of the individual's (or individual's spouse's) current employment status,

there shall be a special enrollment period described in paragraph (3). In the case of an individual not described in the previous sentence who has not attained the age of 65, has enrolled (or has been deemed to have enrolled) in the medical insurance program established under this part during the individual's initial enrollment period, or is an individual described in the second sentence of paragraph (1), has enrolled in such program during any subsequent special enrollment period under this subsection during which the individual was not enrolled in a large group health plan (as that term is defined in section 1862(b)(1)(B)(iii)) by reason of the individual's current employment status (or the current employment status of a family member of the individual), and has not terminated enrollment under this section at any time at which the individual is not enrolled in such a large group health plan by reason of the individual's current employment status (or the current employment status of a family member of the individual), there shall be a special enrollment period described in paragraph (3)(B).

(3)(A) The special enrollment period referred to in the first sentences of paragraphs (1) and (2) is the period including each month during any part of which the individual is enrolled" status in a group health plan described in section 1862(b)(1)(A)(v) by reason of current employment ending with the last day of the eighth consecutive month in which the individual is at no time so enrolled.

(B) The special enrollment period referred to in the second sentences of paragraphs (1) and (2) is the period including each month during any part of which the individual is enrolled in a large group health plan (as that term is defined in section 1862(b)(1)(B)(iii)) by reason of the individual's current employment status (or the current employment status of a family member of the individual ending with the last day of the eighth consecutive month in which the individual is at no time so enrolled.

(4)(A) In the case of an individual who is entitled to benefits under part A pursuant to section 226(b) and—

(i) who at the time the individual first satisfies paragraph (1) of section 1836—

(I) is enrolled in a group health plan described in section 1862(b)(1)(A)(v) by reason of the individual's current or former employment or by reason of the current or former employment status of a member of the individual's family, and

(II) has elected not to enroll (or to be deemed enrolled) under this section during the individual's initial enrollment period; and

(ii) whose continuous enrollment under such group health plan is involuntarily terminated at a time when the enrollment under the plan is not by reason of the individual's current employment or by reason of the current employment of a member of the individual's family,

there shall be a special enrollment period described in subparagraph (B).

(B) The special enrollment period referred to in subparagraph (A) is the 6–month period beginning on the first day of the month which includes the date of the enrollment termination described in subparagraph (A)(ii).

(j) In applying this section in the case of an individual who is entitled to benefits under part A pursuant to the operation of section 226(h), the following special rules apply:

(1) The initial enrollment period under subsection (d) shall begin on the first day of the first month in which the individual satisfies the requirement of section 1836(1).

(2) In applying subsection (g)(1), the initial enrollment period shall begin on the first day of the first month of entitlement to disability insurance benefits referred to in such subsection.

COVERAGE PERIOD

SEC. 1838. [42 U.S.C. 1395q] (a) The period during which an individual is entitled to benefits under the insurance program established by this part (hereinafter referred to as his "coverage period") shall begin on whichever of the following is the latest:

(1) July 1, 1966,[189] or (in the case of a disabled individual who has not attained age 65) July 1, 1973; or

(2)(A) in the case of an individual who enrolls pursuant to subsection (d) of section 1837 before the month in which he first satisfies paragraph (1) or (2) of section 1836, the first day of such month, or

(B) in the case of an individual who enrolls pursuant to such subsection (d) in the month in which he first satisfies such paragraph, the first day of the month following the month in which he so enrolls, or

(C) in the case of an individual who enrolls pursuant to such subsection (d) in the month following the month in which he first satisfies such paragraph, the first day of the second month following the month in which he so enrolls, or

(D) in the case of an individual who enrolls pursuant to such subsection (d) more than one month following the month in which he satisfies such paragraph, the first day of the third month following the month in which he so enrolls, or

(E) in the case of an individual who enrolls pursuant to subsection (e) of section 1837, the July 1 following the month in which he so enrolls; or

(3)(A) in the case of an individual who is deemed to have enrolled on or before the last day of the third month of his initial enrollment period, the first day of the month in which he first meets the applicable requirements of section 1836 or July 1, 1973, whichever is later, or

[189] P.L. 108–173, §736(b)(6), inserted a comma.

(B) in the case of an individual who is deemed to have enrolled on or after the first day of the fourth month of his initial enrollment period, as prescribed under subparagraphs (B), (C), (D), and (E) of paragraph (2) of this subsection.

(b) An individual's coverage period shall continue until his enrollment has been terminated—

(1) by the filing of notice that the individual no longer wishes to participate in the insurance program established by this part, or

(2) for nonpayment of premiums.

The termination of a coverage period under paragraph (1) shall (except as otherwise provided in section 1843(e)) take effect at the close of the month following the month in which the notice is filed. The termination of a coverage period under paragraph (2) shall take effect on a date determined under regulations, which may be determined so as to provide a grace period in which overdue premiums may be paid and coverage continued. The grace period determined under the preceding sentence shall not exceed 90 days; except that it may be extended to not to exceed 180 days in any case where the Secretary determines that there was good cause for failure to pay the overdue premiums within such 90-day period.

Where an individual who is deemed to have enrolled for medical insurance pursuant to section 1837(f) files a notice before the first day of the month in which his coverage period begins advising that he does not wish to be so enrolled, the termination of the coverage period resulting from such deemed enrollment shall take effect with the first day of the month the coverage would have been effective. Where an individual who is deemed enrolled for medical insurance benefits pursuant to section 1837(f) files a notice requesting termination of his deemed coverage in or after the month in which such coverage becomes effective, the termination of such coverage shall take effect at the close of the month following the month in which the notice is filed.

(c) In the case of an individual satisfying paragraph (1) of section 1836 whose entitlement to hospital insurance benefits under part A is based on a disability rather than on his having attained the age of 65, his coverage period (and his enrollment under this part) shall be terminated as of the close of the last month for which he is entitled to hospital insurance benefits.

(d) No payments may be made under this part with respect to the expenses of an individual unless such expenses were incurred by such individual during a period which, with respect to him, is a coverage period.

(e) Notwithstanding subsection (a), in the case of an individual who enrolls during a special enrollment period pursuant to section 1837(i)(3) or 1837(i)(4)(B)—

(1) in any month of the special enrollment period in which the individual is at any time enrolled in a plan (specified in subparagraph (A) or (B), as applicable, of section 1837(i)(3) or specified in section 1837(i)(4)(A)(i)) or in the first month following such a month, the coverage period shall begin on the first day of the month in which the individual so enrolls (or, at the option of the individual, on the first day of any of the following three months), or

(2) in any other month of the special enrollment period, the coverage period shall begin on the first day of the month following the month in which the individual so enrolls.

AMOUNTS OF PREMIUMS

SEC. 1839. [42 U.S.C. 1395r] (a)(1) The Secretary shall, during September of 1983 and of each year thereafter, determine the monthly actuarial rate for enrollees age 65 and over which shall be applicable for the succeeding calendar year. Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such calendar year with respect to those enrollees age 65 and older will equal one-half of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services performed and related administrative costs incurred in such calendar year with respect to such enrollees. In calculating the monthly actuarial rate, the Secretary shall include an appropriate amount for a contingency margin.

(2) The monthly premium of each individual enrolled under this part for each month after December 1983 shall, except as provided in subsections (b), (c), (f), and (i)[190], be the amount determined under paragraph (3).

(3) The Secretary, during September of each year, shall determine and promulgate a monthly premium rate for the succeeding calendar year that (except as provided in subsection (g)) is equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1), for that succeeding calendar year.

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

(4) The Secretary shall also, during September of 1983 and of each year thereafter, determine the monthly actuarial rate for disabled enrollees under age 65 which shall be applicable for the succeeding calendar year. Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such calendar year with respect to disabled enrollees under age 65 will[191] equal one-half of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services performed and related administrative costs incurred in such calendar year with respect to such enrollees. In calculating the monthly actuarial rate under this paragraph, the Secretary shall include an appropriate amount for a contingency margin.

(b) In the case of an individual whose coverage period began pursuant to an enrollment after his initial enrollment period (determined pursuant to subsection (c) or (d) of section 1837) and not pursuant to a special enrollment period under section 1837(i)(4), the monthly premium determined under subsection (a) (without re-

[190] P.L. 108–173, §811(b)(1)(A), struck out "and (f)" and substituted "(f), and (i)".
[191] P.L. 108–173, §736(b)(7), struck out "which will" and substituted "will".

gard to any adjustment under subsection (i))[192] shall be increased by 10 percent of the monthly premium so determined for each full 12 months (in the same continuous period of eligibility) in which he could have been but was not enrolled. For purposes of the preceding sentence, there shall be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual who reenrolls) (2) the months which elapsed between the date of termination of a previous coverage period and the close of the enrollment period in which he reenrolled, but there shall not be taken into account months for which the individual can demonstrate that the individual was enrolled in a group health plan described in section 1862(b)(1)(A)(v) by reason of the individual's (or the individual's spouse's) current employment status or months during which the individual has not attained the age of 65 and for which the individual can demonstrate that the individual was enrolled in a large group health plan (as that term is defined in section 1862(b)(1)(B)(iii)) by reason of the individual's current employment status (or the current employment status of a family member of the individual). Any increase in an individual's monthly premium under the first sentence of this subsection with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which such individual may have. No increase in the premium shall be effected for a month in the case of an individual who enrolls under this part during 2001, 2002, 2003, or 2004 and who demonstrates to the Secretary before December 31, 2004, that the individual is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code). The Secretary of Health and Human Services shall consult with the Secretary of Defense in identifying individuals described in the previous sentence.[193]

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

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

(e) (1) Upon the request of a State (or any appropriate State or local governmental entity specified by the Secretary), the Secretary may enter into an agreement with the State (or such entity) under which the State (or such entity) agrees to pay on a quarterly or other periodic basis to the Secretary (to be deposited in the Treasury to the credit of the Federal Supplementary Medical Insurance Trust Fund) an amount equal to the amount of the part B late en-

[192] P.L. 108–173, §811(b)(1)(B), inserted "(without regard to any adjustment under subsection (i))", effective December 8, 2003.

[193] P.L. 108–173, §625(a)(1), added this last sentence to subsection (c), applicable to premiums for months beginning with January 2004.

rollment premium increases with respect to the premiums for eligible individuals (as defined in paragraph (3)(A)).

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

(3) In this subsection:

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

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

(f) For any calendar year after 1988, if an individual is entitled to monthly benefits under section 202 or 223 or to a monthly annuity under section 3(a), 4(a), or 4(f) of the Railroad Retirement Act of 1974 [194] for November and December of the preceding year, if [195] the monthly premium of the individual under this section for December and for January is deducted from those benefits under section 1840(a)(1) or section 1840(b)(1), and if the amount of the individual's premium is not adjusted for such January under subsection (i), [196] the monthly premium otherwise determined under this section for an individual for that year shall not be increased, pursuant to this subsection, to the extent that such increase would reduce the amount of benefits payable to that individual for that December below the amount of benefits payable to that individual for that November (after the deduction of the premium under this section). For purposes of this subsection, retroactive adjustments or payments and deductions on account of work shall not be taken into account in determining the monthly benefits to which an individual is entitled under section 202 or 223 or under the Railroad Retirement Act of 1974.

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

(1) the application of section [197] 1861(v)(1)(L)(viii) or to the establishment under section 1861(v)(1)(L)(i)(V) of a per visit limit at 106 percent of the median (instead of 105 percent of the median), but only to the extent payment for home health services under this title is not being made under section 1895 (relating to prospective payment for home health services); and [198]

(2) [199] the medicare prescription drug discount card and transitional assistance program under section 1860D-31.

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[194] See Vol. II, P.L. 75-162.

[195] P.L. 108–173, §811(b)(1)(C)(i), struck out "and if" and substituted "if".

[196] P.L. 108–173, §811(b)(1)(C)(ii), inserted "and if the amount of the individual's premium is not adjusted for such January under subsection (i),".

[197] P.L. 108–173, §105(a)(1), struck out "attributable to the application of section" and substituted "attributable to—

(1) the application of section", effective December 8, 2003.

[198] P.L. 108–173, §105(a)(2), struck out the period and substituted "; and".

[199] P.L. 108–173, §105(a)(3), added paragraph (2), effective December 8, 2003.

(h)[200] POTENTIAL APPLICATION OF COMPARATIVE COST ADJUSTMENT IN CCA AREAS.—

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

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

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

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

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

(i)[201] REDUCTION IN PREMIUM SUBSIDY BASED ON INCOME.—

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

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

(A) except as provided in subparagraph (B), $80,000, and

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

(3) MONTHLY ADJUSTMENT AMOUNT.—

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

(i) SLIDING SCALE PERCENTAGE.—The applicable percentage specified in the table in subparagraph (C) for the individual minus 25 percentage points.

(ii) UNSUBSIDIZED PART B PREMIUM AMOUNT.—200 percent of the monthly actuarial rate for enrollees age 65 and over (as determined under subsection (a)(1) for the year).

(B) 5-YEAR PHASE IN.—The monthly adjustment amount specified in this paragraph for an individual for a month in a year before 2011 is equal to the following percentage

[200] P.L. 108–173, §241(b)(2)(A), added subsection (h), effective December 8, 2003.
[201] P.L. 108–173, §811(a), added subsection (i), effective December 8, 2003.

of the monthly adjustment amount specified in subparagraph (A):

(i) For 2007, 20 percent.

(ii) For 2008, 40 percent.

(iii) For 2009, 60 percent.

(iv) for 2010, 80 percent.

(C) APPLICABLE PERCENTAGE.—

(i) IN GENERAL.—

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

(ii) JOINT RETURNS.—In the case of a joint return, clause (i) shall be applied by substituting dollar amounts which are twice the dollar amounts otherwise applicable under clause (i) for the calendar year.

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

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

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

(4) MODIFIED ADJUSTED GROSS INCOME.—

(A) IN GENERAL.—For purposes of this subsection, the term "modified adjusted gross income" means adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986)—

(i) determined without regard to sections 135, 911, 931, and 933 of such Code; and

(ii) increased by the amount of interest received or accrued during the taxable year which is exempt from tax under such Code. In the case of an individual filing a joint return, any reference in this subsection to the modified adjusted gross income of such individual shall be to such return's modified adjusted gross income.

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

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

(ii) TEMPORARY USE OF OTHER DATA.—If, as of October 15 before a calendar year, the Secretary of the Treasury does not have adequate data for an individ-

ual in appropriate electronic form for the taxable year referred to in clause (i), the individual's modified adjusted gross income shall be determined using the data in such form from the previous taxable year. Except as provided in regulations prescribed by the Commissioner of Social Security in consultation with the Secretary, the preceding sentence shall cease to apply when adequate data in appropriate electronic form are available for the individual for the taxable year referred to in clause (i), and proper adjustments shall be made to the extent that the premium adjustments determined under the preceding sentence were inconsistent with those determined using such taxable year.

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

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

(II) proper adjustments in the case of the application of an applicable percentage under subclause (I) to such individual which is inconsistent with such individual's modified adjusted gross income for such taxable year.

(C) USE OF MORE RECENT TAXABLE YEAR.—

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

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

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

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

(I) the individual furnishes to such Commissioner with respect to such year such documentation, such as a copy of a filed Federal

income tax return or an equivalent document, as the Commissioner specifies for purposes of determining the premium adjustment (if any) under this subsection; and

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

(5) INFLATION ADJUSTMENT.—

(A) IN GENERAL.—In the case of any calendar year beginning after 2007, each dollar amount in paragraph (2) or (3) shall be increased by an amount equal to—

(i) such dollar amount, multiplied by

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

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

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

PAYMENT OF PREMIUMS

SEC. 1840. [42 U.S.C. 1395s] (a)(1) In the case of an individual who is entitled to monthly benefits under section 202 or 223, his monthly premiums under this part shall (except as provided in subsections (b)(1) and (c)) be collected by deducting the amount thereof from the amount of such monthly benefits. Such deduction shall be made in such manner and at such times as the Commissioner of Social Security shall by regulation prescribe. Such regulations shall be prescribed after consultation with the Secretary.

(2) The Secretary of the Treasury shall, from time to time, transfer from the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund to the Federal Supplementary Medical Insurance Trust Fund the aggregate amount deducted under paragraph (1) for the period to which such transfer relates from benefits under section 202 or 223 which are payable from such Trust Fund. Such transfer shall be made on the basis of a certification by the Commissioner of Social Security and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

(b)(1) In the case of an individual who is entitled to receive for a month an annuity under the Railroad Retirement Act of 1974 [202] (whether or not such individual is also entitled for such month to a monthly insurance benefit under section 202), his monthly pre-

[202] P.L. 75–162 [as amended by P.L. 93–445].

miums under this part shall (except as provided in subsection (c)) be collected by deducting the amount thereof from such annuity or pension. Such deduction shall be made in such manner and at such times as the Secretary shall by regulations prescribe. Such regulations shall be prescribed only after consultation with the Railroad Retirement Board.

(2) The Secretary of the Treasury shall, from time to time, transfer from the Railroad Retirement Account to the Federal Supplementary Medical Insurance Trust Fund the aggregate amount deducted under paragraph (1) for the period to which such transfer relates. Such transfers shall be made on the basis of a certification by the Railroad Retirement Board and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

(c) If an individual to whom subsection (a) or (b) applies estimates that the amount which will be available for deduction under such subsection for any premium payment period will be less than the amount of the monthly premiums for such period, he may (under regulations) pay to the Secretary such portion of the monthly premiums for such period as he desires.

(d)(1) In the case of an individual receiving an annuity under subchapter III of chapter 83 of title 5, United States Code, or any other law administered by the Director of the Office of Personnel Management providing retirement or survivorship protection, to whom neither subsection (a) nor subsection (b) applies, his monthly premiums under this part (and the monthly premiums of the spouse of such individual under this part if neither subsection (a) nor subsection (b) applies to such spouse and if such individual agrees) shall, upon notice from the Secretary of Health and Human Services to the Director of the Office of Personnel Management, be collected by deducting the amount thereof from each installment of such annuity. Such deduction shall be made in such manner and at such times as the Director of the Office of Personnel Management may determine. The Director of the Office of Personnel Management shall furnish such information as the Secretary of Health and Human Services may reasonably request in order to carry out his functions under this part with respect to individuals to whom this subsection applies. A plan described in section 8903 or 8903a of title 5, United States Code, may reimburse each annuitant enrolled in such plan an amount equal to the premiums paid by him under this part if such reimbursement is paid entirely from funds of such plan which are derived from sources other than the contributions described in section 8906 of such title.

(2) The Secretary of the Treasury shall, from time to time, but not less often than quarterly, transfer from the Civil Service Retirement and Disability Fund, or the account (if any) applicable in the case of such other law administered by the Director of the Office of Personnel Management, to the Federal Supplementary Medical Insurance Trust Fund the aggregate amount deducted under paragraph (1) for the period to which such transfer relates. Such transfer shall be made on the basis of a certification by the Director of the Office of Personnel Management and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

(e) In the case of an individual who participates in the insurance program established by this part but with respect to whom none of the preceding provisions of this section applies, or with respect

to whom subsection (c) applies, the premiums shall be paid to the Secretary at such times, and in such manner, as the Secretary shall by regulations prescribe.

(f) Amounts paid to the Secretary under subsection (c) or (e) shall be deposited in the Treasury to the credit of the Federal Supplementary Medical Insurance Trust Fund.

(g) In the case of an individual who participates in the insurance program established by this part, premiums shall be payable for the period commencing with the first month of his coverage period and ending with the month in which he dies or, if earlier, in which his coverage under such

(h) In the case of an individual who is enrolled under the program established by this part as a member of a coverage group to which an agreement with a State entered into pursuant to section 1843 is applicable, subsections (a), (b), (c), and (d) of this section shall not apply to his monthly premium for any month in his coverage period which is determined under section 1843(d).

(i) In the case of an individual enrolled in a Medicare+Choice plan, the Secretary shall provide for necessary adjustments of the monthly beneficiary premium to reflect 80 percent of any reduction elected under section 1854(f)(1)(E) and to reflect any credit provided under section 1854(b)(1)(C)(iv)[203]. To the extent to which the Secretary determines that such an adjustment is appropriate, with the concurrence of any agency responsible for the administration of such benefits, such premium adjustment may be provided directly, as an adjustment to any social security, railroad retirement, or civil service retirement benefits, or, in the case of an individual who receives medical assistance under title XIX for medicare costs described in section 1905(p)(3)(A)(ii), as an adjustment to the amount otherwise owed by the State for such medical assistance.

FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

SEC. 1841. [42 U.S.C. 1395t] (a) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Supplementary Medical Insurance Trust Fund" (hereinafter in this section referred to as the "Trust Fund"). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1),[204] such amounts as may be deposited in, or appropriated to, such fund as provided in this part, and such amounts as may be deposited in, or appropriated to, the Medicare Prescription Drug Account established by section 1860D-16[205] or the Transitional Assistance Account established by section 1860D-31(k)(1)[206].

(b) With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this section referred to as the "Board of Trustees") composed of the Commissioner of Social Security, Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, all ex officio, and of two members of the public

[203] P.L. 108–173, §222(l)(2)(B), inserted "and to reflect any credit provided under section 1854(b)(1)(C)(iv)" effective December 8, 2003.

[204] P.L. 108–173, §101(e)(3)(C)(i)(I), struck out "and".

[205] P.L. 108–173, §101(e)(3)(C)(i)(II), inserted ", and such amounts as may be deposited in, or appropriated to, the Medicare Prescription Drug Account established by section 1860D-16", effective December 8, 2003.

[206] P.L. 108–173, §105(d)(1), inserted "or the Transitional Assistance Account established by section 1860D-31(k)(1)", effective December 8, 2003.

(both of whom may not be from the same political party), who shall be nominated by the President for a term of four years and subject to confirmation by the Senate. A member of the Board of Trustees serving as a member of the public and nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term. An individual nominated and confirmed as a member of the public may serve in such position after the expiration of such member's term until the earlier of the time at which the member's successor takes office or the time at which a report of the Board is first issued under paragraph (2) after the expiration of the member's term. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (hereinafter in this section referred to as the "Managing Trustee"). The Administrator of the Centers for Medicare and Medicaid Services[207] shall serve as the Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

(1) Hold the Trust Fund;

(2) Report to the Congress not later than the first day of April of each year on the operation and status of the Trust Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years; Each report provided under paragraph (2) beginning with the report in 2005 shall include the information specified in section 801(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.[208]

(3) Report immediately to the Congress whenever the Board is of the opinion that the amount of the Trust Fund is unduly small; and

(4) Review the general policies followed in managing the Trust Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the Trust Fund is to be managed.

The report provided for in paragraph (2) shall include a statement of the assets of, and the disbursements made from, the Trust Fund during the preceding fiscal year, an estimate of the expected income to, and disbursements to be made from, the Trust Fund during the current fiscal year and each of the next 2 fiscal years, and a statement of the actuarial status of the Trust Fund. Such report shall also include an actuarial opinion by the Chief Actuary[209] of the Centers for Medicare and Medicaid Services[210] certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable. Such report shall be printed as a House document of the session of the Congress to which the report is made. A person serving on the Board of Trustees shall not be considered to be a fiduciary and shall not be personally liable for actions taken in such capacity with respect to the Trust Fund.

(c) It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund as is not, in his judgment, required to

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[207] P.L. 108–173, §900(e)(1)(E)(i), struck out "Health Care Financing Administration" and substituted "Centers for Medicare and Medicaid Services".

[208] P.L. 108–173, §801(d)(2), added this last sentence to subparagraph (2).

[209] P.L. 108–173, §900(e)(1)(E)(ii), struck out "Chief Actuarial Officer" and substituted "Chief Actuary".

[210] P.L. 108–173, §900(e)(1)(E)(i), struck out "Health Care Financing Administration" and substituted "Centers for Medicare and Medicaid Services".

meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired (1) on original issue at the issue price, or (2) by purchase of outstanding obligations at the market price. The purposes for which obligations of the United States may be issued under chapter 31 of title 31, United States Code, are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Fund. Such obligations issued for purchase by the Trust Fund shall have maturities fixed with due regard for the needs of the Trust Fund and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such calendar month; except that where such average market yield is not a multiple of one-eighth of 1 per centum, the rate of interest on such obligations shall be the multiple of one-eighth of 1 per centum nearest such market yield. The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where he determines that the purchase of such other obligations is in the public interest.

(d) Any obligations acquired by the Trust Fund (except public-debt obligations issued exclusively to the Trust Fund) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

(e) The interest on, and the proceeds from the sale or redemption of, any obligations held in the Trust Fund shall be credited to and form a part of the Trust Fund.

(f) There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Federal Old-Age and Survivors Insurance Trust Fund and from the Federal Disability Insurance Trust Fund amounts equivalent to the amounts not previously so transferred which the Secretary of Health and Human Services shall have certified as overpayments (other than amounts so certified to the Railroad Retirement Board) pursuant to section 1870(b) of this Act. There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Railroad Retirement Account amounts equivalent to the amounts not previously so transferred which the Secretary of Health and Human Services shall have certified as overpayments to the Railroad Retirement Board pursuant to section 1870(b) of this Act.

(g) The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Secretary of Health and Human Services certifies are necessary to make the payments provided for by this part, and the payments with respect to administrative expenses in accordance with section 201(g)(1). The payments provided for under part D, other than under section 1860D-31(k)(2), shall be made from the Medicare Prescription Drug Account in the Trust

Fund.[211] The payments provided for under section 1860D-31(k)(2) shall be made from the Transitional Assistance Account in the Trust Fund.[212]

(h) The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Secretary of Health and Human Services certifies are necessary to pay the costs incurred by the Director of the Office of Personnel Management in making deductions pursuant to section 1840(d) or pursuant to section 1860D-13(c)(1) or 1854(d)(2)(A) (in which case payments shall be made in appropriate part from the Medicare Prescription Drug Account in the Trust Fund)[213]. During each fiscal year, or after the close of such fiscal year, the Director of the Office of Personnel Management shall certify to the Secretary the amount of the costs the Director incurred in making such deductions, and such certified amount shall be the basis for the amount of such costs certified by the Secretary to the Managing Trustee.

(i) The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Secretary of Health and Human Services certifies are necessary to pay the costs incurred by the Railroad Retirement Board for services performed pursuant to section 1840(b)(1) and section 1842(g) or pursuant to section 1860D-13(c)(1) or 1854(d)(2)(A) (in which case payments shall be made in appropriate part from the Medicare Prescription Drug Account in the Trust Fund)[214]. During each fiscal year or after the close of such fiscal year, the Railroad Retirement Board shall certify to the Secretary the amount of the costs it incurred in performing such services and such certified amount shall be the basis for the amount of such costs certified by the Secretary to the Managing Trustee.

USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS[215]

SEC. 1842. [42 U.S.C. 1395u] (a) In order to provide for the administration of the benefits under this part with maximum efficiency and convenience for individuals entitled to benefits under this part and for providers of services and other persons furnishing services to such individuals, and with a view to furthering coordination of the administration of the benefits under part A of this subchapter and under this part, the Secretary is authorized to enter into contracts with carriers, including carriers with which agreements under section 1816 are in effect, which will perform some or all of the following functions (or, to the extent provided in such contracts, will secure performance thereof by other organizations); and, with respect to any of the following functions which in-

[211] P.L. 108–173, §101(e)(3)(C)(ii), added this second sentence to subsection (g).

[212] P.L. 108–173, §105(d)(2), added this last sentence to subsection (g).

[213] P.L. 108–173, §101(e)(3)(C)(iii), inserted "or pursuant to section 1860D-13(c)(1) or 1854(d)(2)(A) (in which case payments shall be made in appropriate part from the Medicare Prescription Drug Account in the Trust Fund)".

[214] P.L. 108–173, §101(e)(3)(C)(iv), inserted "and pursuant to sections 1860D-13(c)(1) and 1854(d)(2)(A) (in which case payments shall be made in appropriate part from the Medicare Prescription Drug Account in the Trust Fund)".

[215] See Vol. II, P. L. 103–66, §13515(b), with respect to budget neutrality adjustment.

See Vol. II, P.L. 108-173, §303(f), with respect to linkage of verified drug payments and increases for drug administration; §303(h), with respect to the continuation of payment methodology for radio pharmaceuticals; §303(i)(5), with respect to implementation of certain regulations; and §303(j), with respect to the application of some specific amendments to certain physician specialties; §304, with respect to the extension of application of payment reform for covered outpatient drugs and biologicals to other physician specialties; §731(c), with respect to the issuance of temporary national codes.

volve payments for physicians' services on a reasonable charge basis, the Secretary shall to the extent possible enter into such contracts:

(1)(A) make determinations of the rates and amounts of payments required pursuant to this part to be made to providers of services and other persons on a reasonable cost or reasonable charge basis (as may be applicable);

(B) receive, disburse, and account for funds in making such payments; and

(C) make such audits of the records of providers of services as may be necessary to assure that proper payments are made under this part;

(2)(A) determine compliance with the requirements of section 1861(k) of this title as to utilization review; and

(B) assist providers of services and other persons who furnish services for which payment may be made under this part in the development of procedures relating to utilization practices, make studies of the effectiveness of such procedures and methods for their improvement, assist in the application of safeguards against unnecessary utilization of services furnished by providers of services and other persons to individuals entitled to benefits under this part, and provide procedures for and assist in arranging, where necessary, the establishment of groups outside hospitals (meeting the requirements of section 1861(k)(2)) to make reviews of utilization;

(3) serve as a channel of communication of information relating to the administration of this part; and

(4) otherwise assist, in such manner as the contract may provide, in discharging administrative duties necessary to carry out the purposes of this part.[216]

(b)(1) Contracts with carriers under subsection (a) of this section may be entered into without regard to section 5 of title 41 or any other provision of law requiring competitive bidding.

(2)(A) No such contract shall be entered into with any carrier unless the Secretary finds that such carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent. The Secretary shall publish in the Federal Register standards and criteria for the efficient and effective performance of contract obligations under this section, and opportunity shall be provided for public comment prior to implementation. In establishing such standards and criteria, the Secretary shall provide a system to measure a carrier's performance of responsibilities described in paragraph (3)(H), subsection (h) of this section, and section 1845(e)(2). The Secretary may not require, as a condition of entering into or renewing a contract under this section or under section 1871, that a carrier match data obtained other than in its activities under this part with data used in the administration of this part for purposes of identifying situations in which section 1862(b) may apply.

(B) The Secretary shall establish standards for evaluating carriers' performance of reviews of initial carrier deter-

[216] See Vol. II, P. L. 99–177, §256, as amended by P.L. 100-119, with respect to special rules applicable to the Medicare program.

minations and of fair hearings under paragraph (3)(C), under which a carrier is expected—

(i) to complete such reviews, within 45 days after the date of a request by an individual enrolled under this part for such a review, in 95 percent of such requests, and

(ii) to make a final determination, within 120 days after the date of receipt of a request by an individual enrolled under this part for a fair hearing under paragraph (3)(C), in 90 percent of such cases.

(C) In the case of residents of nursing facilities who receive services described in clause (i) or (ii) of section 1861(s)(2)(K) performed by a member of a team, the Secretary shall instruct carriers to develop mechanisms which permit routine payment under this part for up to 1.5 visits per month per resident. In the previous sentence, the term "team" refers to a physician and includes a physician assistant acting under the supervision of the physician or a nurse practitioner working in collaboration with that physician, or both.

(D) In addition to any other standards and criteria established by the Secretary for evaluating carrier performance under this paragraph relating to avoiding erroneous payments, the carrier shall be subject to standards and criteria relating to the carrier's success in recovering payments made under this part for items or services for which payment has been or could be made under a primary plan (as defined in section 1862(b)(2)(A)).

(E) With respect to the payment of claims for home health services under this part that, but for the amendments made by section 4611 of the Balanced Budget Act of 1997, would be payable under part A of this subchapter instead of under this part, the Secretary shall continue administration of such claims through fiscal intermediaries under section 1816.

(3) Each such contract shall provide that the carrier—

(A) will take such action as may be necessary to assure that, where payment under this part for a service is on a cost basis, the cost is reasonable cost (as determined under section 1861(v));

(B) will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carriers, and such payment will (except as otherwise provided in section 1870(f)) be made—

(i) on the basis of an itemized bill; or

(ii) on the basis of an assignment under the terms of which (I) the reasonable charge is the full charge for the service, (II) the physician or other person furnishing such service agrees not to charge (and to refund amounts already collected) for services for which payment under this title is denied under section 1154(a)(2) by reason of a determination under section 1154(a)(1)(B), and (III) the physician or other person

furnishing such service agrees not to charge (and to refund amounts already collected) for such service if payment may not be made therefor by reason of the provisions of paragraph (1) of section 1862(a), and if the individual to whom such service was furnished was without fault in incurring the expenses of such service, and if the Secretary's determination that payment (pursuant to such assignment) was incorrect and was made subsequent to the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title (except in the case of physicians' services and ambulance service furnished as described in section 1862(a)(4), other than for purposes of section 1870(f));

but (in the case of bills submitted, or requests for payment made, after March 1968) only if the bill is submitted, or a written request for payment is made in such other form as may be permitted under regulations, no later than the close of the calendar year following the year in which such service is furnished (deeming any service furnished in the last 3 months of any calendar year to have been furnished in the succeeding calendar year);

(C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is at least $100, but less than $500, when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy;

(D) will furnish to the Secretary such timely information and reports as he may find necessary in performing his functions under this part;

(E) will maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (D) and otherwise to carry out the purposes of this part;

(F) will take such action as may be necessary to assure that where payment under this part for a service rendered is on a charge basis, such payment shall be determined on the basis of the charge that is determined in accordance with this section on the basis of customary and prevailing charge levels in effect at the time the service was rendered or, in the case of services rendered more than 12 months before the year in which the bill is submitted or request for payment is made, on the basis of such levels in effect for the 12-month period preceding such year;

(G) will, for a service that is furnished with respect to an individual enrolled under this part, that is not paid on an assignment-related basis, and that is subject to a limiting charge under section 1848(g)—

(i) determine, prior to making payment, whether the amount billed for such service exceeds the limiting charge applicable under section 1848(g)(2);

(ii) notify the physician, supplier, or other person periodically (but not less often than once every 30 days) of determinations that amounts billed exceeded such applicable limiting charges; and

(iii) provide for prompt response to inquiries of physicians, suppliers, and other persons concerning the accuracy of such limiting charges for their services;

(H) if it makes determinations or payments with respect to physicians' services, will implement—

(i) programs to recruit and retain physicians as participating physicians in the area served by the carrier, including educational and outreach activities and the use of professional relations personnel to handle billing and other problems relating to payment of claims of participating physicians; and

(ii) programs to familiarize beneficiaries with the participating physician program and to assist such beneficiaries in locating participating physicians;

(I) will submit annual reports to the Secretary describing the steps taken to recover payments made under this part for items or services for which payment has been or could be made under a primary plan (as defined in section 1862(b)(2)(A)); and

(J) [Repealed.[217]]

(K) [Repealed.[218]]

(L) will monitor and profile physicians' billing patterns within each area or locality and provide comparative data to physicians whose utilization patterns vary significantly from other physicians in the same payment area or locality;

and shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary or appropriate. In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services. No charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (ii) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the 12–month period ending on the June 30 last preceding the start of the calendar year in which the service is rendered. In the case of physicians' services the prevailing charge level determined for purposes of clause (ii) of the preceding sentence for any twelve–month period (beginning after June 30,

[217] P.L. 101–234, §201(a)(1); 103 Stat. 1981.
[218] P.L. 101–234, §201(a)(1); 103 Stat. 1981.

1973) specified in clause (ii) of such sentence may not exceed (in the aggregate) the level determined under such clause for the fiscal year ending June 30, 1973, or (with respect to physicians' services furnished in a year after 1987) the level determined under this sentence (or under any other provision of law affecting the prevailing charge level) for the previous year except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such higher level is justified by year–to–year economic changes. With respect to power–operated wheelchairs for which payment may be made in accordance with section 1861(s)(6), charges determined to be reasonable may not exceed the lowest charge at which power–operated wheelchairs are available in the locality. In the case of medical services, supplies, and equipment (including equipment servicing) that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after December 31, 1972, determined to be reasonable may not exceed the lowest charge levels at which such services, supplies, and equipment are widely and consistently available in a locality except to the extent and under the circumstances specified by the Secretary. The requirement in subparagraph (B) that a bill be submitted or request for payment be made by the close of the following calendar year shall not apply if (I) failure to submit the bill or request the payment by the close of such year is due to the error or misrepresentation of an officer, employee, fiscal intermediary, carrier, or agent of the Department of Health and Human Services performing functions under this title and acting within the scope of his or its authority, and (II) the bill is submitted or the payment is requested promptly after such error or misrepresentation is eliminated or corrected. Notwithstanding the provisions of the third and fourth sentences preceding this sentence, the prevailing charge level in the case of a physician service in a particular locality determined pursuant to such third and fourth sentences for any calendar year after 1974 shall, if lower than the prevailing charge level for the fiscal year ending June 30, 1975, in the case of a similar physician service in the same locality by reason of the application of economic index data, be raised to such prevailing charge level for the fiscal year ending June 30, 1975, and shall remain at such prevailing charge level until the prevailing charge for a year (as adjusted by economic index data) equals or exceeds such prevailing charge level. The amount of any charges for outpatient services which shall be considered reasonable shall be subject to the limitations established by regulations issued by the Secretary pursuant to section 1861(v)(1)(K), and in determining the reasonable charge for such services, the Secretary may limit such reasonable charge to a percentage of the amount of the prevailing charge for similar services furnished in a physician's office, taking into account the extent to which overhead costs associated with such outpatient services have been included in the reasonable cost or charge of the facility.

(4)(A)(i) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during the 15-month period beginning July 1, 1984, the Secretary shall not set any level higher than the same level as was set for the 12-month period beginning July 1, 1983.

(ii)(I) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during the 8-month period beginning May 1, 1986, by a physician who is not a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the Secretary shall not set any level higher than the same level as was set for the 12-month period beginning July 1, 1983.

(II) In determining the prevailing charge levels under the fourth sentence of paragraph (3) for physicians' services furnished during the 8-month period beginning May 1, 1986, by a physician who is a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the Secretary shall permit an additional one percentage point increase in the increase otherwise permitted under that sentence.

(iii) In determining the maximum allowable prevailing charges which may be recognized consistent with the index described in the fourth sentence of paragraph (3) for physicians' services furnished on or after January 1, 1987, by participating physicians, the Secretary shall treat the maximum allowable prevailing charges recognized as of December 31, 1986, under such sentence with respect to participating physicians as having been justified by economic changes.

(iv) The reasonable charge for physicians' services furnished on or after January 1, 1987, and before January 1, 1992, by a nonparticipating physician shall be no greater than the applicable percent of the prevailing charge levels established under the third and fourth sentences of paragraph (3) (or under any other applicable provision of law affecting the prevailing charge level). In the previous sentence, the term "applicable percent" means for services furnished (I) on or after January 1, 1987, and before April 1, 1988, 96 percent, (II) on or after April 1, 1988, and before January 1, 1989, 95.5 percent, and (III) on or after January 1, 1989, 95 percent.

(v) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during the 3-month period beginning January 1, 1988, the Secretary shall not set any level higher than the same level as was set for the 12-month period beginning January 1, 1987.

(vi) Before each year (beginning with 1989), the Secretary shall establish a prevailing charge floor for primary care services (as defined in subsection (i)(4)) equal to 60 percent of the estimated average prevailing charge levels based on the best available data (determined, under the third and fourth sentences of paragraph (3) and under paragraph (4), without regard to this clause and without regard to physician specialty) for such service for all localities in the Unit-

ed States (weighted by the relative frequency of the service in each locality) for the year.

(vii) Beginning with 1987, the percentage increase in the MEI (as defined in subsection (i)(3)) for each year shall be the same for nonparticipating physicians as for participating physicians.

(B)(i) In determining the reasonable charge under paragraph (3) for physicians' services furnished during the 15-month period beginning July 1, 1984, the customary charges shall be the same customary charges as were recognized under this section for the 12-month period beginning July 1, 1983.

(ii) In determining the reasonable charge under paragraph (3) for physicians' services furnished during the 8-month period beginning May 1, 1986, by a physician who is not a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services—

(I) if the physician was not a participating physician at any time during the 12-month period beginning on October 1, 1984, the customary charges shall be the same customary charges as were recognized under this section for the 12-month period beginning July 1, 1983, and

(II) if the physician was a participating physician at any time during the 12-month period beginning on October 1, 1984, the physician's customary charges shall be determined based upon the physician's actual charges billed during the 12-month period ending on March 31, 1985.

(iii) In determining the reasonable charge under paragraph (3) for physicians' services furnished during the 3-month period beginning January 1, 1988, the customary charges shall be the same customary charges as were recognized under this section for the 12-month period beginning January 1, 1987.

(iv) In determining the reasonable charge under paragraph (3) for physicians' services (other than primary care services, as defined in subsection (i)(4)) furnished during 1991, the customary charges shall be the same customary charges as were recognized under this section for the 9-month period beginning April 1, 1990. In a case in which subparagraph (F) applies (relating to new physicians) so as to limit the customary charges of a physician during 1990 to a percent of prevailing charges, the previous sentence shall not prevent such limit on customary charges under such subparagraph from increasing in 1991 to a higher percent of such prevailing charges.

(C) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during periods beginning after September 30, 1985, the Secretary shall treat the level as set under subparagraph (A)(i) as having fully provided for the economic changes which would have been taken into

account but for the limitations contained in subparagraph (A)(i).

(D)(i) In determining the customary charges for physicians' services furnished during the 8-month period beginning May 1, 1986, or the 12-month period beginning January 1, 1987, by a physician who was not a participating physician (as defined in subsection (h)(1)) on September 30, 1985, the Secretary shall not recognize increases in actual charges for services furnished during the 15month period beginning on July 1, 1984, above the level of the physician's actual charges billed in the 3-month period ending on June 30, 1984.

(ii) In determining the customary charges for physicians' services furnished during the 12-month period beginning January 1, 1987, by a physician who is not a participating physician (as defined in subsection (h)(1)) on April 30, 1986, the Secretary shall not recognize increases in actual charges for services furnished during the 7-month period beginning on October 1, 1985, above the level of the physician's actual charges billed during the 3-month period ending on June 30, 1984.

(iii) In determining the customary charges for physicians' services furnished during the 12-month period beginning January 1, 1987, or January 1, 1988, by a physician who is not a participating physician (as defined in subsection (h)(1)) on December 31, 1986, the Secretary shall not recognize increases in actual charges for services furnished during the 8-month period beginning on May 1, 1986, above the level of the physician's actual charges billed during the 3-month period ending on June 30, 1984.

(iv) In determining the customary charges for a[219] physicians' service furnished on or after January 1, 1988, if a physician was a nonparticipating physician in a previous year (beginning with 1987), the Secretary shall not recognize any amount of such actual charges (for that service furnished during such previous year) that exceeds the maximum allowable actual charge for such service established under subsection (j)(1)(C).

(E)(i) For purposes of this part for physicians' services furnished in 1987, the percentage increase in the MEI is 3.2 percent.

(ii) For purposes of this part for physicians' services furnished in 1988, on or after April 1, the percentage increase in the MEI is—

(I) 3.6 percent for primary care services (as defined in subsection (i)(4)), and

(II) 1 percent for other physicians' services.

(iii) For purposes of this part for physicians' services furnished in 1989, the percentage increase in the MEI is—

(I) 3.0 percent for primary care services, and

[219] As in original.

(II) 1 percent for other physicians' services.

(iv) For purposes of this part for items and services furnished in 1990, after March 31, 1990, the percentage increase in the MEI is—

(I) 0 percent for radiology services, for anesthesia services, and for other services specified in the list referred to in paragraph (14)(C)(i),

(II) 2 percent for other services (other than primary care services), and

(III) such percentage increase in the MEI (as defined in subsection (i)(3)) as would be otherwise determined for primary care services (as defined in subsection (i)(4)).

(v) For purposes of this part for items and services furnished in 1991, the percentage increase in the MEI is—

(I) 0 percent for services (other than primary care services), and

(II) 2 percent for primary care services (as defined in subsection (i)(4)).

(5) Each contract under this section shall be for a term of at least one year, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the carrier involved as he may provide in regulations) if he finds that the carrier has failed substantially to carry out the contract or is carrying out the contract in a manner inconsistent with the efficient and effective administration of the insurance program established by this part.

(6) No payment under this part for a service provided to any individual shall (except as provided in section 1870) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) the physician or other person who provided the service, except that (A) payment may be made (i) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer, or (ii) where the service was provided under a contractual arrangement between such physician or other person and an entity, to the entity if, under the contractual arrangement, the entity submits the bill for the service and the contractual arrangement meets such program integrity and other safeguards as the Secretary may determine to be appropriate,[220] (B) payment may be made to an entity (i) which provides coverage of the services under a health benefits plan, but only to the extent that payment is not made under

[220] P.L. 108–173, §952(a), struck out "or (ii) (where the service was provided in a hospital, critical access hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service," and substituted "or (ii) where the service was provided under a contractual arrangement between such physician or other person and an entity, to the entity if, under the contractual arrangement, the entity submits the bill for the service and the contractual arrangement meets such program integrity and other safeguards as the Secretary may determine to be appropriate,", applicable to payments made on or after December 8, 2003.

this part, (ii) which has paid the person who provided the service an amount (including the amount payable under this part) which that person has accepted as payment in full for the service, and (iii) to which the individual has agreed in writing that payment may be made under this part, (C) in the case of services described in clause (i) of section 1861(s)(2)(K), payment shall be made to either (i) the employer of the physician assistant involved, or (ii) with respect to a physician assistant who was the owner of a rural health clinic (as described in section 1861(aa)(2)) for a continuous period beginning prior to the date of the enactment of the Balanced Budget Act of 1997 and ending on the date that the Secretary determines such rural health clinic no longer meets the requirements of section 1861(aa)(2), payment may be made directly to the physician assistant, (D) payment may be made to a physician for physicians' services (and services furnished incident to such services) furnished by a second physician to patients of the first physician if (i) the first physician is unavailable to provide the services; (ii) the services are furnished pursuant to an arrangement between the two physicians that (I) is informal and reciprocal, or (II) involves per diem or other fee-for-time compensation for such services; (iii) the services are not provided by the second physician over a continuous period of more than 60 days; and (iv) the claim form submitted to the carrier for such services includes the second physician's unique identifier (provided under the system established under subsection (r)) and indicates that the claim meets the requirements of this subparagraph for payment to the first physician. No payment which under the preceding sentence may be made directly to the physician or other person providing the service involved (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) shall be made to anyone else under a reassignment or power of attorney (except to an employer or entity as described in subparagraph (A)[221] of such sentence); but nothing in this subsection shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the individual to whom the service was provided or a reassignment from the physician or other person providing such service if such assignment or reassignment 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 the physician or other person providing the service 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 physician or other person under this title 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, (E) in the case of an item or service (other than services described in section 1888(e)(2)(A)(ii)) furnished by, or under arrangements made by, a skilled nursing facility to an individual who (at the time the item or service is furnished) is

[221] P.L. 108–173, §952(b), struck out "except to an employer or facility as described in clause (A)" and substituted "except to an employer or entity as described in subparagraph (A)", applicable to payments made on or after December 8, 2003.

a resident of a skilled nursing facility, payment shall be made to the facility, (F) in the case of home health services (including medical supplies described in section 1861(m)(5), but excluding durable medical equipment to the extent provided for in such section) furnished to an individual who (at the time the item or service is furnished) is under a plan of care of a home health agency, payment shall be made to the agency (without regard to whether or not the item or service was furnished by the agency, by others under arrangement with them made by the agency, or when any other contracting or consulting arrangement, or otherwise). For purposes of subparagraph (C) of the first sentence of this paragraph, an employment relationship may include any independent contractor arrangement, and employer status shall be determined in accordance with the law of the State in which the services described in such clause are performed, and (G) in the case of services in a hospital or clinic to which section 1880(e) applies, payment shall be made to such hospital or clinic.

(7)(A) In the case of physicians' services furnished to a patient in a hospital with a teaching program approved as specified in section 1861(b)(6) but which does not meet the conditions described in section 1861(b)(7), the carrier shall not provide (except on the basis described in subparagraph (C)) for payment for such services under this part—

(i) unless—

(I) the physician renders sufficient personal and identifiable physicians' services to the patient to exercise full, personal control over the management of the portion of the case for which the payment is sought,

(II) the services are of the same character as the services the physician furnishes to patients not entitled to benefits under this title, and

(III) at least 25 percent of the hospital's patients (during a representative past period, as determined by the Secretary) who were not entitled to benefits under this title and who were furnished services described in subclauses (I) and (II) paid all or a substantial part of charges (other than nominal charges) imposed for such services; and

(ii) to the extent that the payment is based upon a reasonable charge for the services in excess of the customary charge as determined in accordance with subparagraph (B).

(B) The customary charge for such services in a hospital shall be determined in accordance with regulations issued by the Secretary and taking into account the following factors:

(i) In the case of a physician who is not a teaching physician (as defined by the Secretary), the carrier shall take into account the amounts the physician charges for similar services in the physician's practice outside the teaching setting.

(ii) In the case of a teaching physician, if the hospital, its physicians, or other appropriate billing entity

has established one or more schedules of charges which are collected for medical and surgical services, the carrier shall base payment under this title on the greatest of—

(I) the charges (other than nominal charges) which are most frequently collected in full or substantial part with respect to patients who were not entitled to benefits under this title and who were furnished services described in subclauses (I) and (II) of subparagraph (A)(i),

(II) the mean of the charges (other than nominal charges) which were collected in full or substantial part with respect to such patients, or

(III) 85 percent of the prevailing charges paid for similar services in the same locality.

(iii) If all the teaching physicians in a hospital agree to have payment made for all of their physicians' services under this part furnished to patients in such hospital on an assignment-related basis, the customary charge for such services shall be equal to 90 percent of the prevailing charges paid for similar services in the same locality.

(C) In the case of physicians' services furnished to a patient in a hospital with a teaching program approved as specified in section 1861(b)(6) but which does not meet the conditions described in section 1861(b)(7), if the conditions described in subclauses (I) and (II) of subparagraph (A)(i) are met and if the physician elects payment to be determined under this subparagraph, the carrier shall provide for payment for such services under this part on the basis of regulations of the Secretary governing reimbursement for the services of hospital-based physicians (and not on any other basis).

(D)(i) In the case of physicians' services furnished to a patient in a hospital with a teaching program approved as specified in section 1861(b)(6) but which does not meet the conditions described in section 1861(b)(7), no payment shall be made under this part for services of assistants at surgery with respect to a surgical procedure if such hospital has a training program relating to the medical specialty required for such surgical procedure and a qualified individual on the staff of the hospital is available to provide such services; except that payment may be made under this part for such services, to the extent that such payment is otherwise allowed under this paragraph, if such services, as determined under regulations of the Secretary—

(I) are required due to exceptional medical circumstances,

(II) are performed by team physicians needed to perform complex medical procedures, or

(III) constitute concurrent medical care relating to a medical condition which requires the presence of, and active care by, a physician of another specialty during surgery,

and under such other circumstances as the Secretary determines by regulation to be appropriate.

(ii) For purposes of this subparagraph, the term "assistant at surgery" means a physician who actively assists the physician in charge of a case in performing a surgical procedure.

(iii) The Secretary shall determine appropriate methods of reimbursement of assistants at surgery where such services are reimbursable under this part.

(8)(A)(i) The Secretary shall by regulation—

(I) describe the factors to be used in determining the cases (of particular items or services) in which the application of this title to payment under this part (other than to physicians' services paid under section 1848) results in the determination of an amount that, because of its being grossly excessive or grossly deficient, is not inherently reasonable, and

(II) provide in those cases for the factors to be considered in determining an amount that is realistic and equitable.

(ii) Notwithstanding the determination made in clause (i), the Secretary may not apply factors that would increase or decrease the payment under this part during any year for any particular item or service by more than 15 percent from such payment during the preceding year except as provided in subparagraph (B).

(B) The Secretary may make a determination under this subparagraph that would result in an increase or decrease under subparagraph (A) of more than 15 percent of the payment amount for a year, but only if—

(i) the Secretary's determination takes into account the factors described in subparagraph (C) and any additional factors the Secretary determines appropriate,

(ii) the Secretary's determination takes into account the potential impacts described in subparagraph (D), and

(iii) the Secretary complies with the procedural requirements of paragraph (9).

(C) The factors described in this subparagraph are as follows:

(i) The programs established under this title and title XIX are the sole or primary sources of payment for an item or service.

(ii) The payment amount does not reflect changing technology, increased facility with that technology, or reductions in acquisition or production costs.

(iii) The payment amount for an item or service under this part is substantially higher or lower than the payment made for the item or service by other purchasers.

(D) The potential impacts of a determination under subparagraph (B) on quality, access, and beneficiary liability, including the likely effects on assignment rates and participation rates.

(9)(A) The Secretary shall consult with representatives of suppliers or other individuals who furnish an item or service before making a determination under paragraph (8)(B) with regard to that item or service.

(B) The Secretary shall publish notice of a proposed determination under paragraph (8)(B) in the Federal Register—

(i) specifying the payment amount proposed to be established with respect to an item or service,

(ii) explaining the factors and data that the Secretary took into account in determining the payment amount so specified, and

(iii) explaining the potential impacts described in paragraph (8)(D).

(C) After publication of the notice required by subparagraph (B), the Secretary shall allow not less than 60 days for public comment on the proposed determination.

(D)(i) Taking into consideration the comments made by the public, the Secretary shall publish in the Federal Register a final determination under paragraph (8)(B) with respect to the payment amount to be established with respect to the item or service.

(ii) A final determination published pursuant to clause (i) shall explain the factors and data that the Secretary took into consideration in making the final determination.

(10)(A)(i) In determining the reasonable charge for procedures described in subparagraph (B) and performed during the 9-month period beginning on April 1, 1988, the prevailing charge for such procedure shall be the prevailing charge otherwise recognized for such procedure for 1987—

(I) subject to clause (iii), reduced by 2.0 percent, and

(II) further reduced by the applicable percentage specified in clause (ii).

(ii) For purposes of clause (i), the applicable percentage specified in this clause is—

(I) 15 percent, in the case of a prevailing charge otherwise recognized (without regard to this paragraph and determined without regard to physician specialty) that is at least 150 percent of the weighted national average (as determined by the Secretary) of such prevailing charges for such procedure for all localities in the United States for 1987;

(II) 0 percent, in the case of a prevailing charge that does not exceed 85 percent of such weighted national average; and

(III) in the case of any other prevailing charge, a percent determined on the basis of a straight-line sliding scale, equal to 3/13 of a percentage point for each percent by which the prevailing charge exceeds 85 percent of such weighted national average.

(iii) In no case shall the reduction under clause (i) for a procedure result in a prevailing charge in a local-

ity for 1988 which is less than 85 percent of the Secretary's estimate of the weighted national average of such prevailing charges for such procedure for all localities in the United States for 1987 (based upon the best available data and determined without regard to physician specialty) after making the reduction described in clause (i)(I).

(B) The procedures described in this subparagraph are as follows: bronchoscopy, carpal tunnel repair, cataract surgery (including subsequent insertion of an intraocular lens), coronary artery bypass surgery, diagnostic and/or therapeutic dilation and curettage, knee arthroscopy, knee arthroplasty, pacemaker implantation surgery, total hip replacement, suprapubic prostatectomy, transurethral resection of the prostate, and upper gastrointestinal endoscopy.

(C) In the case of a reduction in the reasonable charge for a physicians' service under subparagraph (A), if a nonparticipating physician furnishes the service to an individual entitled to benefits under this part, after the effective date of such reduction, the physician's actual charge is subject to a limit under subsection (j)(1)(D).

(D) There shall be no administrative or judicial review under section 1869 or otherwise of any determination under subparagraph (A) or under paragraph (11)(B)(ii).

(11)(A) In providing payment for cataract eyeglasses and cataract contact lenses, and professional services relating to them, under this part, each carrier shall—

(i) provide for separate determinations of the payment amount for the eyeglasses and lenses and of the payment amount for the professional services of a physician (as defined in section 1861(r)), and

(ii) not recognize as reasonable for such eyeglasses and lenses more than such amount as the Secretary establishes in guidelines relating to the inherent reasonableness of charges for such eyeglasses and lenses.

(B)(i) In determining the reasonable charge under paragraph (3) for a cataract surgical procedure, subject to clause (ii), the prevailing charge for such procedure otherwise recognized for participating and nonparticipating physicians shall be reduced by 10 percent with respect to procedures performed in 1987.

(ii) In no case shall the reduction under clause (i) for a surgical procedure result in a prevailing charge in a locality for a year which is less than 75 percent of the weighted national average of such prevailing charges for such procedure for all the localities in the United States for 1986.

(C)(i) The prevailing charge level determined with respect to A-mode ophthalmic ultrasound procedures may not exceed 5 percent of the prevailing charge level established with respect to extracapsular cataract removal with lens insertion.

(ii) The reasonable charge for an intraocular lens inserted during or subsequent to cataract surgery in a physician's office may not exceed the actual acquisi-

tion cost for the lens (taking into account any discount) plus a handling fee (not to exceed 5 percent of such actual acquisition cost).

(D) In the case of a reduction in the reasonable charge for a physicians' service or item under subparagraph (B) or (C), if a nonparticipating physician furnishes the service or item to an individual entitled to benefits under this part after the effective date of such reduction, the physician's actual charge is subject to a limit under subsection (j)(1)(D).

(12) [Repealed.[222]]

(13)(A) In determining payments under section 1833(l) and section 1848 for anesthesia services furnished on or after January 1, 1994, the methodology for determining the base and time units used shall be the same for services furnished by physicians, for medical direction by physicians of two, three, or four certified registered nurse anesthetists, or for services furnished by a certified registered nurse anesthetist (whether or not medically directed) and shall be based on the methodology in effect, for anesthesia services furnished by physicians, as of the date of the enactment of the Omnibus Budget Reconciliation Act of 1993[223].

(B) The Secretary shall require claims for physicians' services for medical direction of nurse anesthetists during the periods in which the provisions of subparagraph (A) apply to indicate the number of such anesthetists being medically directed concurrently at any time during the procedure, the name of each nurse anesthetist being directed, and the type of procedure for which the services are provided.

(14)(A)(i) In determining the reasonable charge for a physicians' service specified in subparagraph (C)(i) and furnished during the 9-month period beginning on April 1, 1990, the prevailing charge for such service shall be the prevailing charge otherwise recognized for such service for 1989 reduced by 15 percent or, if less, ⅓ of the percent (if any) by which the prevailing charge otherwise applied in the locality in 1989 exceeds the locally-adjusted reduced prevailing amount (as determined under subparagraph (B)(i)) for the service.

(ii) In determining the reasonable charge for a physicians' service specified in subparagraph (C)(i) and furnished during 1991, the prevailing charge for such service shall be the prevailing charge otherwise recognized for such service for the period during 1990 beginning on April 1, reduced by the same amount as the amount of the reduction effected under this paragraph (as amended by the Omnibus Budget Reconciliation Act of 1990[224]) for such service during such period.

(B) For purposes of this paragraph:

(i) The "locally-adjusted reduced prevailing amount" for a locality for a physicians' service is equal to the product of—

[222] P.L. 105–33, §4512(b)(2); 111 Stat. 443.
[223] P.L. 103-66 was enacted August 10, 1993.
[224] P.L. 101–508.

(I) the reduced national weighted average prevailing charge for the service (specified under clause (ii)), and

(II) the adjustment factor (specified under clause (iii)) for the locality.

(ii) The "reduced national weighted average prevailing charge" for a physicians' service is equal to the national weighted average prevailing charge for the service (specified in subparagraph (C)(ii)) reduced by the percentage change (specified in subparagraph (C)(iii)) for the service.

(iii) The "adjustment factor", for a physicians' service for a locality, is the sum of—

(I) the practice expense component (percent), divided by 100, specified in appendix A (pages 187 through 194) of the Report of the Medicare and Medicaid Health Budget Reconciliation Amendments of 1989, prepared by the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, House of Representatives, (Committee Print 101-M, 101st Congress, 1st Session) for the service, multiplied by the geographic practice cost index value (specified in subparagraph (C)(iv)) for the locality, and

(II) 1 minus the practice expense component (percent), divided by 100.

(C) For purposes of this paragraph:

(i) The physicians' services specified in this clause are the procedures specified (by code and description) in the Overvalued Procedures List for Finance Committee, Revised September 20, 1989, prepared by the Physician Payment Review Commission which specification is of physicians' services that have been identified as overvalued by at least 10 percent based on a comparison of payments for such services under a resource-based relative value scale and of the national average prevailing charges under this part.

(ii) The "national weighted average prevailing charge" specified in this clause, for a physicians' service specified in clause (i), is the national weighted average prevailing charge for the service in 1989 as determined by the Secretary using the best data available.

(iii) The "percentage change" specified in this clause, for a physicians' service specified in clause (i), is the percent difference (but expressed as a positive number) specified for the service in the list referred to in clause (i).

(iv) The geographic practice cost index value specified in this clause for a locality is the Geographic Overhead Costs Index specified for the locality in table 1 of the September 1989 Supplement to the Geographic Medicare Economic Index: Alternative Approaches (prepared by the Urban Institute and the Center for Health Economics Research).

(D) In the case of a reduction in the prevailing charge for a physicians' service under subparagraph (A), if a nonparticipating physician furnishes the service to an individual entitled to benefits under this part, after the effective date of such reduction, the physician's actual charge is subject to a limit under subsection (j)(1)(D).

(15)(A) In determining the reasonable charge for surgery, radiology, and diagnostic physicians' services which the Secretary shall designate (based on their high volume of expenditures under this part) and for which the prevailing charge (but for this paragraph) differs by physician specialty, the prevailing charge for such a service may not exceed the prevailing charge or fee schedule amount for that specialty of physicians that furnish the service most frequently nationally.

(B) In the case of a reduction in the prevailing charge for a physician's service under subparagraph (A), if a nonparticipating physician furnishes the service to an individual entitled to benefits under this part, after the effective date of the reduction, the physician's actual charge is subject to a limit under subsection (j)(1)(D).

(16)(A) In determining the reasonable charge for all physicians' services other than physicians' services specified in subparagraph (B) furnished during 1991, the prevailing charge for a locality shall be 6.5 percent below the prevailing charges used in the locality under this part in 1990 after March 31.

(B) For purposes of subparagraph (A), the physicians' services specified in this subparagraph are as follows:

(i) Radiology, anesthesia and physician pathology services, the technical components of diagnostic tests specified in paragraph (17) and physicians' services specified in paragraph (14)(C)(i).

(ii) Primary care services specified in subsection (i)(4), hospital inpatient medical services, consultations, other visits, preventive medicine visits, psychiatric services, emergency care facility services, and critical care services.

(iii) Partial mastectomy; tendon sheath injections and small joint arthrocentesis; femoral fracture and trochanteric fracture treatments; endotracheal intubation; thoracentesis; thoracostomy; aneurysm repair; cystourethroscopy; transurethral fulguration and resection, tympanoplasty with mastoidectomy; and ophthalmoscopy.[225]

(17) With respect to payment under this part for the technical (as distinct from professional) component of diagnostic tests (other than clinical diagnostic laboratory tests, tests specified in paragraph (14)(C)(i), and radiology services, including portable x-ray services) which the Secretary shall designate (based on their high volume of expenditures under this part), the reasonable charge for such technical component (including the applicable portion of a global service) may not exceed the national median of such charges for all localities, as estimated by the Secretary using the best available data.

[225] See Vol. II, P.L. 101–508, §4101(b)(2), with respect to the codes for the procedures specified in clauses (16)(B)(ii) and (iii).

(18)(A) Payment for any service furnished by a practitoner described in subparagraph (C) and for which payment may be made under this part on a reasonable charge or fee schedule basis may only be made under this part on an assignment-related basis.

(B) A practitioner described in subparagraph (C) or other person may not bill (or collect any amount from) the individual or another person for any service described in subparagraph (A), except for deductible and coinsurance amounts applicable under this part. No person is liable for payment of any amounts billed for such a service in violation of the previous sentence. If a practitioner or other person knowingly and willfully bills (or collects an amount) for such a service in violation of such sentence, the Secretary may apply sanctions against the practitioner or other person in the same manner as the Secretary may apply sanctions against a physician in accordance with subsection (j)(2) in the same manner as such section applies with respect to a physician. Paragraph (4) of subsection (j) shall apply in this subparagraph in the same manner as such paragraph applies to such section.

(C) A practitioner described in this subparagraph is any of the following:

(i) A physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5)).

(ii) A certified registered nurse anesthetist (as defined in section 1861(bb)(2)).

(iii) A certified nurse-midwife (as defined in section 1861(gg)(2)).

(iv) A clinical social worker (as defined in section 1861(hh)(1)).

(v) A clinical psychologist (as defined by the Secretary for purposes of section 1861(ii)).

(vi) A registered dietitian or nutrition professional.

(D) For purposes of this paragraph, a service furnished by a practitioner described in subparagraph (C) includes any services and supplies furnished as incident to the service as would otherwise be covered under this part if furnished by a physician or as incident to a physician's service.

(19) For purposes of section 1833(a)(1), the reasonable charge for ambulance services (as described in section 1861(s)(7)) provided during calendar year 1998 and calendar year 1999 may not exceed the reasonable charge for such services provided during the previous calendar year (after application of this paragraph), increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12–month period ending with the midpoint of the year involved reduced by 1.0 percentage point.

(c)(1) Any contract entered into with a carrier under this section shall provide for advances of funds to the carrier for the making of payments by it under this part, and shall provide for payment of the cost of administration of the carrier, as determined by the Secretary to be necessary and proper for carrying out the functions covered by the contract. The Secretary shall provide that in deter-

mining a carrier's necessary and proper cost of administration, the Secretary shall, with respect to each contract, take into account the amount that is reasonable and adequate to meet the costs which must be incurred by an efficiently and economically operated carrier in carrying out the terms of its contract. The Secretary shall cause to have published in the Federal Register, by not later than September 1 before each fiscal year, data, standards, and methodology to be used to establish budgets for carriers under this section for that fiscal year, and shall cause to be published in the Federal Register for public comment, at least 90 days before such data, standards, and methodology are published, the data, standards, and methodology proposed to be used.

(2)(A) Each contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), shall provide that payment shall be issued, mailed, or otherwise transmitted with respect to not less than 95 percent of all claims submitted under this part—

(i) which are clean claims, and

(ii) for which payment is not made on a periodic interim payment basis,

within the applicable number of calendar days after the date on which the claim is received.

(B) In this paragraph:

(i) The term "clean claim" means a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this part.

(ii) The term "applicable number of calendar days" means—

(I) with respect to claims received in the 12-month period beginning October 1, 1986, 30 calendar days,

(II) with respect to claims received in the 12-month period beginning October 1, 1987, 26 calendar days (or 19 calendar days with respect to claims submitted by participating physicians),

(III) with respect to claims received in the 12-month period beginning October 1, 1988, 25 calendar days (or 18 calendar days with respect to claims submitted by participating physicians), and

(IV) with respect to claims received in the 12-month period beginning October 1, 1989, and claims received in any succeeding 12-month period ending on or before September 30, 1993, 24 calendar days (or 17 calendar days with respect to claims submitted by participating physicians).

(V) with respect to claims received in the 12-month period beginning October 1, 1993, and claims received in any succeeding 12-month period, 30 calendar days.

(C) If payment is not issued, mailed, or otherwise transmitted within the applicable number of calendar days (as defined in clause (ii) of subparagraph (B)) after a clean claim (as defined in clause (i) of such subparagraph) is re-

ceived, interest shall be paid at the rate used for purposes of section 3902(a) of title 31, United States Code (relating to interest penalties for failure to make prompt payments) for the period beginning on the day after the required payment date and ending on the date on which payment is made.

(3)(A) Each contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), shall provide that no payment shall be issued, mailed, or otherwise transmitted with respect to any claim submitted under this title within the applicable number of calendar days after the date on which the claim is received.

(B) In this paragraph, the term "applicable number of calendar days" means—

(i) with respect to claims submitted electronically as prescribed by the Secretary, 13 days, and

(ii) with respect to claims submitted otherwise, 26 days.

(4) Neither a carrier nor the Secretary may impose a fee under this title—

(A) for the filing of claims related to physicians' services,

(B) for an error in filing a claim relating to physicians' services or for such a claim which is denied,

(C) for any appeal under this title with respect to physicians' services,

(D) for applying for (or obtaining) a unique identifier under subsection (r), or

(E) for responding to inquiries respecting physicians' services or for providing information with respect to medical review of such services.

(5) Each contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), shall require the carrier to meet criteria developed by the Secretary to measure the timeliness of carrier responses to requests for payment of items described in section 1834(a)(15)(C).

(6) No carrier may carry out (or receive payment for carrying out) any activity pursuant to a contract under this subsection to the extent that the activity is carried out pursuant to a contract under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5) of this title (relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).

(d) Any contract with a carrier under this section may require such carrier or any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

(e)(1) No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him under this section.

(2) No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him under this section if it was

based upon a voucher signed by a certifying officer designated as provided in paragraph (1) of this subsection.

(3) No such carrier shall be liable to the United States for any payments referred to in paragraph (1) or (2).

(f) For purposes of this part, the term "carrier" means—

(1) with respect to providers of services and other persons, a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization; and

(2) with respect to providers of services only, any agency or organization (not described in paragraph (1)) with which an agreement is in effect under section 1816.

(g) The Railroad Retirement Board shall, in accordance with such regulations as the Secretary may prescribe, contract with a carrier or carriers to perform the functions set out in this section with respect to individuals entitled to benefits as qualified railroad retirement beneficiaries pursuant to section 226(a) of this Act and section 7(d) of the Railroad Retirement Act of 1974 [226].

(h)(1) Any physician or supplier may voluntarily enter into an agreement with the Secretary to become a participating physician or supplier. For purposes of this section, the term "participating physician or supplier" means a physician or supplier (excluding any provider of services) who, before the beginning of any year beginning with 1984, enters into an agreement with the Secretary which provides that such physician or supplier will accept payment under this part on an assignment-related basis for all items and services furnished to individuals enrolled under this part during such year. In the case of a newly licensed physician or a physician who begins a practice in a new area, or in the case of a new supplier who begins a new business, or in such similar cases as the Secretary may specify, such physician or supplier may enter into such an agreement after the beginning of a year, for items and services furnished during the remainder of the year.

(2) Each carrier having an agreement with the Secretary under subsection (a) shall maintain a toll-free telephone number or numbers at which individuals enrolled under this part may obtain the names, addresses, specialty, and telephone numbers of participating physicians and suppliers and may request a copy of an appropriate directory published under paragraph (4). Each such carrier shall, without charge, mail a copy of such directory upon such a request.

(3)(A) In any case in which a carrier having an agreement with the Secretary under subsection (a) is able to develop a system for the electronic transmission to such carrier of bills for services, such carrier shall establish direct lines for the electronic receipt of claims from participating physicians and suppliers.

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[226] See Vol. II, P.L. 75–162 [as amended by P.L. 93–445].

(B) The Secretary shall establish a procedure whereby an individual enrolled under this part may assign, in an appropriate manner on the form claiming a benefit under this part for an item or service furnished by a participating physician or supplier, the individual's rights of payment under a medicare supplemental policy (described in section 1882(g)(1)) in which the individual is enrolled. In the case such an assignment is properly executed and a payment determination is made by a carrier with a contract under this section, the carrier shall transmit to the private entity issuing the medicare supplemental policy notice of such fact and shall include an explanation of benefits and any additional information that the Secretary may determine to be appropriate in order to enable the entity to decide whether (and the amount of) any payment is due under the policy. The Secretary may enter into agreements for the transmittal of such information to entities electronically. The Secretary shall impose user fees for the transmittal of information under this subparagraph by a carrier, whether electronically or otherwise, and such user fees shall be collected and retained by the carrier.

(4) At the beginning of each year the Secretary shall publish directories (for appropriate local geographic areas) containing the name, address, and specialty of all participating physicians and suppliers (as defined in paragraph (1)) for that area for that year. Each directory shall be organized to make the most useful presentation of the information (as determined by the Secretary) for individuals enrolled under this part. Each participating physician directory for an area shall provide an alphabetical listing of all participating physicians practicing in the area and an alphabetical listing by locality and specialty of such physicians.

(5)(A) The Secretary shall promptly notify individuals enrolled under this part through an annual mailing of the participation program under this subsection and the publication and availability of the directories and shall make the appropriate area directory or directories available in each district and branch office of the Social Security Administration, in the offices of carriers, and to senior citizen organizations.

(B) The annual notice provided under subparagraph (A) shall include—

(i) a description of the participation program,

(ii) an explanation of the advantages to beneficiaries of obtaining covered services through a participating physician or supplier,

(iii) an explanation of the assistance offered by carriers in obtaining the names of participating physicians and suppliers, and

(iv) the toll-free telephone number under paragraph (2)(A) for inquiries concerning the program and for requests for free copies of appropriate directories.

(6) The Secretary shall provide that the directories shall be available for purchase by the public. The Secretary shall provide that each appropriate area directory is sent to each participating physician located in that area and that an appropriate number of copies of each such directory is sent to hos-

pitals located in the area. Such copies shall be sent free of charge.

(7) The Secretary shall provide that each explanation of benefits provided under this part for services furnished in the United States, in conjunction with the payment of claims under section 1833(a)(1) (made other than on an assignment-related basis), shall include—

(A) a prominent reminder of the participating physician and supplier program established under this subsection (including the limitation on charges that may be imposed by such physicians and suppliers and a clear statement of any amounts charged for the particular items or services on the claim involved above the amount recognized under this part),

(B) the toll-free telephone number or numbers, maintained under paragraph (2), at which an individual enrolled under this part may obtain information on participating physicians and suppliers,

(C)(i) an offer of assistance to such an individual in obtaining the names of participating physicians of appropriate specialty and

(ii) an offer to provide a free copy of the appropriate participating physician directory, and

(D) in the case of services for which the billed amount exceeds the limiting charge imposed under section 1848(g), information regarding such applicable limiting charge (including information concerning the right to a refund under section 1848(g)(1)(A)(iv)).

(8) The Secretary may refuse to enter into an agreement with a physician or supplier under this subsection, or may terminate or refuse to renew such agreement, in the event that such physician or supplier has been convicted of a felony under Federal or State law for an offense which the Secretary determines is detrimental to the best interests of the program or program beneficiaries.

(i) For purposes of this title:

(1) A claim is considered to be paid on an "assignment-related basis" if the claim is paid on the basis of an assignment described in subsection (b)(3)(B)(ii), in accordance with subsection (b)(6)(B), or under the procedure described in section 1870(f)(1).

(2) The term "participating physician" refers, with respect to the furnishing of services, to a physician who at the time of furnishing the services is a participating physician (under subsection (h)(1)); the term "nonparticipating physician" refers, with respect to the furnishing of services, to a physician[227] who at the time of furnishing the services is not a participating physician; and the term "nonparticipating supplier or other person" means a supplier or other person (excluding a provider of services) that is not a participating physician or supplier (as defined in subsection (h)(1)).

(3) The term "percentage increase in the MEI" means, with respect to physicians' services furnished in a year, the percentage increase in the medicare economic index (referred to in the

[227] P.L. 108–173, §736(b)(9), struck out "services, a physician" and substituted "services, to a physician".

fourth sentence of subsection (b)(3)) applicable to such services furnished as of the first day of that year.

(4) The term "primary care services" means physicians' services which constitute office medical services, emergency department services, home medical services, skilled nursing, intermediate care, and long-term care medical services, or nursing home, boarding home, domiciliary, or custodial care medical services.

(j)(1)(A) In the case of a physician who is not a participating physician for items and services furnished during a portion of the 30-month period beginning July 1, 1984, the Secretary shall monitor the physician's actual charges to individuals enrolled under this part for physicians' services during that portion of that period. If such physician knowingly and willfully bills individuals enrolled under this part for actual charges in excess of such physician's actual charges for the calendar quarter beginning on April 1, 1984, the Secretary may apply sanctions against such physician in accordance with paragraph (2).

(B)(i) During any period (on or after January 1, 1987, and before the date specified in clause (ii)), during which a physician is a nonparticipating physician, the Secretary shall monitor the actual charges of each such physician for physicians' services furnished to individuals enrolled under this part. If such physician knowingly and willfully bills on a repeated basis for such a service an actual charge in excess of the maximum allowable actual charge determined under subparagraph (C) for that service, the Secretary may apply sanctions against such physician in accordance with paragraph (2).

(ii) Clause (i) shall not apply to services furnished after December 31, 1990.

(C)(i) For a particular physicians' service furnished by a nonparticipating physician to individuals enrolled under this part during a year, for purposes of subparagraph (B), the maximum allowable actual charge is determined as follows: If the physician's maximum allowable actual charge for that service in the previous year was—

(I) less than 115 percent of the applicable percent (as defined in subsection (b)(4)(A)(iv)) of the prevailing charge for the year and service involved, the maximum allowable actual charge for the year involved is the greater of the maximum allowable actual charge described in subclause (II) or the charge described in clause (ii), or

(II) equal to, or greater than, 115 percent of the applicable percent (as defined in subsection (b)(4)(A)(iv)) of the prevailing charge for the year and service involved, the maximum allowable actual charge is 101 percent of the physician's maximum allowable actual charge for the service for the previous year.

(ii) For purposes of clause (i)(I), the charge described in this clause for a particular physicians' service furnished in a year is the maximum allowable actual charge for the service of the physician for the previous

year plus the product of (I) the applicable fraction (as defined in clause (iii)) and (II) the amount by which 115 percent of the prevailing charge for the year involved for such service furnished by nonparticipating physicians, exceeds the physician's maximum allowable actual charge for the service for the previous year.

(iii) In clause (ii), the "applicable fraction" is—

(I) for 1987, ¼,

(II) for 1988, ⅓,

(III) for 1989, ½, and

(IV) for any subsequent year, 1.

(iv) For purposes of determining the maximum allowable actual charge under clauses (i) and (ii) for 1987, in the case of a physicians' service for which the physician has actual charges for the calendar quarter beginning on April 1, 1984, the "maximum allowable actual charge" for 1986 is the physician's actual charge for such service furnished during such quarter.

(v) For purposes of determining the maximum allowable actual charge under clauses (i) and (ii) for a year after 1986, in the case of a physicians' service for which the physician has no actual charges for the calendar quarter beginning on April 1, 1984, and for which a maximum allowable actual charge has not been previously established under this clause, the "maximum allowable actual charge" for the previous year shall be the 50th percentile of the customary charges for the service (weighted by frequency of the service) performed by nonparticipating physicians in the locality during the 12-month period ending June 30 of that previous year.

(vi) For purposes of this subparagraph, a "physician's actual charge" for a physicians' service furnished in a year or other period is the weighted average (or, at the option of the Secretary for a service furnished in the calendar quarter beginning April 1, 1984, the median) of the physician's charges for such service furnished in the year or other period.

(vii) In the case of a nonparticipating physician who was a participating physician during a previous period, for the purpose of computing the physician's maximum allowable actual charge during the physician's period of nonparticipation, the physician shall be deemed to have had a maximum allowable actual charge during the period of participation, and such deemed maximum allowable actual charge shall be determined according to clauses (i) through (vi).

(viii) Notwithstanding any other provision of this subparagraph, the maximum allowable actual charge for a particular physician's service furnished by a nonparticipating physician to individuals enrolled under this part during the 3-month period beginning on January 1, 1988, shall be the amount determined under this subparagraph for 1987. The maximum allowable actual charge for any such service otherwise deter-

mined under this subparagraph for 1988 shall take effect on April 1, 1988.

(ix) If there is a reduction under subsection (b)(13) in the reasonable charge for medical direction furnished by a nonparticipating physician, the maximum allowable actual charge otherwise permitted under this subsection for such services shall be reduced in the same manner and in the same percentage as the reduction in such reasonable charge.

(D)(i) If an action described in clause (ii) results in a reduction in a reasonable charge for a physicians' service or item and a nonparticipating physician furnishes the service or item to an individual entitled to benefits under this part after the effective date of such action, the physician may not charge the individual more than 125 percent of the reduced payment allowance (as defined in clause (iii)) plus (for services or items furnished during the 12-month period (or 9-month period in the case of an action described in clause (ii)(II)) beginning on the effective date of the action) ½ of the amount by which the physician's maximum allowable actual charge for the service or item for the previous 12–month period exceeds such 125 percent level. [228]

(ii) The first sentence of clause (i) shall apply to—

(I) an adjustment under subsection (b)(8)(B) (relating to inherent reasonableness),

(II) a reduction under subsection (b)(10)(A) or (b)(14)(A) (relating to certain overpriced procedures),

(III) a reduction under subsection (b)(11)(B) (relating to certain cataract procedures),

(IV) a prevailing charge limit established under subsection (b)(11)(C)(i) or (b)(15)(A),

(V) a reasonable charge limit established under subsection (b)(11)(C)(ii), and

(VI) an adjustment under section 1833(l)(3)(B) (relating to physician supervision of certified registered nurse anesthetists).

(iii) In clause (i), the term "reduced payment allowance" means, with respect to an action—

(I) under subsection (b)(8)(B), the inherently reasonable charge established under subsection (b)(8);

(II) under subsection (b)(10)(A), (b)(11)(B), (b)(11)(C)(i), (b)(14)(A), or (b)(15)(A) or under section 1833(l)(3)(B), the prevailing charge for the service after the action; or

(III) under subsection (b)(11)(C)(ii), the payment allowance established under such subsection.

(iv) If a physician knowingly and willfully bills in violation of clause (i) (whether or not such charge violates subparagraph (B)), the Secretary may apply sanctions against such physician in accordance with paragraph (2).

[228] See Vol. II, P.L. 100–203, §4063(d), with respect to establishing a reasonable charge limit.

(v) Clause (i) shall not apply to items and services furnished after December 31, 1990.[229]

(2) Subject to paragraph (3), the sanctions which the Secretary may apply under this paragraph are—

(A) excluding a physician from participation in the programs under this Act for a period not to exceed 5 years, in accordance with the procedures of subsections (c), (f), and (g) of section 1128, or

(B) civil monetary penalties and assessments, in the same manner as such penalties and assessments are authorized under section 1128A(a),

or both. The provisions of section 1128A (other than the first 2 sentences of subsection (a) and other than subsection (b)) shall apply to a civil money penalty and assessment under subparagraph (B) in the same manner as such provisions apply to a penalty, assessment, or proceeding under section 1128A(a), except to the extent such provisions are inconsistent with subparagraph (A) or paragraph (3).

(3)(A) The Secretary may not exclude a physician pursuant to paragraph (2)(A) if such physician is a sole community physician or sole source of essential specialized services in a community.

(B) The Secretary shall take into account access of beneficiaries to physicians' services for which payment may be made under this part in determining whether to bar a physician from participation under paragraph (2)(A).

(4) The Secretary may, out of any civil monetary penalty or assessment collected from a physician pursuant to this subsection, make a payment to a beneficiary enrolled under this part in the nature of restitution for amounts paid by such beneficiary to such physician which was determined to be an excess charge under paragraph (1).

(k)(1) If a physician knowingly and willfully presents or causes to be presented a claim or bills an individual enrolled under this part for charges for services as an assistant at surgery for which payment may not be made by reason of section 1862(a)(15), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2) in the case of surgery performed on or after March 1, 1987.

(2) If a physician knowingly and willfully presents or causes to be presented a claim or bills an individual enrolled under this part for charges that includes[230] a charge for an assistant at surgery for which payment may not be made by reason of section 1862(a)(15), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2) in the case of surgery performed on or after March 1, 1987.

(l)(1)(A) Subject to subparagraph (C), if—

(i) a nonparticipating physician furnishes services to an individual enrolled for benefits under this part,

(ii) payment for such services is not accepted on an assignment-related basis,

(iii)(I) a carrier determines under this part or a peer review organization determines under part B of title

[229] See Vol. II, P.L. 99–509, §9334(b)(2), with respect to certain reductions in the reasonable charge for physicians' services.

[230] As in original; possibly should be "include".

XI that payment may not be made by reason of section 1862(a)(1) because a service otherwise covered under this title is not reasonable and necessary under the standards described in that section or (II) payment under this title for such services is denied under section 1154(a)(2) by reason of a determination under section 1154(a)(1)(B), and

(iv) the physician has collected any amounts for such services,

the physician shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts so collected.

(B) A refund under subparagraph (A) is considered to be on a timely basis only if—

(i) in the case of a physician who does not request reconsideration or seek appeal on a timely basis, the refund is made within 30 days after the date the physician receives a denial notice under paragraph (2), or

(ii) in the case in which such a reconsideration or appeal is taken, the refund is made within 15 days after the date the physician receives notice of an adverse determination on reconsideration or appeal.

(C) Subparagraph (A) shall not apply to the furnishing of a service by a physician to an individual in the case described in subparagraph (A)(iii)(I) if—

(i) the physician establishes that the physician did not know and could not reasonably have been expected to know that payment may not be made for the service by reason of section 1862(a)(1), or

(ii) before the service was provided, the individual was in- formed that payment under this part may not be made for the specific service and the individual has agreed to pay for that service.

(2) Each carrier with a contract in effect under this section with respect to physicians and each peer review organization with a contract under part B of title XI shall send any notice of denial of payment for physicians' services based on section 1862(a)(1) and for which payment is not requested on an assignment-related basis to the physician and the individual involved.

(3) If a physician knowingly and willfully fails to make refunds in violation of paragraph (1)(A), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

(m)(1) In the case of a nonparticipating physician who—

(A) performs an elective surgical procedure for an individual enrolled for benefits under this part and for which the physician's actual charge is at least $500, and

(B) does not accept payment for such procedure on an assignment-related basis,

the physician must disclose to the individual, in writing and in a form approved by the Secretary, the physician's estimated actual charge for the procedure, the estimated approved charge under this part for the procedure, the excess of the physician's actual charge over the approved charge, and the coinsurance amount applicable to the procedure. The written estimate may not be used as the basis for, or evidence in, a civil suit.

(2) A physician who fails to make a disclosure required under paragraph (1) with respect to a procedure shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts collected for the procedure in excess of the charges recognized and approved under this part.

(3) If a physician knowingly and willfully fails to comply with paragraph (2), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

(4) The Secretary shall provide for such monitoring of requests for payment for physicians' services to which paragraph (1) applies as is necessary to assure compliance with paragraph (2).

(n)(1) If a physician's bill or a request for payment for services billed by a physician includes a charge for a diagnostic test described in section 1861(s)(3) (other than a clinical diagnostic laboratory test) for which the bill or request for payment does not indicate that the billing physician personally performed or supervised the performance of the test or that another physician with whom the physician who shares a practice personally performed or supervised the performance of the test, the amount payable with respect to the test shall be determined as follows:

(A) If the bill or request for payment indicates that the test was performed by a supplier, identifies the supplier, and indicates the amount the supplier charged the billing physician, payment for the test (less the applicable deductible and coinsurance amounts) shall be the actual acquisition costs (net of any discounts) or, if lower, the supplier's reasonable charge (or other applicable limit) for the test.

(B) If the bill or request for payment (i) does not indicate who performed the test, or (ii) indicates that the test was performed by a supplier but does not identify the supplier or include the amount charged by the supplier, no payment shall be made under this part.

(2) A physician may not bill an individual enrolled under this part—

(A) any amount other than the payment amount specified in paragraph (1)(A) and any applicable deductible and coinsurance for a diagnostic test for which payment is made pursuant to paragraph (1)(A), or

(B) any amount for a diagnostic test for which payment may not be made pursuant to paragraph (1)(B).

(3) If a physician knowingly and willfully in repeated cases bills one or more individuals in violation of paragraph (2), the Secretary may apply sanctions against such physician in accordance with section 1842(j)(2).

(o)(1) If a physician's, supplier's, or any other person's bill or request for payment for services includes a charge for a drug or biological for which payment may be made under this part and the drug or biological is not paid on a cost or prospective payment basis as otherwise provided in this part, the amount payable for the drug or biological is equal to the following: [231]

[231] P.L. 108–173, §303(b)(1), struck out "equal to 95 percent of the average wholesale price." and substituted "equal to the following:" and subparagraphs (A)-(G), applicable to physicians in the specialties of hematology, hematology/oncology, and medical oncology, and also applicable to payments for drugs or biologicals and drug administration services furnished by physicians in specialties other than the specialties of hematology, hematology/oncology, and medical oncology. For the effective date, see Vol. II, P.L. 108-173, §303(j) and §304.

(A) In the case of any of the following drugs or biologicals, 95 percent of the average wholesale price:

(i) A drug or biological furnished before January 1, 2004.

(ii) Blood clotting factors furnished during 2004.

(iii) A drug or biological furnished during 2004 that was not available for payment under this part as of April 1, 2003.

(iv) A vaccine described in subparagraph (A) or (B) of section 1861(s)(10) furnished on or after January 1, 2004.

(v) A drug or biological furnished during 2004 in connection with the furnishing of renal dialysis services if separately billed by renal dialysis facilities.

(B) In the case of a drug or biological furnished during 2004 that is not described in—

(i) clause (ii), (iii), (iv), or (v) of subparagraph (A),

(ii) subparagraph (D)(i), or

(iii) subparagraph (F), the amount determined under paragraph (4).

(C) In the case of a drug or biological that is not described in subparagraph (A)(iv), (D)(i), or (F) furnished on or after January 1, 2005, the amount provided under section 1847, section 1847A, section 1847B, or section 1881(b)(13), as the case may be for the drug or biological.

(D)(i) Except as provided in clause (ii), in the case of infusion drugs furnished through an item of durable medical equipment covered under section 1861(n) on or after January 1, 2004, 95 percent of the average wholesale price for such drug in effect on October 1, 2003.

(ii) In the case of such infusion drugs furnished in a competitive acquisition area under section 1847 on or after January 1, 2007, the amount provided under section 1847.

(E) In the case of a drug or biological, consisting of intravenous immune globulin, furnished—

(i) in 2004, the amount of payment provided under paragraph (4); and

(ii) in 2005 and subsequent years, the amount of payment provided under section 1847A.

(F) In the case of blood and blood products (other than blood clotting factors), the amount of payment shall be determined in the same manner as such amount of payment was determined on October 1, 2003.

(G)[232] In the case of inhalation drugs or biologicals furnished through durable medical equipment covered under section 1861(n) that are furnished—

(i) in 2004, the amount provided under paragraph (4) for the drug or biological; and

(ii) in 2005 and subsequent years, the amount provided under section 1847A for the drug or biological.

(2) If payment for a drug or biological is made to a licensed pharmacy approved to dispense drugs or biologicals under this

[232] P.L. 108–173, §305(a), amended subparagraph (G), as added by P.L. 108-173, §303(b)(1), in its entirety, effective December 8, 2003. For subparagraph (G) as it formerly read, see Vol. II, Superseded Provisions, P.L. 108-173.

part, the Secretary may pay a dispensing fee (less the applicable deductible and coinsurance amounts) to the pharmacy.[233] This paragraph shall not apply in the case of payment under paragraph (1)(C).[234]

(3)(A) Payment for a charge for any drug or biological for which payment may be made under this part may be made only on an assignment–related basis.

(B) The provisions of subsection (b)(18)(B) shall apply to charges for such drugs or biologicals in the same manner as they apply to services furnished by a practitioner described in subsection (b)(18)(C).

(4)[235](A) Subject to the succeeding provisions of this paragraph, the amount of payment for a drug or biological under this paragraph furnished in 2004 is equal to 85 percent of the average wholesale price (determined as of April 1, 2003) for the drug or biological.

(B) The Secretary shall substitute for the percentage under subparagraph (A) for a drug or biological the percentage that would apply to the drug or biological under the column entitled "Average of GAO and OIG data (percent)" in the table entitled "Table 3.—Medicare Part B Drugs in the Most Recent GAO and OIG Studies" published on August 20, 2003, in the Federal Register (68 Fed. Reg. 50445).

(C)(i) The Secretary may substitute for the percentage under subparagraph (A) a percentage that is based on data and information submitted by the manufacturer of the drug or biological by October 15, 2003.

(ii) The Secretary may substitute for the percentage under subparagraph (A) with respect to drugs and biologicals furnished during 2004 on or after April 1, 2004, a percentage that is based on data and information submitted by the manufacturer of the drug or biological after October 15, 2003, and before January 1, 2004.

(D) In no case may the percentage substituted under subparagraph (B) or (C) be less than 80 percent.

(5)[236](A) Subject to subparagraph (B), in the case of clotting factors furnished on or after January 1, 2005, the Secretary shall, after reviewing the January 2003 report to Congress by the Comptroller General of the United States entitled "Payment for Blood Clotting Factor Exceeds Providers Acquisition Cost", provide for a separate payment, to the entity which furnishes to the patient blood clotting factors, for items and services related to the furnishing of such factors in an amount that the Secretary determines to be appropriate. Such payment amount may take into account any or all of the following:

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[233] See Vol. II, P.L. 105–33, §4556(c), with respect to the study and report of the effect on the average wholesale price of drugs and biologicals.

[234] P.L. 108–173, §303(i)(1), added "This paragraph shall not apply in the case of payment under paragraph (1)(C)." For the effective date, see Vol. II, P.L. 108-173, §303(j) and §304.

[235] P.L. 108–173, §303(b)(2), added paragraph (4). For the effective date, see Vol. II, P.L. 108-173, §303(j) and §304.

[236] P.L. 108–173, §303(e)(1), added paragraph (5). For the effective date, see Vol. II, P.L. 108-173, §303(j) and §304.

(i) The mixing (if appropriate) and delivery of factors to an individual, including special inventory management and storage requirements.

(ii) Ancillary supplies and patient training necessary for the self-administration of such factors.

(B) In determining the separate payment amount under subparagraph (A) for blood clotting factors furnished in 2005, the Secretary shall ensure that the total amount of payments under this part (as estimated by the Secretary) for such factors under paragraph (1)(C) and such separate payments for such factors does not exceed the total amount of payments that would have been made for such factors under this part (as estimated by the Secretary) if the amendments made by section 303 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 had not been enacted.

(C) The separate payment amount under this subparagraph for blood clotting factors furnished in 2006 or a subsequent year shall be equal to the separate payment amount determined under this paragraph for the previous year increased by the percentage increase in the consumer price index for medical care for the 12-month period ending with June of the previous year.

(6)[237] In the case of an immunosuppressive drug described in subparagraph (J) of section 1861(s)(2) and an oral drug described in subparagraph (Q) or (T) of such section, the Secretary shall pay to the pharmacy a supplying fee for such a drug determined appropriate by the Secretary (less the applicable deductible and coinsurance amounts).

(7)[238] There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of determinations of payment amounts, methods, or adjustments under paragraphs (4) through (6).

(p)(1) Each request for payment, or bill submitted, for an item or service furnished by a physician or practitioner specified in subsection (b)(18)(C) for which payment may be made under this part shall include the appropriate diagnosis code (or codes) as established by the Secretary for such item or service.

(2) In the case of a request for payment for an item or service furnished by a physician or practitioner specified in subsection (b)(18)(C) on an assignment-related basis which does not include the code (or codes) required under paragraph (1), payment may be denied under this part.

(3) In the case of a request for payment for an item or service furnished by a physician not submitted on an assignment-related basis and which does not include the code (or codes) required under paragraph (1)—

(A) if the physician knowingly and willfully fails to provide the code (or codes) promptly upon request of the Secretary or a carrier, the physician may be subject to a civil money penalty in an amount not to exceed $2,000, and

[237] P.L. 108–173, §303(e)(2), added paragraph (6). For the effective date, see Vol. II, P.L. 108-173, §303(j) and §304.

[238] P.L. 108–173, §303(g)(1), added paragraph (7). For the effective date, see Vol. II, P.L. 108-173, §303(j) and §304.

(B) if the physician knowingly, willfully, and in repeated cases fails, after being notified by the Secretary of the obligations and requirements of this subsection, to include the code (or codes) required under paragraph (1), the physician may be subject to the sanction described in section 1842(j)(2)(A).

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under subparagraph (A) in the same manner as they apply to a penalty or proceeding under section 1128A(a).

(4) In the case of an item or service defined in paragraph (3), (6), (8), or (9) of subsection 1861(s) ordered by a physician or a practitioner specified in subsection (b)(18)(C), but furnished by another entity, if the Secretary (or fiscal agent of the Secretary) requires the entity furnishing the item or service to provide diagnostic or other medical information in order for payment to be made to the entity, the physician or practitioner shall provide that information to the entity at the time that the item or service is ordered by the physician or practitioner.

(q)(1)(A) The Secretary, in consultation with groups representing physicians who furnish anesthesia services, shall establish by regulation a relative value guide for use in all carrier localities in making payment for physician anesthesia services furnished under this part. Such guide shall be designed so as to result in expenditures under this title for such services in an amount that would not exceed the amount of such expenditures which would otherwise occur.

(B) For physician anesthesia services furnished under this part during 1991, the prevailing charge conversion factor used in a locality under this subsection shall, subject to clause (iv), be reduced to the adjusted prevailing charge conversion factor for the locality determined as follows:

(i) The Secretary shall estimate the national weighted average of the prevailing charge conversion factors used under this subsection for services furnished during 1990 after March 31, using the best available data.

(ii) The national weighted average estimated under clause (i) shall be reduced by 7 percent.

(iii) Subject to clause (iv), the prevailing charge conversion factor to be applied in a locality is the sum of—

(I) the product of (a) the portion of the reduced national weighted average prevailing charge conversion factor computed under clause (ii) which is attributable to physician work and (b) the geographic work index value for the locality (specified in Addendum C to the Model Fee Schedule for Physician Services (published on September 4, 1990, 55 Federal Register pp. 36238–36243)); and

(II) the product of (a) the remaining portion of the reduced national weighted average prevailing charge conversion factor computed under clause (ii) and (b) the geographic practice cost index value specified in section 1842(b)(14)(C)(iv) for the locality.

In applying this clause, 70 percent of the prevailing charge conversion factor shall be considered to be attributable to physician work.

(iv) The prevailing charge conversion factor to be applied to a locality under this subparagraph shall not be reduced by more than 15 percent below the prevailing charge conversion factor applied in the locality for the period during 1990 after March 31, but in no case shall the prevailing charge conversion factor be less than 60 percent of the national weighted average of the prevailing charge conversion factors (computed under clause (i)).

(2) For purposes of payment for anesthesia services (whether furnished by physicians or by certified registered nurse anesthetists) under this part, the time units shall be counted based on actual time rather than rounded to full time units.

(r) The Secretary shall establish a system which provides for a unique identifier for each physician who furnishes services for which payment may be made under this title. Under such system, the Secretary may impose appropriate fees on such physicians to cover the costs of investigation and recertification activities with respect to the issuance of the identifiers.

(s)(1) Subject to paragraph (3), the Secretary[239] may implement a statewide or other areawide fee schedule to be used for payment of any item or service described in paragraph (2) which is paid on a reasonable charge basis. Any fee schedule established under this paragraph for such item or service shall be updated each year by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12–month period ending with June of the preceding year, except that in no event shall a fee schedule for an item described in paragraph (2)(D) be updated before 2003.

(2) The items and services described in this paragraph are as follows:

(A) Medical supplies.

(B) Home dialysis supplies and equipment (as defined in section 1881(b)(8)).

(C) Therapeutic shoes.

(D) Parenteral and enteral nutrients, equipment, and supplies.

(E) Electromyogram devices.

(F) Salivation devices.

(G) Blood products.

(H) Transfusion medicine.

(3)[240] In the case of items and services described in paragraph (2)(D) that are included in a competitive acquisition program in a competitive acquisition area under section 1847(a)—

(A) the payment basis under this subsection for such items and services furnished in such area shall be the payment basis determined under such competitive acquisition program; and

[239] P.L. 108–173, §302(d)(3)(A), struck out "The Secretary" and substituted "Subject to paragraph (3), the Secretary". For the effective date, see Vol. II, P.L. 108-173, §303(j) and §304, effective December 8, 2003.

[240] P.L. 108–173, §302(d)(3)(B), added paragraph (3), effective December 8, 2003.

(B) the Secretary may use information on the payment determined under such competitive acquisition programs to adjust the payment amount otherwise applicable under paragraph (1) for an area that is not a competitive acquisition area under section 1847, and in the case of such adjustment, paragraphs (8) and (9) of section 1842(b) shall not be applied.

(t) Each request for payment, or bill submitted, for an item or service furnished to an individual who is a resident of a skilled nursing facility for which payment may be made under this part shall include the facility's medicare provider number.

STATE AGREEMENTS FOR COVERAGE OF ELIGIBLE INDIVIDUALS WHO ARE RECEIVING MONEY PAYMENTS UNDER PUBLIC ASSISTANCE PROGRAMS OR ARE ELIGIBLE FOR MEDICAL ASSISTANCE

SEC. 1843. [42 U.S.C. 1395v] (a) The Secretary shall, at the request of a State made before January 1, 1970, or during 1981 or after 1988, enter into an agreement with such State pursuant to which all eligible individuals in either of the coverage groups described in subsection (b) (as specified in the agreement) will be enrolled under the program established by this part.

(b) An agreement entered into with any State pursuant to subsection (a) may be applicable to either of the following coverage groups:

(1) individuals receiving money payments under the plan of such State approved under title I or title XVI; or

(2) individuals receiving money payments under all of the plans of such State approved under titles I, X, XIV, and XVI, and part A of title IV.

Except as provided in subsection (g), there shall be excluded from any coverage group any individual who is entitled to monthly insurance benefits under title II or who is entitled to receive an annuity under the Railroad Retirement Act of 1974[241]. Effective January 1, 1974, and subject to section 1902(f), the Secretary shall, at the request of any State not eligible to participate in the State plan program established under title XVI, continue in effect the agreement entered into under this section with such State subject to such modifications as the Secretary may by regulations provide to take account of the termination of any plans of such State approved under titles I, X, XIV, and XVI and the establishment of the supplemental security income program under title XVI.

(c) For purposes of this section, an individual shall be treated as an eligible individual only if he is an eligible individual (within the meaning of section 1836) on the date an agreement covering him is entered into under subsection (a) or he becomes an eligible individual (within the meaning of such section) at any time after such date; and he shall be treated as receiving money payments described in subsection (b) if he receives such payments for the month in which the agreement is entered into or any month thereafter.

(d) In the case of any individual enrolled pursuant to this section—

[241] P.L. 75–162 [as amended by P.L. 93–445].

(1) the monthly premium to be paid by the State shall be determined under section 1839 (without any increase under subsection (b) thereof);

(2) his coverage period shall begin on whichever of the following is the latest:

(A) July 1, 1966;

(B) the first day of the third month following the month in which the State agreement is entered into;

(C) the first day of the first month in which he is both an eligible individual and a member of a coverage group specified in the agreement under this section; or

(D) such date as may be specified in the agreement; and

(3) his coverage period attributable to the agreement with the State under this section shall end on the last day of whichever of the following first occurs:

(A) the month in which he is determined by the State agency to have become ineligible both for money payments of a kind specified in the agreement and (if there is in effect a modification entered into under subsection (h)) for medical assistance, or

(B) the month preceding the first month for which he becomes entitled to monthly benefits under title II or to an annuity or pension under the Railroad Retirement Act of 1974.

(e) Any individual whose coverage period attributable to the State agreement is terminated pursuant to subsection (d)(3) shall be deemed for purposes of this part (including the continuation of his coverage period under this part) to have enrolled under section 1837 in the initial general enrollment period provided by section 1837(c). The coverage period under this part of any such individual who (in the last month of his coverage period attributable to the State agreement or in any of the following six months) files notice that he no longer wishes to participate in the insurance program established by this part, shall terminate at the close of the month in which the notice is filed.

(f) With respect to eligible individuals receiving money payments under the plan of a State approved under title I, X, XIV, or XVI, or part A of title IV, or eligible to receive medical assistance under the plan of such State approved under title XIX, if the agreement entered into under this section so provides, the term "carrier" as defined in section 1842(f) also includes the State agency, specified in such agreement, which administers or supervises the administration of the plan of such State approved under title I, XVI, or XIX. The agreement shall also contain such provisions as will facilitate the financial transactions of the State and the carrier with respect to deductions, coinsurance, and otherwise, and as will lead to economy and efficiency of operation, with respect to individuals receiving money payments under plans of the State approved under titles I, X, XIV, and XVI, and part A of title IV, and individuals eligible to receive medical assistance under the plan of the State approved under title XIX.

(g)(1) The Secretary shall, at the request of a State made before January 1, 1970, or during 1981 or after 1988, enter into a modification of an agreement entered into with such State pursuant to subsection (a) under which the second sentence of subsection (b) shall not apply with respect to such agreement.

(2) In the case of any individual who would (but for this subsection) be excluded from the applicable coverage group described in subsection (b) by the second sentence of such subsection—

(A) subsections (c) and (d)(2) shall be applied as if such subsections referred to the modification under this subsection (in lieu of the agreement under subsection (a)), and

(B) subsection (d)(3)(B) shall not apply so long as there is in effect a modification entered into by the State under this subsection.

(h)(1) The Secretary shall, at the request of a State made before January 1, 1970, or during 1981 or after 1988, enter into a modification of an agreement entered into with such State pursuant to subsection (a) under which the coverage group described in subsection (b) and specified in such agreement is broadened to include (A) individuals who are eligible to receive medical assistance under the plan of such State approved under title XIX, or (B) qualified medicare beneficiaries (as defined in section 1905(p)(1)).

(2) For purposes of this section, an individual shall be treated as eligible to receive medical assistance under the plan of the State approved under title XIX if, for the month in which the modification is entered into under this subsection or for any month thereafter, he has been determined to be eligible to receive medical assistance under such plan. In the case of any individual who would (but for this subsection) be excluded from the agreement, subsections (c) and (d)(2) shall be applied as if they referred to the modification under this subsection (in lieu of the agreement under subsection (a)), and subsection (d)(2)(C) shall be applied (except in the case of qualified medicare beneficiaries, as defined in section 1905(p)(1)) by substituting "second month following the first month" for "first month".

(3) In this subsection, the term "qualified medicare beneficiary" also includes an individual described in section 1902(a)(10)(E)(iii).

(i) For provisions relating to enrollment of qualified medicare beneficiaries under part A, see section 1818(g).

APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS AND CONTINGENCY RESERVE

SEC. 1844. [42 U.S.C. 1395w] (a) There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Federal Supplementary Medical Insurance Trust Fund—

(1)(A) a Government contribution equal to the aggregate premiums payable for a month for enrollees age 65 and over under this part and deposited in the Trust Fund, multiplied by the ratio of—

(i) twice the dollar amount of the actuarially adequate rate per enrollee age 65 and over as determined under section 1839(a)(1) for such month minus the dollar amount of the premium per enrollee for such month, as determined under section 1839(a)(3), to

(ii) the dollar amount of the premium per enrollee for such month, plus

(B) a Government contribution equal to the aggregate premiums payable for a month for enrollees under age 65 under this part and deposited in the Trust Fund, multiplied by the ratio of—

(i) twice the dollar amount of the actuarially adequate rate per enrollee under age 65 as determined under section 1839(a)(4) for such month minus the dollar amount of the premium per enrollee for such month, as determined under section 1839(a)(3), to

(ii) the dollar amount of the premium per enrollee for such month; minus [242]

(C) the aggregate amount of additional premium payments attributable to the application of section 1839(i); plus [243]

(2) such sums as the Secretary deems necessary to place the Trust Fund, at the end of any fiscal year occurring after June 30, 1967, in the same position in which it would have been at the end of such fiscal year if (A) a Government contribution representing the excess of the premiums deposited in the Trust Fund during the fiscal year ending June 30, 1967, over the Government contribution actually appropriated to the Trust Fund during such fiscal year had been appropriated to it on June 30, 1967, and (B) the Government contribution for premiums deposited in the Trust Fund after June 30, 1967, had been appropriated to it when such premiums were deposited.

(b) In order to assure prompt payment of benefits provided under this part and the administrative expenses thereunder during the early months of the program established by this part, and to provide a contingency reserve, there is also authorized to be appropriated, out of any moneys in the Treasury not otherwise appropriated, to remain available through the calendar year 1969 for repayable advances (without interest) to the Trust Fund, an amount equal to $18 multiplied by the number of individuals (as estimated by the Secretary) who could be covered in July 1966 by the insurance program established by this part if they had theretofore enrolled under this part.

(c) The Secretary shall determine the Government contribution under subparagraphs (A) and (B) of subsection (a)(1) without regard to any premium reduction resulting from an election under section 1854(f)(1)(E) or any credits provided under section 1854(b)(1)(C)(iv) [244] and without regard to any premium adjustment effected under sections 1839(h) and 1860C-1(f) [245].

SEC. 1845. [Repealed. [246]]

INTERMEDIATE SANCTIONS FOR PROVIDERS OR SUPPLIERS OF CLINICAL DIAGNOSTIC LABORATORY TESTS

SEC. 1846. [42 U.S.C. 1395w-2] (a) If the Secretary determines that any provider or clinical laboratory approved for participation under this title no longer substantially meets the conditions of participation or for coverage specified under this title with respect to the provision of clinical diagnostic laboratory tests under this part, the Secretary may (for a period not to exceed one year) impose intermediate sanctions developed pursuant to subsection (b), in lieu

[242] P.L. 108–173, §811(b)(2)(A)(i), struck out "plus" and substituted "minus".
[243] P.L. 108–173, §811(b)(2)(A)(ii), added subparagraph (C).
[244] P.L. 108–173, §222(l)(2)(C), inserted "or any credits provided under section 1854(b)(1)(C)(iv)".
[245] P.L. 108–173, §241(b)(2)(B), inserted "and without regard to any premium adjustment effected under sections 1839(h) and 1860C-1(f)".
[246] P.L. 105–33, §4022(b)(2)(A); 111 Stat. 354.

of terminating immediately the provider agreement or cancelling immediately approval of the clinical laboratory.

(b)(1) The Secretary shall develop and implement—

(A) a range of intermediate sanctions to apply to providers or clinical laboratories under the conditions described in subsection (a), and

(B) appropriate procedures for appealing determinations relating to the imposition of such sanctions.

(2)(A) The intermediate sanctions developed under paragraph (1) shall include—

(i) directed plans of correction,

(ii) civil money penalties in an amount not to exceed $10,000 for each day of substantial noncompliance,

(iii) payment for the costs of onsite monitoring by an agency responsible for conducting surveys, and

(iv) suspension of all or part of the payments to which a provider or clinical laboratory would otherwise be entitled under this title with respect to clinical diagnostic laboratory tests furnished on or after the date on which the Secretary determines that intermediate sanctions should be imposed pursuant to subsection (a).

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (ii) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(B) The sanctions specified in subparagraph (A) are in addition to sanctions otherwise available under State or Federal law.

(3) The Secretary shall develop and implement specific procedures with respect to when and how each of the intermediate sanctions developed under paragraph (1) is to be applied, the amounts of any penalties, and the severity of each of these penalties. Such procedures shall be designed so as to minimize the time between identification of violations and imposition of these sanctions and shall provide for the imposition of incrementally more severe penalties for repeated or uncorrected deficiencies.

COMPETITIVE ACQUISITION OF CERTAIN ITEMS AND SERVICES [247]

SEC. 1847. [42 U.S.C. 1395w–3] (a) ESTABLISHMENT OF COMPETITIVE ACQUISITION PROGRAMS. —

(1) IMPLEMENTATION OF PROGRAMS.—

(A) IN GENERAL.—The Secretary shall establish and implement programs under which competitive acquisition areas are established throughout the United States for contract award purposes for the furnishing under this part of competitively priced items and services (described in paragraph (2)) for which payment is made under this part. Such areas may differ for different items and services.

(B) PHASED-IN IMPLEMENTATION.—The programs—

[247] P.L. 108-173, §302(b)(1), amended §1847 in its entirety, effect December 8, 2003. For §1847 as it formerly read, see Vol. II, Appendix I, Superseded Provisions, P.L. 108-173.

See Vol. II, P.L. 108-173, §302(b)(3), with respect to a GAO report on impact of competitive acquisition on suppliers and §302(e), with respect to a report on activities of suppliers.

(i) shall be phased in among competitive acquisition areas in a manner so that the competition under the programs occurs in—

(I) 10 of the largest metropolitan statistical areas in 2007;

(II) 80 of the largest metropolitan statistical areas in 2009; and

(III) additional areas after 2009; and

(ii) may be phased in first among the highest cost and highest volume items and services or those items and services that the Secretary determines have the largest savings potential.

(C) WAIVER OF CERTAIN PROVISIONS.—In carrying out the programs, the Secretary may waive such provisions of the Federal Acquisition Regulation as are necessary for the efficient implementation of this section, other than provisions relating to confidentiality of information and such other provisions as the Secretary determines appropriate.

(2) ITEMS AND SERVICES DESCRIBED.—The items and services referred to in paragraph (1) are the following:

(A) DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES.—Covered items (as defined in section 1834(a)(13)) for which payment would otherwise be made under section 1834(a), including items used in infusion and drugs (other than inhalation drugs) and supplies used in conjunction with durable medical equipment, but excluding class III devices under the Federal Food, Drug, and Cosmetic Act.

(B) OTHER EQUIPMENT AND SUPPLIES.—Items and services described in section 1842(s)(2)(D), other than parenteral nutrients, equipment, and supplies.

(C) OFF-THE-SHELF ORTHOTICS.—Orthotics described in section 1861(s)(9) for which payment would otherwise be made under section 1834(h) which require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit to the individual.

(3) EXCEPTION AUTHORITY.—In carrying out the programs under this section, the Secretary may exempt—

(A) rural areas and areas with low population density within urban areas that are not competitive, unless there is a significant national market through mail order for a particular item or service; and

(B) items and services for which the application of competitive acquisition is not likely to result in significant savings.

(4) SPECIAL RULE FOR CERTAIN RENTED ITEMS OF DURABLE MEDICAL EQUIPMENT AND OXYGEN.—In the case of a covered item for which payment is made on a rental basis under section 1834(a) and in the case of payment for oxygen under section 1834(a)(5), the Secretary shall establish a process by which rental agreements for the covered items and supply arrangements with oxygen suppliers entered into before the application of the competitive acquisition program under this section for the item may be continued notwithstanding this section. In the case of any such continuation, the supplier in-

volved shall provide for appropriate servicing and replacement, as required under section 1834(a).

(5) PHYSICIAN AUTHORIZATION.—

(A) IN GENERAL.—With respect to items or services included within a particular HCPCS code, the Secretary may establish a process for certain items and services under which a physician may prescribe a particular brand or mode of delivery of an item or service within such code if the physician determines that use of the particular item or service would avoid an adverse medical outcome on the individual, as determined by the Secretary.

(B) NO EFFECT ON PAYMENT AMOUNT.—A prescription under subparagraph (A) shall not affect the amount of payment otherwise applicable for the item or service under the code involved.

(6) APPLICATION.—For each competitive acquisition area in which the program is implemented under this subsection with respect to items and services, the payment basis determined under the competition conducted under subsection (b) shall be substituted for the payment basis otherwise applied under section 1834(a), section 1834(h), or section 1842(s), as appropriate.

(b) PROGRAM REQUIREMENTS.—

(1) IN GENERAL.—The Secretary shall conduct a competition among entities supplying items and services described in subsection (a)(2) for each competitive acquisition area in which the program is implemented under subsection (a) with respect to such items and services.

(2) CONDITIONS FOR AWARDING CONTRACT.—

(A) IN GENERAL.—The Secretary may not award a contract to any entity under the competition conducted in an competitive acquisition area pursuant to paragraph (1) to furnish such items or services unless the Secretary finds all of the following:

(i) The entity meets applicable quality standards specified by the Secretary under section 1834(a)(20).

(ii) The entity meets applicable financial standards specified by the Secretary, taking into account the needs of small providers.

(iii) The total amounts to be paid to contractors in a competitive acquisition area are expected to be less than the total amounts that would otherwise be paid.

(iv) Access of individuals to a choice of multiple suppliers in the area is maintained.

(B) TIMELY IMPLEMENTATION OF PROGRAM.—Any delay in the implementation of quality standards under section 1834(a)(20) or delay in the receipt of advice from the program oversight committee established under subsection (c) shall not delay the implementation of the competitive acquisition program under this section.

(3) CONTENTS OF CONTRACT.—

(A) IN GENERAL.—A contract entered into with an entity under the competition conducted pursuant to paragraph (1) is subject to terms and conditions that the Secretary may specify.

(B) TERM OF CONTRACTS.—The Secretary shall recompete contracts under this section not less often than once every 3 years.

(4) LIMIT ON NUMBER OF CONTRACTORS.—

(A) IN GENERAL.—The Secretary may limit the number of contractors in a competitive acquisition area to the number needed to meet projected demand for items and services covered under the contracts. In awarding contracts, the Secretary shall take into account the ability of bidding entities to furnish items or services in sufficient quantities to meet the anticipated needs of individuals for such items or services in the geographic area covered under the contract on a timely basis.

(B) MULTIPLE WINNERS.—The Secretary shall award contracts to multiple entities submitting bids in each area for an item or service.

(5) Payment.—

(A) IN GENERAL.—Payment under this part for competitively priced items and services described in subsection (a)(2) shall be based on bids submitted and accepted under this section for such items and services. Based on such bids the Secretary shall determine a single payment amount for each item or service in each competitive acquisition area.

(B) Reduced beneficiary cost-sharing.—

(i) APPLICATION OF COINSURANCE.—Payment under this section for items and services shall be in an amount equal to 80 percent of the payment basis described in subparagraph (A).

(ii) APPLICATION OF DEDUCTIBLE.—Before applying clause (i), the individual shall be required to meet the deductible described in section 1833(b).

(C) PAYMENT ON ASSIGNMENT-RELATED BASIS.—Payment for any item or service furnished by the entity may only be made under this section on an assignment-related basis.

(D) CONSTRUCTION.—Nothing in this section shall be construed as precluding the use of an advanced beneficiary notice with respect to a competitively priced item and service.

(6) PARTICIPATING CONTRACTORS.—

(A) IN GENERAL.—Except as provided in subsection (a)(4), payment shall not be made for items and services described in subsection (a)(2) furnished by a contractor and for which competition is conducted under this section unless—

(i) the contractor has submitted a bid for such items and services under this section; and

(ii) the Secretary has awarded a contract to the contractor for such items and services under this section.

(B) BID DEFINED.—In this section, the term "bid" means an offer to furnish an item or service for a particular price and time period that includes, where appropriate, any services that are attendant to the furnishing of the item or service.

(C) RULES FOR MERGERS AND ACQUISITIONS.—In applying subparagraph (A) to a contractor, the contractor shall include a successor entity in the case of a merger or acquisition, if the successor entity assumes such contract along with any liabilities that may have occurred thereunder.

(D) PROTECTION OF SMALL SUPPLIERS.—In developing procedures relating to bids and the awarding of contracts under this section, the Secretary shall take appropriate steps to ensure that small suppliers of items and services have an opportunity to be considered for participation in the program under this section.

(7) CONSIDERATION IN DETERMINING CATEGORIES FOR BIDS.—The Secretary may consider the clinical efficiency and value of specific items within codes, including whether some items have a greater therapeutic advantage to individuals.

(8) AUTHORITY TO CONTRACT FOR EDUCATION, MONITORING, OUTREACH, AND COMPLAINT SERVICES.—The Secretary may enter into contracts with appropriate entities to address complaints from individuals who receive items and services from an entity with a contract under this section and to conduct appropriate education of and outreach to such individuals and monitoring quality of services with respect to the program.

(9) AUTHORITY TO CONTRACT FOR IMPLEMENTATION.—The Secretary may contract with appropriate entities to implement the competitive bidding program under this section.

(10) NO ADMINISTRATIVE OR JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of—

(A) the establishment of payment amounts under paragraph (5);

(B) the awarding of contracts under this section;

(C) the designation of competitive acquisition areas under subsection (a)(1)(A);

(D) the phased-in implementation under subsection (a)(1)(B);

(E) the selection of items and services for competitive acquisition under subsection (a)(2); or

(F) the bidding structure and number of contractors selected under this section.

(c) PROGRAM ADVISORY AND OVERSIGHT COMMITTEE.—

(1) ESTABLISHMENT.—The Secretary shall establish a Program Advisory and Oversight Committee (hereinafter in this section referred to as the "Committee").

(2) MEMBERSHIP; TERMS.—The Committee shall consist of such members as the Secretary may appoint who shall serve for such term as the Secretary may specify.

(3) DUTIES.—

(A) ADVICE.—The Committee shall provide advice to the Secretary with respect to the following functions:

(i) The implementation of the program under this section.

(ii) The establishment of financial standards for purposes of subsection (b)(2)(A)(ii).

(iii) The establishment of requirements for collection of data for the efficient management of the program.

(iv) The development of proposals for efficient interaction among manufacturers, providers of services, suppliers (as defined in section 1861(d)), and individuals.

(v) The establishment of quality standards under section 1834(a)(20).

(B) ADDITIONAL DUTIES.—The Committee shall perform such additional functions to assist the Secretary in carrying out this section as the Secretary may specify.

(4) INAPPLICABILITY OF FACA.—The provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply.

(5) TERMINATION.—The Committee shall terminate on December 31, 2009.

(d) REPORT.—Not later than July 1, 2009, the Secretary shall submit to Congress a report on the programs under this section. The report shall include information on savings, reductions in cost-sharing, access to and quality of items and services, and satisfaction of individuals.

(e) DEMONSTRATION PROJECT FOR CLINICAL LABORATORY SERVICES.—

(1) IN GENERAL.—The Secretary shall conduct a demonstration project on the application of competitive acquisition under this section to clinical diagnostic laboratory tests—

(A) for which payment would otherwise be made under section 1833(h) (other than for pap smear laboratory tests under paragraph (7) of such section) or section 1834(d)(1) (relating to colorectal cancer screening tests); and

(B) which are furnished by entities that did not have a face-to-face encounter with the individual.

(2) TERMS AND CONDITIONS.—

(A) IN GENERAL.—Except as provided in subparagraph (B), such project shall be under the same conditions as are applicable to items and services described in subsection (a)(2), excluding subsection (b)(5)(B) and other conditions as the Secretary determines to be appropriate.

(B) APPLICATION OF CLIA QUALITY STANDARDS.—The quality standards established by the Secretary under section 353 of the Public Health Service Act for clinical diagnostic laboratory tests shall apply to such tests under the demonstration project under this section in lieu of quality standards described in subsection (b)(2)(A)(i).

(3) REPORT.—The Secretary shall submit to Congress—

(A) an initial report on the project not later than December 31, 2005; and

(B) such progress and final reports on the project after such date as the Secretary determines appropriate.

USE OF AVERAGE SALES PRICE PAYMENT METHODOLOGY.[248]

SEC. 1847A. [42 U.S.C. 1395w–3a] (a) APPLICATION.—

(1) IN GENERAL.—Except as provided in paragraph (2), this section shall apply to payment for drugs and biologicals that

[248] P.L. 108-173, §303(c)(1), added §1847A, effective December 8, 2003.

See Vol. II, P.L. 108-173, §303(c)(2), with respect to a report on sales to pharmacy benefit managers and §303(c)(3), with respect to an Inspector General report on the adequacy of the reimbursement rate under the average sales price methodology.

are described in section 1842(o)(1)(C) and that are furnished on or after January 1, 2005.

(2) ELECTION.—This section shall not apply in the case of a physician who elects under subsection (a)(1)(A)(ii) of section 1847B for that section to apply instead of this section for the payment for drugs and biologicals.

(b) PAYMENT AMOUNT.—

(1) IN GENERAL.—Subject to subsections (d)(3)(C) and (e), the amount of payment determined under this section for the billing and payment code for a drug or biological (based on a minimum dosage unit) is, subject to applicable deductible and coinsurance—

(A) in the case of a multiple source drug (as defined in subsection (c)(6)(C)), 106 percent of the amount determined under paragraph (3); or

(B) in the case of a single source drug or biological (as defined in subsection (c)(6)(D)), 106 percent of the amount determined under paragraph (4).

(2) SPECIFICATION OF UNIT.—

(A) SPECIFICATION BY MANUFACTURER.—The manufacturer of a drug or biological shall specify the unit associated with each National Drug Code (including package size) as part of the submission of data under section 1927(b)(3)(A)(iii).

(B) UNIT DEFINED.—In this section, the term "unit" means, with respect to each National Drug Code (including package size) associated with a drug or biological, the lowest identifiable quantity (such as a capsule or tablet, milligram of molecules, or grams) of the drug or biological that is dispensed, exclusive of any diluent without reference to volume measures pertaining to liquids. For years after 2004, the Secretary may establish the unit for a manufacturer to report and methods for counting units as the Secretary determines appropriate to implement this section.

(3) MULTIPLE SOURCE DRUG.—For all drug products included within the same multiple source drug billing and payment code, the amount specified in this paragraph is the volume-weighted average of the average sales prices reported under section 1927(b)(3)(A)(iii) determined by—

(A) computing the sum of the products (for each National Drug Code assigned to such drug products) of—

(i) the manufacturer's average sales price (as defined in subsection (c)); and

(ii) the total number of units specified under paragraph (2) sold; and

(B) dividing the sum determined under subparagraph (A) by the sum of the total number of units under subparagraph (A)(ii) for all National Drug Codes assigned to such drug products.

(4) SINGLE SOURCE DRUG OR BIOLOGICAL.—The amount specified in this paragraph for a single source drug or biological is the lesser of the following:

(A) AVERAGE SALES PRICE.—The average sales price as determined using the methodology applied under paragraph (3) for all National Drug Codes assigned to such drug or biological product.

(B) WHOLESALE ACQUISITION COST (WAC).—The wholesale acquisition cost (as defined in subsection (c)(6)(B)) using the methodology applied under paragraph (3) for all National Drug Codes assigned to such drug or biological product.

(5) BASIS FOR PAYMENT AMOUNT.—The payment amount shall be determined under this subsection based on information reported under subsection (f) and without regard to any special packaging, labeling, or identifiers on the dosage form or product or package.

(c) MANUFACTURER'S AVERAGE SALES PRICE.—

(1) IN GENERAL.—For purposes of this section, subject to paragraphs (2) and (3), the manufacturer's "average sales price" means, of a drug or biological for a National Drug Code for a calendar quarter for a manufacturer for a unit—

(A) the manufacturer's sales to all purchasers (excluding sales exempted in paragraph (2)) in the United States for such drug or biological in the calendar quarter; divided by

(B) the total number of such units of such drug or biological sold by the manufacturer in such quarter.

(2) CERTAIN SALES EXEMPTED FROM COMPUTATION.—In calculating the manufacturer's average sales price under this subsection, the following sales shall be excluded:

(A) SALES EXEMPT FROM BEST PRICE.—Sales exempt from the inclusion in the determination of "best price" under section 1927(c)(1)(C)(i).

(B) SALES AT NOMINAL CHARGE.—Such other sales as the Secretary identifies as sales to an entity that are merely nominal in amount (as applied for purposes of section 1927(c)(1)(C)(ii)(III), except as the Secretary may otherwise provide).

(3) SALE PRICE NET OF DISCOUNTS.--In calculating the manufacturer's average sales price under this subsection, such price shall include volume discounts, prompt pay discounts, cash discounts, free goods that are contingent on any purchase requirement, chargebacks, and rebates (other than rebates under section 1927). For years after 2004, the Secretary may include in such price other price concessions, which may be based on recommendations of the Inspector General, that would result in a reduction of the cost to the purchaser.

(4) PAYMENT METHODOLOGY IN CASES WHERE AVERAGE SALES PRICE DURING FIRST QUARTER OF SALES IS UNAVAILABLE.—In the case of a drug or biological during an initial period (not to exceed a full calendar quarter) in which data on the prices for sales for the drug or biological is not sufficiently available from the manufacturer to compute an average sales price for the drug or biological, the Secretary may determine the amount payable under this section for the drug or biological based on—

(A) the wholesale acquisition cost; or

(B) the methodologies in effect under this part on November 1, 2003, to determine payment amounts for drugs or biologicals.

(5) FREQUENCY OF DETERMINATIONS.—

(A) IN GENERAL ON A QUARTERLY BASIS.—The manufacturer's average sales price, for a drug or biological of a manufacturer, shall be calculated by such manufacturer

under this subsection on a quarterly basis. In making such calculation insofar as there is a lag in the reporting of the information on rebates and chargebacks under paragraph (3) so that adequate data are not available on a timely basis, the manufacturer shall apply a methodology based on a 12-month rolling average for the manufacturer to estimate costs attributable to rebates and chargebacks. For years after 2004, the Secretary may establish a uniform methodology under this subparagraph to estimate and apply such costs.

(B) UPDATES IN PAYMENT AMOUNTS.—The payment amounts under subsection (b) shall be updated by the Secretary on a quarterly basis and shall be applied based upon the manufacturer's average sales price calculated for the most recent calendar quarter for which data is available.

(C) USE OF CONTRACTORS; IMPLEMENTATION.—The Secretary may contract with appropriate entities to calculate the payment amount under subsection (b). Notwithstanding any other provision of law, the Secretary may implement, by program instruction or otherwise, any of the provisions of this section.

(6) DEFINITIONS AND OTHER RULES.—In this section:

(A) MANUFACTURER.—The term "manufacturer" means, with respect to a drug or biological, the manufacturer (as defined in section 1927(k)(5)).

(B) WHOLESALE ACQUISITION COST.—The term 'wholesale acquisition cost' means, with respect to a drug or biological, the manufacturer's list price for the drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug or biological pricing data.

(C) MULTIPLE SOURCE DRUG.—

(i) IN GENERAL.—The term "multiple source drug" means, for a calendar quarter, a drug for which there are 2 or more drug products which—

(I) are rated as therapeutically equivalent (under the Food and Drug Administration's most recent publication of "Approved Drug Products with Therapeutic Equivalence Evaluations"),

(II) except as provided in subparagraph (E), are pharmaceutically equivalent and bioequivalent, as determined under subparagraph (F) and as determined by the Food and Drug Administration, and

(III) are sold or marketed in the United States during the quarter.

(ii) EXCEPTION.—With respect to single source drugs or biologicals that are within the same billing and payment code as of October 1, 2003, the Secretary shall treat such single source drugs or biologicals as if the single source drugs or biologicals were multiple source drugs.

(D) SINGLE SOURCE DRUG OR BIOLOGICAL.—The term "single source drug or biological" means—

(i) a biological; or

(ii) a drug which is not a multiple source drug and which is produced or distributed under a new drug application approved by the Food and Drug Administration, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application.

(E) EXCEPTION FROM PHARMACEUTICAL EQUIVALENCE AND BIOEQUIVALENCE REQUIREMENT.—Subparagraph (C)(ii) shall not apply if the Food and Drug Administration changes by regulation the requirement that, for purposes of the publication described in subparagraph (C)(i), in order for drug products to be rated as therapeutically equivalent, they must be pharmaceutically equivalent and bioequivalent, as defined in subparagraph (F).

(F) DETERMINATION OF PHARMACEUTICAL EQUIVALENCE AND BIOEQUIVALENCE.—For purposes of this paragraph--

(i) drug products are pharmaceutically equivalent if the products contain identical amounts of the same active drug ingredient in the same dosage form and meet compendial or other applicable standards of strength, quality, purity, and identity; and

(ii) drugs are bioequivalent if they do not present a known or potential bioequivalence problem, or, if they do present such a problem, they are shown to meet an appropriate standard of bioequivalence.

(G) INCLUSION OF VACCINES.—In applying provisions of section 1927 under this section, "other than a vaccine" is deemed deleted from section 1927(k)(2)(B).

(d) MONITORING OF MARKET PRICES.—

(1) IN GENERAL.—The Inspector General of the Department of Health and Human Services shall conduct studies, which may include surveys, to determine the widely available market prices of drugs and biologicals to which this section applies, as the Inspector General, in consultation with the Secretary, determines to be appropriate.

(2) COMPARISON OF PRICES.—Based upon such studies and other data for drugs and biologicals, the Inspector General shall compare the average sales price under this section for drugs and biologicals with—

(A) the widely available market price for such drugs and biologicals (if any); and

(B) the average manufacturer price (as determined under section 1927(k)(1)) for such drugs and biologicals.

(3) LIMITATION ON AVERAGE SALES PRICE.—

(A) IN GENERAL.—The Secretary may disregard the average sales price for a drug or biological that exceeds the widely available market price or the average manufacturer price for such drug or biological by the applicable threshold percentage (as defined in subparagraph (B)).

(B) APPLICABLE THRESHOLD PERCENTAGE DEFINED.—In this paragraph, the term "applicable threshold percentage" means—

(i) in 2005, in the case of an average sales price for a drug or biological that exceeds widely available market price or the average manufacturer price, 5 percent; and

(ii) in 2006 and subsequent years, the percentage applied under this subparagraph subject to such adjustment as the Secretary may specify for the widely available market price or the average manufacturer price, or both.

(C) AUTHORITY TO ADJUST AVERAGE SALES PRICE.—If the Inspector General finds that the average sales price for a drug or biological exceeds such widely available market price or average manufacturer price for such drug or biological by the applicable threshold percentage, the Inspector General shall inform the Secretary (at such times as the Secretary may specify to carry out this subparagraph) and the Secretary shall, effective as of the next quarter, substitute for the amount of payment otherwise determined under this section for such drug or biological the lesser of—

(i) the widely available market price for the drug or biological (if any); or

(ii) 103 percent of the average manufacturer price (as determined under section 1927(k)(1)) for the drug or biological.

(4) CIVIL MONEY PENALTY.—

(A) IN GENERAL.—If the Secretary determines that a manufacturer has made a misrepresentation in the reporting of the manufacturer's average sales price for a drug or biological, the Secretary may apply a civil money penalty in an amount of up to $10,000 for each such price misrepresentation and for each day in which such price misrepresentation was applied.

(B) PROCEDURES.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under subparagraph (B) in the same manner as they apply to a penalty or proceeding under section 1128A(a).

(5) WIDELY AVAILABLE MARKET PRICE.—

(A) IN GENERAL.—In this subsection, the term "widely available market price" means the price that a prudent physician or supplier would pay for the drug or biological. In determining such price, the Inspector General shall take into account the discounts, rebates, and other price concessions routinely made available to such prudent physicians or suppliers for such drugs or biologicals.

(B) CONSIDERATIONS.—In determining the price under subparagraph (A), the Inspector General shall consider information from one or more of the following sources:

(i) Manufacturers.

(ii) Wholesalers.

(iii) Distributors.

(iv) Physician supply houses.

(v) Specialty pharmacies.

(vi) Group purchasing arrangements.

(vii) Surveys of physicians.

(viii) Surveys of suppliers.

(ix) Information on such market prices from insurers.

(x) Information on such market prices from private health plans.

(e) AUTHORITY TO USE ALTERNATIVE PAYMENT IN RESPONSE TO PUBLIC HEALTH EMERGENCY.—In the case of a public health emergency under section 319 of the Public Health Service Act in which there is a documented inability to access drugs and biologicals, and a concomitant increase in the price, of a drug or biological which is not reflected in the manufacturer's average sales price for one or more quarters, the Secretary may use the wholesale acquisition cost (or other reasonable measure of drug or biological price) instead of the manufacturer's average sales price for such quarters and for subsequent quarters until the price and availability of the drug or biological has stabilized and is substantially reflected in the applicable manufacturer's average sales price.

(f) QUARTERLY REPORT ON AVERAGE SALES PRICE.—For requirements for reporting the manufacturer's average sales price (and, if required to make payment, the manufacturer's wholesale acquisition cost) for the drug or biological under this section, see section 1927(b)(3).

(g) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of—

(1) determinations of payment amounts under this section, including the assignment of National Drug Codes to billing and

(2) the identification of units (and package size) under subsection (b)(2);

(3) the method to allocate rebates, chargebacks, and other price concessions to a quarter if specified by the Secretary;

(4) the manufacturer's average sales price when it is used for the determination of a payment amount under this section; and

(5) the disclosure of the average manufacturer price by reason of an adjustment under subsection (d)(3)(C) or (e).

COMPETITIVE ACQUISITION OF OUTPATIENT DRUGS AND BIOLOGICALS.[249]

SEC. 1847B. [42 U.S.C. 1395w–3b] (a) IMPLEMENTATION OF COMPETITIVE ACQUISITION.—

(1) IMPLEMENTATION OF PROGRAM.—

(A) IN GENERAL. —The Secretary shall establish and implement a competitive acquisition program under which —

(i) competitive acquisition areas are established for contract award purposes for acquisition of and payment for categories of competitively biddable drugs and biologicals (as defined in paragraph (2)) under this part;

(ii) each physician is given the opportunity annually to elect to obtain drugs and biologicals under the program, rather than under section 1847A; and

[249] P.L. 108-173, §303(d)(1), added §1847B, effective December 8, 2003.
See Vol. II, P.L. 108-173, §303(d)(2), with respect to a report on the program conducted under §1847B.

(iii) each physician who elects to obtain drugs and biologicals under the program makes an annual selection under paragraph (5) of the contractor through which drugs and biologicals within a category of drugs and biologicals will be acquired and delivered to the physician under this part.This section shall not apply in the case of a physician who elects section 1847A to apply.

(B) IMPLEMENTATION. —For purposes of implementing the program, the Secretary shall establish categories of competitively biddable drugs and biologicals. The Secretary shall phase in the program with respect to those categories beginning in 2006 in such manner as the Secretary determines to be appropriate.

(C) WAIVER OF CERTAIN PROVISIONS. —In order to promote competition, in carrying out the program the Secretary may waive such provisions of the Federal Acquisition Regulation as are necessary for the efficient implementation of this section, other than provisions relating to confidentiality of information and such other provisions as the Secretary determines appropriate.

(D) EXCLUSION AUTHORITY. —The Secretary may exclude competitively biddable drugs and biologicals (including a class of such drugs and biologicals) from the competitive bidding system under this section if the application of competitive bidding to such drugs or biologicals —

(i) is not likely to result in significant savings; or

(ii) is likely to have an adverse impact on access to such drugs or biologicals.

(2) COMPETITIVELY BIDDABLE DRUGS AND BIOLOGICALS AND PROGRAM DEFINED. —For purposes of this section —

(A) Competitively biddable drugs and biologicals defined. —The term "competitively biddable drugs and biologicals" means a drug or biological described in section 1842(o)(1)(C) and furnished on or after January 1, 2006.

(B) Program. —The term "program" means the competitive acquisition program under this section.

(C) Competitive acquisition area; area. —The terms "competitive acquisition area" and "area" mean an appropriate geographic region established by the Secretary under the program.

(D) Contractor. —The term "contractor" means an entity that has entered into a contract with the Secretary under this section.

(3) APPLICATION OF PROGRAM PAYMENT METHODOLOGY. —

(A) IN GENERAL. —With respect to competitively biddable drugs and biologicals which are supplied under the program in an area and which are prescribed by a physician who has elected this section to apply —

(i) the claim for such drugs and biologicals shall be submitted by the contractor that supplied the drugs and biologicals;

(ii) collection of amounts of any deductible and coinsurance applicable with respect to such drugs and biologicals shall be the responsibility of such contrac-

tor and shall not be collected unless the drug or biological is administered to the individual involved; and

(iii) the payment under this section (and related amounts of any applicable deductible and coinsurance) for such drugs and biologicals —

(I) shall be made only to such contractor; and

(II) shall be conditioned upon the administration of such drugs and biologicals.

(B) PROCESS FOR ADJUSTMENTS. —The Secretary shall provide a process for adjustments to payments in the case in which payment is made for drugs and biologicals which were billed at the time of dispensing but which were not actually administered.

(C) INFORMATION FOR PURPOSES OF COST-SHARING. —The Secretary shall provide a process by which physicians submit information to contractors for purposes of the collection of any applicable deductible or coinsurance amounts under subparagraph(A)(ii).

(4) CONTRACT REQUIRED. —Payment may not be made under this part for competitively biddable drugs and biologicals prescribed by a physician who has elected this section to apply within a category and a competitive acquisition area with respect to which the program applies unless —

(A) the drugs or biologicals are supplied by a contractor with a contract under this section for such category of drugs and biologicals and area; and

(B) the physician has elected such contractor under paragraph (5) for such category and area.

(5) CONTRACTOR SELECTION PROCESS. —

(A) ANNUAL SELECTION. —

(i) IN GENERAL. —The Secretary shall provide a process for the selection of a contractor, on an annual basis and in such exigent circumstances as the Secretary may provide and with respect to each category of competitively biddable drugs and biologicals for an area by selecting physicians.

(ii) TIMING OF SELECTION. —The selection of a contractor under clause (i) shall be made at the time of the election described in section 1847A(a) for this section to apply and shall be coordinated with agreements entered into under section 1842(h).

(B) INFORMATION ON CONTRACTORS. —The Secretary shall make available to physicians on an ongoing basis, through a directory posted on the Internet website of the Centers for Medicare and Medicaid Services or otherwise and upon request, a list of the contractors under this section in the different competitive acquisition areas.

(C) SELECTING PHYSICIAN DEFINED. —For purposes of this section, the term "selecting physician" means, with respect to a contractor and category and competitive acquisition area, a physician who has elected this section to apply and has selected to apply under this section such contractor for such category and area.

(b) PROGRAM REQUIREMENTS. —

(1) CONTRACT FOR COMPETITIVELY BIDDABLE DRUGS AND BIOLOGICALS. —The Secretary shall conduct a competition

among entities for the acquisition of competitively biddable drugs and biologicals. Notwithstanding any other provision of this title, in the case of a multiple source drug, the Secretary shall conduct such competition among entities for the acquisition of at least one competitively biddable drug and biological within each billing and payment code within each category for each competitive acquisition area.

(2) CONDITIONS FOR AWARDING CONTRACT. —

(A) IN GENERAL. —The Secretary may not award a contract to any entity under the competition conducted in a competitive acquisition area pursuant to paragraph (1) with respect to the acquisition of competitively biddable drugs and biologicals within a category unless the Secretary finds that the entity meets all of the following with respect to the contract period involved:

(i) CAPACITY TO SUPPLY COMPETITIVELY BIDDABLE DRUG OR BIOLOGICAL WITHIN CATEGORY. —

(I) IN GENERAL. —The entity has sufficient arrangements to acquire and to deliver competitively biddable drugs and biologicals within such category in the area specified in the contract.

(II) SHIPMENT METHODOLOGY. —The entity has arrangements in effect for the shipment at least 5 days each week of competitively biddable drugs and biologicals under the contract and for the timely delivery (including for emergency situations) of such drugs and biologicals in the area under the contract.

(ii) QUALITY, SERVICE, FINANCIAL PERFORMANCE AND SOLVENCY STANDARDS. —The entity meets quality, service, financial performance, and solvency standards specified by the Secretary, including —

(I) the establishment of procedures for the prompt response and resolution of complaints of physicians and individuals and of inquiries regarding the shipment of competitively biddable drugs and biologicals; and

(II) a grievance and appeals process for the resolution of disputes.

(B) ADDITIONAL CONSIDERATIONS. —The Secretary may refuse to award a contract under this section, and may terminate such a contract, with an entity based upon —

(i) the suspension or revocation, by the Federal Government or a State government, of the entity's license for the distribution of drugs or biologicals (including controlled substances); or

(ii) the exclusion of the entity under section 1128 from participation under this title.

(C) APPLICATION OF MEDICARE PROVIDER OMBUDSMAN. —For provision providing for a program-wide Medicare Provider Ombudsman to review complaints, see section 1868(b), as added by section 923 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(3) AWARDING MULTIPLE CONTRACTS FOR A CATEGORY AND AREA. —The Secretary may limit (but not below 2) the number

of qualified entities that are awarded such contracts for any category and area. The Secretary shall select among qualified entities based on the following:

(A) The bid prices for competitively biddable drugs and biologicals within the category and area.

(B) Bid price for distribution of such drugs and biologicals.

(C) Ability to ensure product integrity.

(D) Customer service.

(E) Past experience in the distribution of drugs and biologicals, including controlled substances.

(F) Such other factors as the Secretary may specify.

(4) Terms of contracts. —

(A) IN GENERAL. —A contract entered into with an entity under the competition conducted pursuant to paragraph (1) is subject to terms and conditions that the Secretary may specify consistent with this section.

(B) PERIOD OF CONTRACTS. —A contract under this section shall be for a term of 3 years, but may be terminated by the Secretary or the entity with appropriate, advance notice.

(C) INTEGRITY OF DRUG AND BIOLOGICAL DISTRIBUTION SYSTEM. —A contractor (as defined in subsection (a)(2)(D)) shall —

(i) acquire all drug and biological products it distributes directly from the manufacturer or from a distributor that has acquired the products directly from the manufacturer; and

(ii) comply with any product integrity safeguards as may be determined to be appropriate by the Secretary. Nothing in this subparagraph shall be construed to relieve or exempt any contractor from the provisions of the Federal Food, Drug, and Cosmetic Act[250] that relate to the wholesale distribution of prescription drugs or biologicals.

(D) COMPLIANCE WITH CODE OF CONDUCT AND FRAUD AND ABUSE RULES. —Under the contract —

(i) the contractor shall comply with a code of conduct, specified or recognized by the Secretary, that includes standards relating to conflicts of interest; and

(ii) the contractor shall comply with all applicable provisions relating to prevention of fraud and abuse, including compliance with applicable guidelines of the Department of Justice and the Inspector General of the Department of Health and Human Services.

(E) Direct delivery of drugs and biologicals to physicians. —Under the contract the contractor shall only supply competitively biddable drugs and biologicals directly to the selecting physicians and not directly to individuals, except under circumstances and settings where an individual currently receives a drug or biological in the individual's home or other non-physician office setting as the Secretary may provide. The contractor shall not deliver drugs and biologicals to a selecting physician except upon receipt of a prescription for such drugs and biologicals, and such nec-

[250] P.L. 75-717.

essary data as may be required by the Secretary to carry out this section. This section does not —

(i) require a physician to submit a prescription for each individual treatment; or

(ii) change a physician's flexibility in terms of writing a prescription for drugs or biologicals for a single treatment or a course of treatment.

(5) PERMITTING ACCESS TO DRUGS AND BIOLOGICALS. —The Secretary shall establish rules under this section under which drugs and biologicals which are acquired through a contractor under this section may be used to resupply inventories of such drugs and biologicals which are administered consistent with safe drug practices and with adequate safeguards against fraud and abuse. The previous sentence shall apply if the physicians can demonstrate to the Secretary all of the following:

(A) The drugs or biologicals are required immediately.

(B) The physician could not have reasonably anticipated the immediate requirement for the drugs or biologicals.

(C) The contractor could not deliver to the physician the drugs or biologicals in a timely manner.

(D) The drugs or biologicals were administered in an emergency situation.

(6) CONSTRUCTION. —Nothing in this section shall be construed as waiving applicable State requirements relating to licensing of pharmacies.

(c) BIDDING PROCESS. —

(1) IN GENERAL. —In awarding a contract for a category of drugs and biologicals in an area under the program, the Secretary shall consider with respect to each entity seeking to be awarded a contract the bid price and the other factors referred to in subsection (b)(3).

(2) BID DEFINED. —In this section, the term "bid" means an offer to furnish a competitively biddable drug or biological for a particular price and time period.

(3) BIDDING ON A NATIONAL OR REGIONAL BASIS. —Nothing in this section shall be construed as precluding a bidder from bidding for contracts in all areas of the United States or as requiring a bidder to submit a bid for all areas of the United States.

(4) UNIFORMITY OF BIDS WITHIN AREA. —The amount of the bid submitted under a contract offer for any competitively biddable drug or biological for an area shall be the same for that drug or biological for all portions of that area.

(5) CONFIDENTIALITY OF BIDS. —The provisions of subparagraph (D) of section 1927(b)(3) shall apply to periods during which a bid is submitted with respect to a competitively biddable drug or biological under this section in the same manner as it applies to information disclosed under such section, except that any reference —

(A) in that subparagraph to a "manufacturer or wholesaler" is deemed a reference to a "bidder" under this section;

(B) in that section to "prices charged for drugs" is deemed a reference to a "bid" submitted under this section; and

(C) in clause (i) of that section to "this section", is deemed a reference to "part B of title XVIII".

(6) INCLUSION OF COSTS. —The bid price submitted in a contract offer for a competitively biddable drug or biological shall —

(A) include all costs related to the delivery of the drug or biological to the selecting physician (or other point of delivery); and

(B) include the costs of dispensing (including shipping) of such drug or biological and management fees, but shall not include any costs related to the administration of the drug or biological, or wastage, spillage, or spoilage.

(7) PRICE ADJUSTMENTS DURING CONTRACT PERIOD; DISCLOSURE OF COSTS. —Each contract awarded shall provide for —

(A) disclosure to the Secretary the contractor's reasonable, net acquisition costs for periods specified by the Secretary, not more often than quarterly, of the contract; and

(B) appropriate price adjustments over the period of the contract to reflect significant increases or decreases in a contractor's reasonable, net acquisition costs, as so disclosed.

(d) COMPUTATION OF PAYMENT AMOUNTS. —

(1) IN GENERAL. —Payment under this section for competitively biddable drugs or biologicals shall be based on bids submitted and accepted under this section for such drugs or biologicals in an area. Based on such bids the Secretary shall determine a single payment amount for each competitively biddable drug or biological in the area. (2) SPECIAL RULES. —The Secretary shall establish rules regarding the use under this section of the alternative payment amount provided under section 1847A to the use of a price for specific competitively biddable drugs and biologicals in the following cases:

(A) NEW DRUGS AND BIOLOGICALS. —A competitively biddable drug or biological for which a payment and billing code has not been established.

(B) OTHER CASES. —Such other exceptional cases as the Secretary may specify in regulations.

(e) COST-SHARING. —

(1) APPLICATION OF COINSURANCE. —Payment under this section for competitively biddable drugs and biologicals shall be in an amount equal to 80 percent of the payment basis described in subsection (d)(1).

(2) DEDUCTIBLE. —Before applying paragraph (1), the individual shall be required to meet the deductible described in section 1833(b).

(3) COLLECTION. —Such coinsurance and deductible shall be collected by the contractor that supplies the drug or biological involved. Subject to subsection (a)(3)(B), such coinsurance and deductible may be collected in a manner similar to the manner in which the coinsurance and deductible are collected for durable medical equipment under this part.

(f) SPECIAL PAYMENT RULES. —

(1) USE IN EXCLUSION CASES. —If the Secretary excludes a drug or biological (or class of drugs or biologicals) under subsection (a)(1)(D), the Secretary may provide for payment to be made under this part for such drugs and biologicals (or class) using the payment methodology under section 1847A.

(2) APPLICATION OF REQUIREMENT FOR ASSIGNMENT. —For provision requiring assignment of claims for competitively biddable drugs and biologicals, see section 1842(o)(3).

(3) PROTECTION FOR BENEFICIARY IN CASE OF MEDICAL NECESSITY DENIAL. —For protection of individuals against liability in the case of medical necessity determinations, see section 1842(b)(3)(B)(ii)(III).

(g) JUDICIAL REVIEW. —There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of —

(1) the establishment of payment amounts under subsection (d)(1);

(2) the awarding of contracts under this section;

(3) the establishment of competitive acquisition areas under subsection (a)(2)(C);

(4) the phased-in implementation under subsection (a)(1)(B);

(5) the selection of categories of competitively biddable drugs and biologicals for competitive acquisition under such subsection or the selection of a drug in the case of multiple source drugs; or

(6) the bidding structure and number of contractors selected under this section.

PAYMENT FOR PHYSICIANS' SERVICES [251]

SEC. 1848. [42 U.S.C. 1395w–4] (a) PAYMENT BASED ON FEE SCHEDULE.—

(1) IN GENERAL.—Effective for all physicians' services (as defined in subsection (j)(3)) furnished under this part during a year (beginning with 1992) for which payment is otherwise made on the basis of a reasonable charge or on the basis of a fee schedule under section 1834(b), payment under this part shall instead be based on the lesser of—

(A) the actual charge for the service, or

(B) subject to the succeeding provisions of this subsection, the amount determined under the fee schedule established under subsection (b) for services furnished during that year (in this subsection referred to as the "fee schedule amount").

(2) TRANSITION TO FULL FEE SCHEDULE.—

(A) LIMITING REDUCTIONS AND INCREASES TO 15 PERCENT IN 1992.—

(i) LIMIT ON INCREASE.—In the case of a service in a fee schedule area (as defined in subsection (j)(2)) for which the adjusted historical payment basis (as defined in subparagraph (D)) is less than 85 percent of the fee schedule amount for services furnished in 1992, there shall be substituted for the fee schedule

[251] See Vol. II, P.L. 106–554, §1(a)(6) [542], with respect to treatment of certain physician pathology services under Medicare.

See Vol. II, P.L. 108-173, §303(a)(2), with respect to the treatment of other services currently in non-physician work pool; §303(a)(3), with respect to payment for multiple chemotherapy agents furnished on a single day through the push technique; §303(a)(4), with respect to a transitional adjustment; §303(a)(5), with respect to MEDPAC review and reports and secretarial response; §303(g)(3), with respect to multiple chemotherapy agents, other services currently on the non-physician work pool, and transitional adjustment; §413(c), with respect to a GAO study of geographic differences in payments for physicians' services; §605, with respect to a collaborative demonstration-based review of physician practice to a MEDPAC report on payment for physicians' services; §644, with respect to a MEDPAC study of payment for cario-thoracic surgeons; and §953(a)(2), with respect to physician compensation generally.

amount an amount equal to the adjusted historical payment basis plus 15 percent of the fee schedule amount otherwise established (without regard to this paragraph).

(ii) LIMIT IN REDUCTION.—In the case of a service in a fee schedule area for which the adjusted historical payment basis exceeds 115 percent of the fee schedule amount for services furnished in 1992, there shall be substituted for the fee schedule amount an amount equal to the adjusted historical payment basis minus 15 percent of the fee schedule amount otherwise established (without regard to this paragraph).

(B) SPECIAL RULE FOR 1993, 1994, AND 1995.—If a physicians' service in a fee schedule area is subject to the provisions of subparagraph (A) in 1992, for physicians' services furnished in the area—

(i) during 1993, there shall be substituted for the fee schedule amount an amount equal to the sum of—

(I) 75 percent of the fee schedule amount determined under subparagraph (A), adjusted by the update established under subsection (d)(3) for 1993, and

(II) 25 percent of the fee schedule amount determined under paragraph (1) for 1993 without regard to this paragraph;

(ii) during 1994, there shall be substituted for the fee schedule amount an amount equal to the sum of—

(I) 67 percent of the fee schedule amount determined under clause (i), adjusted by the update established under subsection (d)(3) for 1994 and as adjusted under subsection (c)(2)(F)(ii) and under section 13515(b) of the Omnibus Budget Reconciliation Act of 1993, and

(II) 33 percent of the fee schedule amount determined under paragraph (1) for 1994 without regard to this paragraph; and

(iii) during 1995, there shall be substituted for the fee schedule amount an amount equal to the sum of—

(I) 50 percent of the fee schedule amount determined under clause (ii) adjusted by the update established under subsection (d)(3) for 1995, and

(II) 50 percent of the fee schedule amount determined under paragraph (1) for 1995 without regard to this paragraph.

(C) SPECIAL RULE FOR ANESTHESIA AND RADIOLOGY SERVICES.—With respect to physicians' services which are anesthesia services, the Secretary shall provide for a transition in the same manner as a transition is provided for other services under subparagraph (B). With respect to radiology services, "109 percent" and "9 percent" shall be substituted for "115 percent" and "15 percent", respectively, in subparagraph (A)(ii).

(D) ADJUSTED HISTORICAL PAYMENT BASIS DEFINED.—

(i) IN GENERAL.—In this paragraph, the term "adjusted historical payment basis" means, with respect

to a physicians' service furnished in a fee schedule area, the weighted average prevailing charge applied in the area for the service in 1991 (as determined by the Secretary without regard to physician specialty and as adjusted to reflect payments for services with customary charges below the prevailing charge or other payment limitations imposed by law or regulation) adjusted by the update established under subsection (d)(3) for 1992.

(ii) APPLICATION TO RADIOLOGY SERVICES.—In applying clause (i) in the case of physicians' services which are radiology services (including radiologist services, as defined in section 1834(b)(6)), but excluding nuclear medicine services that are subject to section 6105(b) of the Omnibus Budget Reconciliation Act of 1989, there shall be substituted for the weighted average prevailing charge the amount provided under the fee schedule established for the service for the fee schedule area under section 1834(b).

(iii) NUCLEAR MEDICINE SERVICES.—In applying clause (i) in the case of physicians' services which are nuclear medicine services, there shall be substituted for the weighted average prevailing charge the amount provided under section 6105(b) of the Omnibus Budget Reconciliation Act of 1989.

(3) INCENTIVES FOR PARTICIPATING PHYSICIANS AND SUPPLIERS.—In applying paragraph (1)(B) in the case of a nonparticipating physician or a nonparticipating supplier or other person, the fee schedule amount shall be 95 percent of such amount otherwise applied under this subsection (without regard to this paragraph). In the case of physicians' services (including services which the Secretary excludes pursuant to subsection (j)(3)) of a nonparticipating physician, supplier, or other person for which payment is made under this part on a basis other than the fee schedule amount, the payment shall be based on 95 percent of the payment basis for such services furnished by a participating physician, supplier, or other person.

(4) SPECIAL RULE FOR MEDICAL DIRECTION.—

(A) IN GENERAL.—With respect to physicians' services furnished on or after January 1, 1994, and consisting of medical direction of two, three, or four concurrent anesthesia cases, the fee schedule amount to be applied shall be equal to one-half of the amount described in subparagraph (B).

(B) AMOUNT.—The amount described in this subparagraph, for a physician's medical direction of the performance of anesthesia services, is the following percentage of the fee schedule amount otherwise applicable under this section if the anesthesia services were personally performed by the physician alone:

(i) For services furnished during 1994, 120 percent.
(ii) For services furnished during 1995, 115 percent.
(iii) For services furnished during 1996, 110 percent.
(iv) For services furnished during 1997, 105 percent.
(v) For services furnished after 1997, 100 percent.

(b) ESTABLISHMENT OF FEE SCHEDULES.—

(1) IN GENERAL.—Before November 1 of the preceding year, for each year beginning with 1998, the Secretary shall establish, by regulation, fee schedules that establish payment amounts for all physicians' services furnished in all fee schedule areas (as defined in subsection (j)(2)) for the year. Except as provided in paragraph (2), each such payment amount for a service shall be equal to the product of—

(A) the relative value for the service (as determined in subsection (c)(2)),

(B) the conversion factor (established under subsection (d)) for the year, and

(C) the geographic adjustment factor (established under subsection (e)(2)) for the service for the fee schedule area.

(2) TREATMENT OF RADIOLOGY SERVICES AND ANESTHESIA SERVICES.—

(A) RADIOLOGY SERVICES.—With respect to radiology services (including radiologist services, as defined in section 1834(b)(6)), the Secretary shall base the relative values on the relative value scale developed under section 1834(b)(1)(A), with appropriate modifications of the relative values to assure that the relative values established for radiology services which are similar or related to other physicians' services are consistent with the relative values established for those similar or related services.

(B) ANESTHESIA SERVICES.—In establishing the fee schedule for anesthesia services for which a relative value guide has been established under section 4048(b) of the Omnibus Budget Reconciliation Act of 1987[252], the Secretary shall use, to the extent practicable, such relative value guide, with appropriate adjustment of the conversion factor, in a manner to assure that the fee schedule amounts for anesthesia services are consistent with the fee schedule amounts for other services determined by the Secretary to be of comparable value. In applying the previous sentence, the Secretary shall adjust the conversion factor by geographic adjustment factors in the same manner as such adjustment is made under paragraph (1)(C).

(C) CONSULTATION.—The Secretary shall consult with the Physician Payment Review Commission and organizations representing physicians or suppliers who furnish radiology services and anesthesia services in applying subparagraphs (A) and (B).

(3) TREATMENT OF INTERPRETATION OF ELECTROCARDIOGRAMS.—The Secretary—

(A) shall make separate payment under this section for the interpretation of electrocardiograms performed or ordered to be performed as part of or in conjunction with a visit to or a consultation with a physician, and

(B) shall adjust the relative values established for visits and consultations under subsection (c) so as not to include relative value units for interpretations of electrocardiograms in the relative value for visits and consultations.

[252] See Vol. II, P.L. 100–203.

(c) DETERMINATION OF RELATIVE VALUES FOR PHYSICIANS' SERVICES.—

(1) DIVISION OF PHYSICIANS' SERVICES INTO COMPONENTS.—In this section, with respect to a physicians' service:

(A) WORK COMPONENT DEFINED.—The term "work component" means the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service. Such portion shall—

(i) include activities before and after direct patient contact, and

(ii) be defined, with respect to surgical procedures, to reflect a global definition including pre-operative and post-operative physicians' services.

(B) PRACTICE EXPENSE COMPONENT DEFINED.—The term "practice expense component" means the portion of the resources used in furnishing the service that reflects the general categories of expenses (such as office rent and wages of personnel, but excluding malpractice expenses) comprising practice expenses.

(C) MALPRACTICE COMPONENT DEFINED.—The term "malpractice component" means the portion of the resources used in furnishing the service that reflects malpractice expenses in furnishing the service.

(2) DETERMINATION OF RELATIVE VALUES.—

(A) IN GENERAL.—

(i) COMBINATION OF UNITS FOR COMPONENTS.—The Secretary shall develop a methodology for combining the work, practice expense, and malpractice relative value units, determined under subparagraph (C), for each service in a manner to produce a single relative value for that service. Such relative values are subject to adjustment under subparagraph (F)(i) and section 13515(b) of the Omnibus Budget Reconciliation Act of 1993[253].

(ii) EXTRAPOLATION.—The Secretary may use extrapolation and other techniques to determine the number of relative value units for physicians' services for which specific data are not available and shall take into account recommendations of the Physician Payment Review Commission and the results of consultations with organizations representing physicians who provide such services.

(B) PERIODIC REVIEW AND ADJUSTMENTS IN RELATIVE VALUES.—

(i) PERIODIC REVIEW.—The Secretary, not less often than every 5 years, shall review the relative values established under this paragraph for all physicians' services.

(ii) ADJUSTMENTS.—

(I) IN GENERAL.—The Secretary shall, to the extent the Secretary determines to be necessary and subject to subclause (II), adjust the number of such units to take into account changes in medical practice, coding changes, new data on relative

[253] See Vol. II, P.L. 103–66, §13515(b)

value components, or the addition of new procedures. The Secretary shall publish an explanation of the basis for such adjustments.

(II) LIMITATION ON ANNUAL ADJUSTMENTS.—Subject to clause (iv), the adjustments[254] under subclause (I) for a year may not cause the amount of expenditures under this part for the year to differ by more than $20,000,000 from the amount of expenditures under this part that would have been made if such adjustments had not been made.

(iii) CONSULTATION.—The Secretary, in making adjustments under clause (ii), shall consult with the Medicare Payment Advisory Commission and organizations representing physicians.

(C) COMPUTATION OF RELATIVE VALUE UNITS FOR COMPONENTS.—For purposes of this section for each physicians' service—

(i) WORK RELATIVE VALUE UNITS.—The Secretary shall determine a number of work relative value units for the service based on the relative resources incorporating physician time and intensity required in furnishing the service.

(ii) PRACTICE EXPENSE RELATIVE VALUE UNITS[255].—The Secretary shall determine a number of practice expense relative value units for the service for years before 1999 equal to the product of—

(I) the base allowed charges (as defined in subparagraph (D)) for the service, and

(II) the practice expense percentage for the service (as determined under paragraph (3)(C)(ii)),

and for years beginning with 1999 based on the relative practice expense resources involved in furnishing the service.

For 1999, such number of units shall be determined based 75 percent on such product and based 25 percent on the relative practice expense resources involved in furnishing the service. For 2000, such number of units shall be determined based 50 percent on such product and based 50 percent on such relative practice expense resources. For 2001, such number of units shall be determined based 25 percent on such product and based 75 percent on such relative practice expense resources. For a subsequent year, such number of units shall be determined based entirely on such relative practice expense resources.

(iii) MALPRACTICE RELATIVE VALUE UNITS.—The Secretary shall determine a number of malpractice relative value units for the service for years before 2000 equal to the product of—

(I) the base allowed charges (as defined in subparagraph (D)) for the service, and

[254] P.L. 108–173, §303(a)(1)(A)(i), struck out "The adjustments" and substituted "Subject to clause (iv), the adjustments".

[255] See Vol. II, P.L. 105–33, §4505(f)(2), with respect to application of certain budget neutrality provisions.

(II) the malpractice percentage for the service (as determined under paragraph (3)(C)(iii)),

and for years beginning with 2000 based on the malpractice expense resources involved in furnishing the service.

(D) BASE ALLOWED CHARGES DEFINED.—In this paragraph, the term "base allowed charges" means, with respect to a physician's service, the national average allowed charges for the service under this part for services furnished during 1991, as estimated by the Secretary using the most recent data available.

(E) REDUCTION IN PRACTICE EXPENSE RELATIVE VALUE UNITS FOR CERTAIN SERVICES.—

(i) IN GENERAL.—Subject to clause (ii), the Secretary shall reduce the practice expense relative value units applied to services described in clause (iii) furnished in—

(I) 1994, by 25 percent of the number by which the number of practice expense relative value units (determined for 1994 without regard to this subparagraph) exceeds the number of work relative value units determined for 1994,

(II) 1995, by an additional 25 percent of such excess, and

(III) 1996, by an additional 25 percent of such excess.

(ii) FLOOR ON REDUCTIONS.—The practice expense relative value units for a physician's service shall not be reduced under this subparagraph to a number less than 128 percent of the number of work relative value units.

(iii) SERVICES COVERED.—For purposes of clause (i), the services described in this clause are physicians' services that are not described in clause (iv) and for which—

(I) there are work relative value units, and

(II) the number of practice expense relative value units (determined for 1994) exceeds 128 percent of the number of work relative value units (determined for such year).

(iv) EXCLUDED SERVICES.—For purposes of clause (iii), the services described in this clause are services which the Secretary determines at least 75 percent of which are provided under this title in an office setting.

(F) BUDGET NEUTRALITY ADJUSTMENTS.—The Secretary—

(i) shall reduce the relative values for all services (other than anesthesia services) established under this paragraph (and in the case of anesthesia services, the coversion factor established by the Secretary for such services) by such percentage as the Secretary determines to be necessary so that, beginning in 1996, the amendment made by section 13514(a) of the Omnibus Budget Reconciliation Act of 1993 would not result in expenditures under this section that exceed the amount of such expenditures that would have been made if such amendment had not been made, and

(ii) shall reduce the amounts determined under subsection (a)(2)(B)(ii)(I) by such percentage as the Secretary determines to be required to assure that, taking into account the reductions made under clause (i), the amendment made by section 13514(a) of the Omnibus Budget Reconciliation Act of 1993 would not result in expenditures under this section in 1994 that exceed the amount of such expenditures that would have been made if such amendment had not been made.

(G) ADJUSTMENTS IN RELATIVE VALUE UNITS FOR 1998.—

(i) IN GENERAL.—The Secretary shall—

(I) subject to clauses (iv) and (v), reduce the practice expense relative value units applied to any services described in clause (ii) furnished in 1998 to a number equal to 110 percent of the number of work relative value units, and

(II) increase the practice expense relative value units for office visit procedure codes during 1998 by a uniform percentage which the Secretary estimates will result in an aggregate increase in payments for such services equal to the aggregate decrease in payments by reason of subclause (I).

(ii) SERVICES COVERED.—For purposes of clause (i), the services described in this clause are physicians' services that are not described in clause (iii) and for which—

(I) there are work relative value units, and

(II) the number of practice expense relative value units (determined for 1998) exceeds 110 percent of the number of work relative value units (determined for such year).

(iii) EXCLUDED SERVICES.—For purposes of clause (ii), the services described in this clause are services which the Secretary determines at least 75 percent of which are provided under this title in an office setting.

(iv) LIMITATION ON AGGREGATE REALLOCATION.—If the application of clause (i)(I) would result in an aggregate amount of reductions under such clause in excess of $390,000,000, such clause shall be applied by substituting for 110 percent such greater percentage as the Secretary estimates will result in the aggregate amount of such reductions equaling $390,000,000.

(v) NO REDUCTION FOR CERTAIN SERVICES.—Practice expense relative value units for a procedure performed in an office or in a setting out of an office shall not be reduced under clause (i) if the in–office or out–of–office practice expense relative value, respectively, for the procedure would increase under the proposed rule on resource–based practice expenses issued by the Secretary on June 18, 1997 (62 Federal Register 33158 et seq.).

(3)[256] COMPONENT PERCENTAGES.—For purposes of paragraph (2), the Secretary shall determine a work percentage, a

[256] See Vol. II, P.L. 101–508, §4104(c), with respect to physician pathology services.

practice expense percentage, and a malpractice percentage for each physician's service as follows:

(A) DIVISION OF SERVICES BY SPECIALTY.—For each physician's service or class of physicians' services, the Secretary shall determine the average percentage of each such service or class of services that is performed, nationwide, under this part by physicians in each of the different physician specialties (as identified by the Secretary).

(B) DIVISION OF SPECIALTY BY COMPONENT.—The Secretary shall determine the average percentage division of resources, among the work component, the practice expense component, and the malpractice component, used by physicians in each of such specialties in furnishing physicians' services. Such percentages shall be based on national data that describe the elements of physician practice costs and revenues, by physician specialty. The Secretary may use extrapolation and other techniques to determine practice costs and revenues for specialties for which adequate data are not available.

(C) DETERMINATION OF COMPONENT PERCENTAGES.—

(i) WORK PERCENTAGE.—The work percentage for a service (or class of services) is equal to the sum (for all physician specialties) of—

(I) the average percentage division for the work component for each physician specialty (determined under subparagraph (B)), multiplied by

(II) the proportion (determined under subparagraph (A)) of such service (or services) performed by physicians in that specialty.

(ii) PRACTICE EXPENSE PERCENTAGE.—For years before 1999, the practice expense percentage for a service (or class of services) is equal to the sum (for all physician specialties) of—

(I) the average percentage division for the practice expense component for each physician specialty (determined under subparagraph (B)), multiplied by

(II) the proportion (determined under subparagraph (A)) of such service (or services) performed by physicians in that specialty.

(iii) MALPRACTICE PERCENTAGE.—For years before 1999, the malpractice percentage for a service (or class of services) is equal to the sum (for all physician specialties) of—

(I) the average percentage division for the malpractice component for each physician specialty (determined under subparagraph (B)), multiplied by

(II) the proportion (determined under subparagraph (A)) of such service (or services) performed by physicians in that specialty.

(D) PERIODIC RECOMPUTATION.—The Secretary may, from time to time, provide for the recomputation of work percentages, practice expense percentages, and malpractice percentages determined under this paragraph.

(4) ANCILLARY POLICIES.—The Secretary may establish ancillary policies (with respect to the use of modifiers, local codes, and other matters) as may be necessary to implement this section.

(5) CODING.—The Secretary shall establish a uniform procedure coding system for the coding of all physicians' services. The Secretary shall provide for an appropriate coding structure for visits and consultations. The Secretary may incorporate the use of time in the coding for visits and consultations. The Secretary, in establishing such coding system, shall consult with the Physician Payment Review Commission and other organizations representing physicians.

(6) NO VARIATION FOR SPECIALISTS.—The Secretary may not vary the conversion factor or the number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician.

(d) CONVERSION FACTORS.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The conversion factor for each year shall be the conversion factor established under this subsection for the previous year (or, in the case of 1992, specified in subparagraph (B)) adjusted by the update (established under paragraph (3)) for the year involved (for years before 2001) and, for years beginning with 2001, multiplied by the update (established under paragraph (4)) for the year involved.

(B) SPECIAL PROVISION FOR 1992.—For purposes of subparagraph (A), the conversion factor specified in this subparagraph is a conversion factor (determined by the Secretary) which, if this section were to apply during 1991 using such conversion factor, would result in the same aggregate amount of payments under this part for physicians' services as the estimated aggregate amount of the payments under this part for such services in 1991.

(C) SPECIAL RULES FOR 1998.—Except as provided in subparagraph (D), the single conversion factor for 1998 under this subsection shall be the conversion factor for primary care services for 1997, increased by the Secretary's estimate of the weighted average of the three separate updates that would otherwise occur were it not for the enactment of chapter 1 of subtitle F of title IV of the Balanced Budget Act of 1997.

(D) SPECIAL RULES FOR ANESTHESIA SERVICES.—The separate conversion factor for anesthesia services for a year shall be equal to 46 percent of the single conversion factor established for other physicians' services, except as adjusted for changes in work, practice expense, or malpractice relative value units.

(E) PUBLICATION AND DISSEMINATION OF INFORMATION.—The Secretary shall—

(i) cause to have published in the Federal Register not later than November 1 of each year (beginning with 2000) the conversion factor which will apply to physicians' services for the succeeding year, the update determined under paragraph (4) for such succeed-

ing year, and the allowed expenditures under such paragraph for such succeeding year; and

(ii) make available to the Medicare Payment Advisory Commission and the public by March 1 of each year (beginning with 2000) an estimate of the sustainable growth rate and of the conversion factor which will apply to physicians' services for the succeeding year and data used in making such estimate.

(2) [Stricken.[257]]

(3) UPDATE FOR 1999 AND 2000.—

(A) IN GENERAL.—Unless otherwise provided by law, subject to subparagraph (D) and the budget–neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii), the update to the single conversion factor established in paragraph (1)(C) for a year beginning with 1999 and 2000 is equal to the product of—

(i) 1 plus the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year (divided by 100), and

(ii) 1 plus the Secretary's estimate of the update adjustment factor for the year (divided by 100), minus 1 and multiplied by 100.

(B) UPDATE ADJUSTMENT FACTOR.—For purposes of subparagraph (A)(ii), the "update adjustment factor" for a year is equal (as estimated by the Secretary) to—

(i) the difference between (I) the sum of the allowed expenditures for physicians' services (as determined under subparagraph (C)) for the period beginning April 1, 1997, and ending on March 31 of the year involved, and (II) the amount of actual expenditures for physicians' services furnished during the period beginning April 1, 1997, and ending on March 31 of the preceding year; divided by

(ii) the actual expenditures for physicians' services for the 12–month period ending on March 31 of the preceding year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12–month period.

(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of this paragraph and paragraph (4), the allowed expenditures for physicians' services for the 12–month period ending with March 31 of—

(i) 1997 is equal to the actual expenditures for physicians' services furnished during such 12–month period, as estimated by the Secretary; or

(ii) a subsequent year is equal to the allowed expenditures for physicians' services for the previous year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12–month period.

(D) RESTRICTION ON VARIATION FROM MEDICARE ECONOMIC INDEX.—Notwithstanding the amount of the update adjustment factor determined under subparagraph (B) for

[257] P.L. 105–33, §4502(b); 111 Stat. 433.

a year, the update in the conversion factor under this paragraph for the year may not be—

(i) greater than 100 times the following amount: (1.03 + (MEI percentage/100)) –1; or

(ii) less than 100 times the following amount: (0.93 + (MEI percentage/100)) –1,

where "MEI percentage" means the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year involved.

(4) UPDATE FOR YEARS BEGINNING WITH 2001.—

(A) IN GENERAL.—Unless otherwise provided by law, subject to the budget–neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii) and subject to adjustment under subparagraph (F), the update to the single conversion factor established in paragraph (1)(C) for a year beginning with 2001 is equal to the product of—

(i) 1 plus the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year (divided by 100); and

(ii) 1 plus the Secretary's estimate of the update adjustment factor under subparagraph (B) for the year.

(B) UPDATE ADJUSTMENT FACTOR.—For purposes of subparagraph (A)(ii), subject to subparagraph (D) and paragraph (5)[258], the "update adjustment factor" for a year is equal (as estimated by the Secretary) to the sum of the following:

(i) PRIOR YEAR ADJUSTMENT COMPONENT.—An amount determined by—

(I) computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services for the prior year (as determined under subparagraph (C)) and the amount of the actual expenditures for such services for that year;

(II) dividing that difference by the amount of the actual expenditures for such services for that year; and

(III) multiplying that quotient by 0.75.

(ii) CUMULATIVE ADJUSTMENT COMPONENT.—An amount determined by—

(I) computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services (as determined under subparagraph (C)) from April 1, 1996, through the end of the prior year and the amount of the actual expenditures for such services during that period;

(II) dividing that difference by actual expenditures for such services for the prior year as increased by the sustainable growth rate under subsection (f) for the year for which the update adjustment factor is to be determined; and

(III) multiplying that quotient by 0.33.

[258] P.L. 108–173, §601(a)(2), inserted "and paragraph (5)".

(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of this paragraph:

(i) PERIOD UP TO APRIL 1, 1999.—The allowed expenditures for physicians' services for a period before April 1, 1999, shall be the amount of the allowed expenditures for such period as determined under paragraph (3)(C).

(ii) TRANSITION TO CALENDAR YEAR ALLOWED EXPENDITURES.—Subject to subparagraph (E), the allowed expenditures for—

(I) the 9–month period beginning April 1, 1999, shall be the Secretary's estimate of the amount of the allowed expenditures that would be permitted under paragraph (3)(C) for such period; and

(II) the year of 1999, shall be the Secretary's estimate of the amount of the allowed expenditures that would be permitted under paragraph (3)(C) for such year.

(iii) YEARS BEGINNING WITH 2000.—The allowed expenditures for a year (beginning with 2000) is equal to the allowed expenditures for physicians' services for the previous year, increased by the sustainable growth rate under subsection (f) for the year involved.

(D) RESTRICTION ON UPDATE ADJUSTMENT FACTOR.—The update adjustment factor determined under subparagraph (B) for a year may not be less than –0.07 or greater than 0.03.

(E) RECALCULATION OF ALLOWED EXPENDITURES FOR UPDATES BEGINNING WITH 2001.—For purposes of determining the update adjustment factor for a year beginning with 2001, the Secretary shall recompute the allowed expenditures for previous periods beginning on or after April 1, 1999, consistent with subsection (f)(3).

(F) TRANSITIONAL ADJUSTMENT DESIGNED TO PROVIDE FOR BUDGET NEUTRALITY.—Under this subparagraph the Secretary shall provide for an adjustment to the update under subparagraph (A)—

(i) for each of 2001, 2002, 2003, and 2004, of –0.2 percent; and

(ii) for 2005 of +0.8 percent.

(5)[259] Update for 2004 and 2005.—The update to the single conversion factor established in paragraph (1)(C) for each of 2004 and 2005 shall be not less than 1.5 percent.

(e) GEOGRAPHIC ADJUSTMENT FACTORS.—

(1) ESTABLISHMENT OF GEOGRAPHIC INDICES.—

(A) IN GENERAL.—Subject to subparagraphs (B), (C), (E), (F) and (G)[260], the Secretary shall establish—

(i) an index which reflects the relative costs of the mix of goods and services comprising practice expenses (other than malpractice expenses) in the different fee

[259] P.L. 108–173, §601(a)(1), added paragraph (5), applicable to computations of the sustainable growth rate for years beginning with 2003; §601(a)(3), provides that this amendment shall not be treated at a change in law for purpose of applying §1848(f)(2)(D).

[260] P.L. 108-173, §412(1), struck out "subparagraphs (B) and (C)" and substituted "subparagraphs (B), (C), and (E)".

P.L. 108-173, §602(1), struck out "subparagraphs (B), (C), (E), and (F)" and substituted "subparagraphs (B), (C), (E), (F) and (G)".

schedule areas compared to the national average of such costs,

(ii) an index which reflects the relative costs of malpractice expenses in the different fee schedule areas compared to the national average of such costs, and

(iii) an index which reflects ¼ of the difference between the relative value of physicians' work effort in each of the different fee schedule areas and the national average of such work effort.

(B) CLASS–SPECIFIC GEOGRAPHIC COST–OF–PRACTICE INDICES.—The Secretary may establish more than one index under subparagraph (A)(i) in the case of classes of physicians' services, if, because of differences in the mix of goods and services comprising practice expenses for the different classes of services, the application of a single index under such clause to different classes of such services would be substantially inequitable.

(C) PERIODIC REVIEW AND ADJUSTMENTS IN GEOGRAPHIC ADJUSTMENT FACTORS.—The Secretary, not less often than every 3 years, shall, in consultation with appropriate representatives of physicians, review the indices established under subparagraph (A) and the geographic index values applied under this subsection for all fee schedule areas. Based on such review, the Secretary may revise such index and adjust such index values, except that, if more than 1 year has elapsed since the date of the last previous adjustment, the adjustment to be applied in the first year of the next adjustment shall be ½ of the adjustment that otherwise would be made.

(D) USE OF RECENT DATA.—In establishing indices and index values under this paragraph, the Secretary shall use the most recent data available relating to practice expenses, malpractice expenses, and physician work effort in different fee schedule areas.

(E)[261] FLOOR AT 1.0 ON WORK GEOGRAPHIC INDEX.—After calculating the work geographic index in subparagraph (A)(iii), for purposes of payment for services furnished on or after January 1, 2004, and before January 1, 2007, the Secretary shall increase the work geographic index to 1.00 for any locality for which such work geographic index is less than 1.00.

(G)[262] FLOOR FOR PRACTICE EXPENSE, MALPRACTICE, AND WORK GEOGRAPHIC INDICES FOR SERVICES FURNISHED IN ALASKA.—For purposes of payment for services furnished in Alaska on or after January 1, 2004, and before January 1, 2006, after calculating the practice expense, alpractice, and work geographic indices in clauses (i), (ii), and (iii) of subparagraph (A) and in subparagraph (B), the Secretary shall increase any such index to 1.67 if such index would otherwise be less than 1.67.

(2) COMPUTATION OF GEOGRAPHIC ADJUSTMENT FACTOR.—For purposes of subsection (b)(1)(C), for all physicians' services for each fee schedule area the Secretary shall establish a geo-

[261] P.L. 108-173, §412(2), added subparagraph (E), effective December 8, 2003.
[262] P.L. 108-173, §602(2), added subparagraph (G), effective December 8, 2003.
As in original. No subparagraph (F) was enacted.

graphic adjustment factor equal to the sum of the geographic cost–of–practice adjustment factor (specified in paragraph (3)), the geographic malpractice adjustment factor (specified in paragraph (4)), and the geographic physician work adjustment factor (specified in paragraph (5)) for the service and the area.

(3) GEOGRAPHIC COST–OF–PRACTICE ADJUSTMENT FACTOR.—For purposes of paragraph (2), the "geographic cost-of-practice adjustment factor", for a service for a fee schedule area, is the product of—

(A) the proportion of the total relative value for the service that reflects the relative value units for the practice expense component, and

(B) the geographic cost–of–practice index value for the area for the service, based on the index established under paragraph (1)(A)(i) or (1)(B) (as the case may be).

(4) GEOGRAPHIC MALPRACTICE ADJUSTMENT FACTOR.—For purposes of paragraph (2), the "geographic malpractice adjustment factor", for a service for a fee schedule area, is the product of—

(A) the proportion of the total relative value for the service that reflects the relative value units for the malpractice component, and

(B) the geographic malpractice index value for the area, based on the index established under paragraph (1)(A)(ii).

(5) GEOGRAPHIC PHYSICIAN WORK ADJUSTMENT FACTOR.—For purposes of paragraph (2), the "geographic physician work adjustment factor", for a service for a fee schedule area, is the product of—

(A) the proportion of the total relative value for the service that reflects the relative value units for the work component, and

(B) the geographic physician work index value for the area, based on the index established under paragraph (1)(A)(iii).

(f) SUSTAINABLE GROWTH RATE.—

(1) PUBLICATION.—The Secretary shall cause to have published in the Federal Register not later than—

(A) November 1, 2000, the sustainable growth rate for 2000 and 2001; and

(B) November 1 of each succeeding year the sustainable growth rate for such succeeding year and each of the preceding 2 years.

(2) SPECIFICATION OF GROWTH RATE.—The sustainable growth rate for all physicians' services for a fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2000) and a year beginning with 2000 shall be equal to the product of—

(A) 1 plus the Secretary's estimate of the weighted average percentage increase (divided by 100) in the fees for all physicians' services in the applicable period involved,

(B) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than Medicare+Choice plan enrollees) from the previous fiscal year to the applicable period involved,

(C) 1 plus the Secretary's estimate of the annual average[263] percentage growth in real gross domestic product per capita (divided by 100) during the 10-year period ending with the applicable period involved[264], and

(D) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in the fiscal year (compared with the previous fiscal year) which will result from changes in law and regulations, determined without taking into account estimated changes in expenditures resulting from the update adjustment factor determined under subsection (d)(3)(B) or (d)(4)(B), as the case may be,

minus 1 and multiplied by 100.

(3) DATA TO BE USED.—For purposes of determining the update adjustment factor under subsection (d)(4)(B) for a year beginning with 2001, the sustainable growth rates taken into consideration in the determination under paragraph (2) shall be determined as follows:

(A) FOR 2001.—For purposes of such calculations for 2001, the sustainable growth rates for fiscal year 2000 and the years 2000 and 2001 shall be determined on the basis of the best data available to the Secretary as of September 1, 2000.

(B) FOR 2002.—For purposes of such calculations for 2002, the sustainable growth rates for fiscal year 2000 and for years 2000, 2001, and 2002 shall be determined on the basis of the best data available to the Secretary as of September 1, 2001.

(C) FOR 2003 AND SUCCEEDING YEARS.—For purposes of such calculations for a year after 2002—

(i) the sustainable growth rates for that year and the preceding 2 years shall be determined on the basis of the best data available to the Secretary as of September 1 of the year preceding the year for which the calculation is made; and

(ii) the sustainable growth rate for any year before a year described in clause (i) shall be the rate as most recently determined for that year under this subsection.

Nothing in this paragraph shall be construed as affecting the sustainable growth rates established for fiscal year 1998 or fiscal year 1999.

(4) DEFINITIONS.—In this subsection:

(A) SERVICES INCLUDED IN PHYSICIANS' SERVICES.—The term "physicians' services" includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to a Medicare+Choice plan enrollee.

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[263] P.L. 108-173, §601(b)(1)(A), struck out "projected" and substituted "annual average", applicable to computations of the sustainable growth rate for years beginning with 2003.

[264] P.L. 108-173, §601(b)(1)(B), struck out "from the previous applicable period to the applicable period involved" and substituted "during the 10-year period ending with the applicable period involved", applicable to computations of the sustainable growth rate for years beginning with 2003.

(B) MEDICARE+CHOICE PLAN ENROLLEE.—The term "Medicare+Choice plan enrollee" means, with respect to a fiscal year, an individual enrolled under this part who has elected to receive benefits under this title for the fiscal year through a Medicare+Choice plan offered under part C, and also includes an individual who is receiving benefits under this part through enrollment with an eligible organization with a risk–sharing contract under section 1876.

(C) APPLICABLE PERIOD.—The term "applicable period" means—

(i) a fiscal year, in the case of fiscal year 1998, fiscal year 1999, and fiscal year 2000; or

(ii) a calendar year with respect to a year beginning with 2000; as the case may be.

(g) LIMITATION ON BENEFICIARY LIABILITY.—

(1) LIMITATION ON ACTUAL CHARGES.—

(A) IN GENERAL.—In the case of a nonparticipating physician or nonparticipating supplier or other person (as defined in section 1842(i)(2)) who does not accept payment on an assignment-related basis for a physician's service furnished with respect to an individual enrolled under this part, the following rules apply:

(i) APPLICATION OF LIMITING CHARGE.—No person may bill or collect an actual charge for the service in excess of the limiting charge described in paragraph (2) for such service.

(ii) NO LIABILITY FOR EXCESS CHARGES.—No person is liable for payment of any amounts billed for the service in excess of such limiting charge.

(iii) CORRECTION OF EXCESS CHARGES.—If such a physician, supplier, or other person bills, but does not collect, an actual charge for a service in violation of clause (i), the physician, supplier, or other person shall reduce on a timely basis the actual charge billed for the service to an amount not to exceed the limiting charge for the service.

(iv) REFUND OF EXCESS COLLECTIONS.—If such a physician, supplier, or other person collects an actual charge for a service in violation of clause (i), the physician, supplier, or other person shall provide on a timely basis a refund to the individual charged in the amount by which the amount collected exceeded the limiting charge for the service. The amount of such a refund shall be reduced to the extent the individual has an outstanding balance owed by the individual to the physician.

(B) SANCTIONS.—If a physician, supplier, or other person—

(i) knowingly and willfully bills or collects for services in violation of subparagraph (A)(i) on a repeated basis, or

(ii) fails to comply with clause (iii) or (iv) of subparagraph (A) on a timely basis,

the Secretary may apply sanctions against the physician, supplier, or other person in accordance with paragraph (2) of section 1842(j). In applying this subparagraph, para-

graph (4) of such section applies in the same manner as such paragraph applies to such section and any reference in such section to a physician is deemed also to include a reference to a supplier or other person under this subparagraph.

(C) TIMELY BASIS.—For purposes of this paragraph, a correction of a bill for an excess charge or refund of an amount with respect to a violation of subparagraph (A)(i) in the case of a service is considered to be provided "on a timely basis", if the reduction or refund is made not later than 30 days after the date the physician, supplier, or other person is notified by the carrier under this part of such violation and of the requirements of subparagraph (A).

(2) LIMITING CHARGE DEFINED.—

(A) FOR 1991.—For physicians' services of a physician furnished during 1991, other than radiologist services subject to section 1834(b), the "limiting charge" shall be the same percentage (or, if less, 25 percent) above the recognized payment amount under this part with respect to the physician (as a nonparticipating physician) as the percentage by which—

(i) the maximum allowable actual charge (as determined under section 1842(j)(1)(C) as of December 31, 1990, or, if less, the maximum actual charge otherwise permitted for the service under this part as of such date) for the service of the physician, exceeds

(ii) the recognized payment amount for the service of the physician (as a nonparticipating physician) as of such date.

In the case of evaluation and management services (as specified in section 1842(b)(16)(B)(ii)), the preceding sentence shall be applied by substituting "40 percent" for "25 percent".[265]

(B) FOR 1992.—For physicians' services furnished during 1992, other than radiologist services subject to section 1834(b), the "limiting charge" shall be the same percentage (or, if less, 20 percent) above the recognized payment amount under this part for nonparticipating physicians as the percentage by which—

(i) the limiting charge (as determined under subparagraph (A) as of December 31, 1991) for the service, exceeds

(ii) the recognized payment amount for the service for nonparticipating physicians as of such date.

(C) AFTER 1992.—For physicians' services furnished in a year after 1992, the "limiting charge" shall be 115 percent of the recognized payment amount under this part for nonparticipating physicians or for nonparticipating suppliers or other persons.

(D) RECOGNIZED PAYMENT AMOUNT.—In this section, the term "recognized payment amount" means, for services furnished on or after January 1, 1992, the fee schedule amount determined under subsection (a) (or, if payment under this part is made on a basis other than the fee

[265] Margin as in original.

schedule under this section, 95 percent of the other payment basis), and, for services furnished during 1991, the applicable percentage (as defined in section 1842(b)(4)(A)(iv)) of the prevailing charge (or fee schedule amount) for nonparticipating physicians for that year.

(3) LIMITATION ON CHARGES FOR MEDICARE BENEFICIARIES ELIGIBLE FOR MEDICAID BENEFITS.—

(A) IN GENERAL.—Payment for physicians' services furnished on or after April 1, 1990, to an individual who is enrolled under this part and eligible for any medical assistance (including as a qualified medicare beneficiary, as defined in section 1905(p)(1)) with respect to such services under a State plan approved under title XIX may only be made on an assignment-related basis and the provisions of section 1902(n)(3)(A) apply to further limit permissible charges under this section.

(B) PENALTY.—A person may not bill for physicians' services subject to subparagraph (A) other than on an assignment-related basis. No person is liable for payment of any amounts billed for such a service in violation of the previous sentence. If a person knowingly and willfully bills for physicians' services in violation of the first sentence, the Secretary may apply sanctions against the person in accordance with section 1842(j)(2).

(4) PHYSICIAN SUBMISSION OF CLAIMS.—

(A) IN GENERAL.—For services furnished on or after September 1, 1990, within 1 year after the date of providing a service for which payment is made under this part on a reasonable charge or fee schedule basis, a physician, supplier, or other person (or an employer or facility in the cases described in section 1842(b)(6)(A))—

(i) shall complete and submit a claim for such service on a standard claim form specified by the Secretary to the carrier on behalf of a beneficiary, and

(ii) may not impose any charge relating to completing and submitting such a form.

(B) PENALTY.—(i) With respect to an assigned claim wherever a physician, provider, supplier or other person (or an employer or facility in the cases described in section 1842(b)(6)(A)) fails to submit such a claim as required in subparagraph (A), the Secretary shall reduce by 10 percent the amount that would otherwise be paid for such claim under this part.

(ii) If a physician, supplier, or other person (or an employer or facility in the cases described in section 1842(b)(6)(A)) fails to submit a claim required to be submitted under subparagraph (A) or imposes a charge in violation of such subparagraph, the Secretary shall apply the sanction with respect to such a violation in the same manner as a sanction may be imposed under section 1842(p)(3) for a violation of section 1842(p)(1).

(5) ELECTRONIC BILLING; DIRECT DEPOSIT.—The Secretary shall encourage and develop a system providing for expedited payment for claims submitted electronically. The Secretary shall also encourage and provide incentives allowing for direct

deposit as payments for services furnished by participating physicians. The Secretary shall provide physicians with such technical information as necessary to enable such physicians to submit claims electronically. The Secretary shall submit a plan to Congress on this paragraph by May 1, 1990.

(6) MONITORING OF CHARGES.—

(A) IN GENERAL.—The Secretary shall monitor—

(i) the actual charges of nonparticipating physicians for physicians' services furnished on or after January 1, 1991, to individuals enrolled under this part, and

(ii) changes (by specialty, type of service, and geographic area) in (I) the proportion of expenditures for physicians' services provided under this part by participating physicians, (II) the proportion of expenditures for such services for which payment is made under this part on an assignment-related basis, and (III) the amounts charged above the recognized payment amounts under this part.

(B) REPORT.—The Secretary shall, by not later than April 15 of each year (beginning in 1992), report to the Congress information on the extent to which actual charges exceed limiting charges, the number and types of services involved, and the average amount of excess charges and information regarding the changes described in subparagraph (A)(ii).

(C) PLAN.—If the Secretary finds that there has been a significant decrease in the proportions described in subclauses (I) and (II) of subparagraph (A)(ii) or an increase in the amounts described in subclause (III) of that subparagraph, the Secretary shall develop a plan to address such a problem and transmit to Congress recommendations regarding the plan. The Medicare Payment Advisory Commission shall review the Secretary's plan and recommendations and transmit to Congress its comments regarding such plan and recommendations.

(7) MONITORING OF UTILIZATION AND ACCESS.—

(A) IN GENERAL.—The Secretary shall monitor—

(i) changes in the utilization of and access to services furnished under this part within geographic, population, and service related categories,

(ii) possible sources of inappropriate utilization of services furnished under this part which contribute to the overall level of expenditures under this part, and

(iii) factors underlying these changes and their interrelationships.

(B) REPORT.—The Secretary shall by not later than April 15, of each year (beginning with 1991) report to the Congress on the changes described in subparagraph (A)(i) and shall include in the report an examination of the factors (including factors relating to different services and specific categories and groups of services and geographic and demographic variations in utilization) which may contribute to such changes.

(C) RECOMMENDATIONS.—The Secretary shall include in each annual report under subparagraph (B) recommendations—

(i) addressing any identified patterns of inappropriate utilization,

(ii) on utilization review,

(iii) on physician education or patient education,

(iv) addressing any problems of beneficiary access to care made evident by the monitoring process, and

(v) on such other matters as the Secretary deems appropriate.

The Medicare Payment Advisory Commission shall comment on the Secretary's recommendations and in developing its comments, the Commission shall convene and consult a panel of physician experts to evaluate the implications of medical utilization patterns for the quality of and access to patient care.

(h) SENDING INFORMATION TO PHYSICIANS.—Before the beginning of each year (beginning with 1992), the Secretary shall send to each physician or nonparticipating supplier or other person furnishing physicians' services (as defined in section 1848(j)(3)) furnishing physicians' services under this part, for services commonly performed by the physician, supplier, or other person, information on fee schedule amounts that apply for the year in the fee schedule area for participating and non-participating physicians, and the maximum amount that may be charged consistent with subsection (g)(2). Such information shall be transmitted in conjunction with notices to physicians, suppliers, and other persons under section 1842(h) (relating to the participating physician program) for a year.

(i) MISCELLANEOUS PROVISIONS.—

(1) RESTRICTION ON ADMINISTRATIVE AND JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869 or otherwise of—

(A) the determination of the adjusted historical payment basis (as defined in subsection (a)(2)(D)(i)),

(B) the determination of relative values and relative value units under subsection (c), including adjustments under subsections (c)(2)(F), (c)(2)(H), and (c)(2)(I)[266] and section 13515(b) of the Omnibus Budget Reconciliation Act of 1993,[267]

(C) the determination of conversion factors under subsection (d), including without limitation a prospective redetermination of the sustainable growth rates for any or all previous fiscal years,[268]

(D) the establishment of geographic adjustment factors under subsection (e), and

(E) the establishment of the system for the coding of physicians' services under this section.

(2) ASSISTANTS-AT-SURGERY.—

(A) IN GENERAL.—Subject to subparagraph (B), in the case of a surgical service furnished by a physician, if payment is made separately under this part for the services of a physician serving as an assistant-at-surgery, the fee schedule amount shall not exceed 16 percent of the fee

[266] P.L. 108-173, §303(g)(2), struck out "subsection (c)(2)(F)" and substituted "subsections (c)(2)(F), (c)(2)(H), and (c)(2)(I)."

[267] See Vol. II, P.L. 108-66, §13515(b)

[268] P.L. 108-7, Division G, Title IV, §402(a), amended subparagraph (C) in its entirety, effective February 20, 2003.

schedule amount otherwise determined under this section for the global surgical service involved.

(B) DENIAL OF PAYMENT IN CERTAIN CASES.—If the Secretary determines, based on the most recent data available, that for a surgical procedure (or class of surgical procedures) the national average percentage of such procedure performed under this part which involve the use of a physician as an assistant at surgery is less than 5 percent, no payment may be made under this part for services of an assistant at surgery involved in the procedure.

(3) NO COMPARABILITY ADJUSTMENT.—For physicians' services for which payment under this part is determined under this section—

(A) a carrier may not make any adjustment in the payment amount under section 1842(b)(3)(B) on the basis that the payment amount is higher than the charge applicable, for comparable services[269] and under comparable circumstances, to the policyholders and subscribers of the carrier,

(B) no payment adjustment may be made under section 1842(b)(8), and

(C) section 1842(b)(9) shall not apply.

(j) DEFINITIONS.—In this section:

(1) CATEGORY.—For services furnished before January 1, 1998, the term "category" means, with respect to physicians' services, surgical services (as defined by the Secretary and including anesthesia services), primary care services (as defined in section 1842(i)(4)), and all other physicians' services. The Secretary shall define surgical services and publish such definitions in the Federal Register no later than May 1, 1990, after consultation with organizations representing physicians.

(2) FEE SCHEDULE AREA.—The term "fee schedule area" means a locality used under section 1842(b) for purposes of computing payment amounts for physicians' services.[270]

(3) PHYSICIANS' SERVICES.—The term "physicians' services" includes items and services described in paragraphs (1), (2)(A), (2)(D), (2)(G), (2)(P) (with respect to services described in subparagraphs (A) and (C) of section 1861(oo)(2)), (2)(R) (with respect to services described in subparagraphs (B), (C), and (D) of section 1861(pp)(1)), (2)(S), (2)(W),[271] (3), (4), (13) (14) (with respect to services described in section 1861(nn)(2)), and (15) of section 1861(s) (other than clinical diagnostic laboratory tests and, except for purposes of subsections (a)(3), (g), and (h) such other items and services as the Secretary may specify).

(4) PRACTICE EXPENSES.—The term "practice expenses" includes all expenses for furnishing physicians' services, excluding malpractice expenses, physician compensation, and other physician fringe benefits.

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[269] P.L. 108-173, §736(b)(10), struck out "a comparable services" and substituted "comparable services".

[270] See Vol. II, P.L. 101–508, §4117(a), with respect to Statewide fee schedule areas for physicians' services.

[271] P.L. 108-173, §611(c), inserted "(2)(W),", applicable to services furnished on or after January 1, 2005, but only for individuals whose coverage period under part B begins on or after such date.

PART C—MEDICARE+CHOICE PROGRAM [272]

ELIGIBILITY, ELECTION, AND ENROLLMENT

SEC. 1851. [42 U.S.C. 1395w–21] (a) CHOICE OF MEDICARE BENEFITS THROUGH MEDICARE+CHOICE PLANS.—

(1) IN GENERAL.—Subject to the provisions of this section, each Medicare+Choice eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits (other than qualified prescription drug benefits) [273] under this title—

(A) through the original medicare fee–for–service program under parts A and B, or

(B) through enrollment in a Medicare+Choice plan under this part, [274]

and may elect qualified prescription drug coverage in accordance with section 1860D-1. [275]

(2) TYPES OF MEDICARE+CHOICE PLANS THAT MAY BE AVAILABLE.—A Medicare+Choice plan may be any of the following types of plans of health insurance:

(A) COORDINATED CARE PLANS (INCLUDING REGIONAL PLANS).—

(i) IN GENERAL.—Coordinated [276] care plans which provide health care services, including but not limited to health maintenance organization plans (with or without point of service options), plans offered by provider–sponsored organizations (as defined in section 1855(d)), and regional or local [277] preferred provider organization plans (including MA regional plans) [278].

(ii) [279] SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.—Specialized MA plans for special needs individuals (as defined in section 1859(b)(6)) may be any type of coordinated care plan.

(B) COMBINATION OF MSA PLAN AND CONTRIBUTIONS TO MEDICARE+CHOICE MSA.—An MSA plan, as defined in section 1859(b)(3), and a contribution into a Medicare+Choice medical savings account (MSA).

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[272] See Vol. II, P.L. 108-173, §201, with respect to implementation of the Medicare Advantage Program; §211(g), with respect to a report on the impact of increased financial assistance to Medicare Advantage (MA) plans; §211(h), with respect to a MEDPAC study on the clarification of authority regarding disapproval of unreasonable beneficiary cost-sharing; §221(a)(2), with respect to a moratorium on new local preferred provider organization plans; §221(c)(2), with respect to construction of part C; §231(d), with respect to the authority to designate other plans as specialized MA plans; and §231(a), with respect to a report to Congress on the impact of MA plans.

P.L. 108-173, §222, amends §1851 in several places; however, P.L. 108-173, §223(a) provides that these amendments shall apply with respect to plan years beginning on or after January 1, 2006.

P.L. 108-173, §223(b), provides that the Secretary shall revise the regulations previously promulgated to carry out the provisions of P.L. 108-173.

[273] P.L. 108-173, §102(c)(1)(A), inserted "(other than qualified prescription drug benefits)", applicable on and after January 1, 2006.

[274] P.L. 108-173, §102(c)(1)(B), struck out the period and substituted a comma.

[275] P.L. 108-173, §102(c)(1)(C), added "and may elect qualified prescription drug coverage in accordance with section 1860D-1.", applicable on and after January 1, 2006.

[276] P.L. 108-173, §221(a)(1)(A), struck out "COORDINATED CARE PLANS.—
Coordinated" and substituted "COORDINATED CARE PLANS (INCLUDING REGIONAL PLANS).—
(i) IN GENERAL.—Coordinated".

[277] P.L. 108-173, §221(a)(1)(B), inserted "regional or local".

[278] P.L. 108-173, §221(a)(1)(C), inserted "(including MA regional plans)".

[279] P.L. 108-173, §231(a), added clause (ii), effective December 8, 2003.

(C) PRIVATE FEE–FOR–SERVICE PLANS.—A Medicare+Choice private fee–for–service plan, as defined in section 1859(b)(2).

(3) MEDICARE+CHOICE ELIGIBLE INDIVIDUAL.—

(A) IN GENERAL.—In this title, subject to subparagraph (B), the term Medicare+Choice eligible individual means an individual who is entitled to benefits under part A and enrolled under part B.

(B) SPECIAL RULE FOR END–STAGE RENAL DISEASE.—Such term shall not include an individual medically determined to have end–stage renal disease, except that—

(i) an individual who develops end–stage renal disease while enrolled in a Medicare+Choice plan may continue to be enrolled in that plan; and

(ii) in the case of such an individual who is enrolled in a Medicare+Choice plan under clause (i) (or subsequently under this clause), if the enrollment is discontinued under circumstances described in section 1851(e)(4)(A), then the individual will be treated as a "Medicare+Choice eligible individual" for purposes of electing to continue enrollment in another Medicare+Choice plan.

(b) SPECIAL RULES.—

(1) RESIDENCE REQUIREMENT.—

(A) IN GENERAL.—Except as the Secretary may otherwise provide and except as provided in subparagraph (C), an individual is eligible to elect a Medicare+Choice plan offered by a Medicare+Choice organization only if the plan serves the geographic area in which the individual resides.

(B) CONTINUATION OF ENROLLMENT PERMITTED.—Pursuant to rules specified by the Secretary, the Secretary shall provide that an MA local plan[280] may offer to all individuals residing in a geographic area the option to continue enrollment in the plan, notwithstanding that the individual no longer resides in the service area of the plan, so long as the plan provides that individuals exercising this option have, as part of the benefits under the original medicare fee-for-service program option[281], reasonable access within that geographic area to the full range of basic benefits, subject to reasonable cost sharing liability in obtaining such benefits.

(C) CONTINUATION OF ENROLLMENT PERMITTED WHERE SERVICE CHANGED.—Notwithstanding subparagraph (A) and in addition to subparagraph (B), if a Medicare+Choice organization eliminates from its service area a Medicare+Choice payment area that was previously within its service area, the organization may elect to offer individuals residing in all or portions of the affected area who would otherwise be ineligible to continue enrollment the option to continue enrollment in an MA local plan[282] it offers so long as—

[280] P.L. 108-173, §221(l)(3)(A)(i), struck out "a plan" and substituted "an MA local plan".

[281] P.L. 108-173, §221(l)(3)(A)(ii), struck out "basic benefits described in section 1852(a)(1)(A)" and substituted "benefits under the original medicare fee-for-service program option".

[282] P.L. 108-173, §221(l)(3)(A)(iii), struck out "in a Medicare+Choice plan" and substituted "in an MA local plan".

(i) the enrollee agrees to receive the full range of basic benefits (excluding emergency and urgently needed care) exclusively at facilities designated by the organization within the plan service area; and

(ii) there is no other Medicare+Choice plan offered in the area in which the enrollee resides at the time of the organization's election.

(2) SPECIAL RULE FOR CERTAIN INDIVIDUALS COVERED UNDER FEHBP OR ELIGIBLE FOR VETERANS OR MILITARY HEALTH BENEFITS, VETERANS.—

(A) FEHBP.—An individual who is enrolled in a health benefit plan under chapter 89 of title 5, United States Code, is not eligible to enroll in an MSA plan until such time as the Director of the Office of Management and Budget certifies to the Secretary that the Office of Personnel Management has adopted policies which will ensure that the enrollment of such individuals in such plans will not result in increased expenditures for the Federal Government for health benefit plans under such chapter.

(B) VA AND DOD.—The Secretary may apply rules similar to the rules described in subparagraph (A) in the case of individuals who are eligible for health care benefits under chapter 55 of title 10, United States Code, or under chapter 17 of title 38 of such Code.

(3) LIMITATION ON ELIGIBILITY OF QUALIFIED MEDICARE BENEFICIARIES AND OTHER MEDICAID BENEFICIARIES TO ENROLL IN AN MSA PLAN.—An individual who is a qualified medicare beneficiary (as defined in section 1905(p)(1)), a qualified disabled and working individual (described in section 1905(s)), an individual described in section 1902(a)(10)(E)(iii), or otherwise entitled to medicare cost–sharing under a State plan under title XIX is not eligible to enroll in an MSA plan.

(4) COVERAGE UNDER MSA PLANS [283].—

(A) IN GENERAL.— [284]Under rules established by the Secretary, an individual is not eligible to enroll (or continue enrollment) in an MSA plan for a year unless the individual provides assurances satisfactory to the Secretary that the individual will reside in the United States for at least 183 days during the year.

(B) EVALUATION.—The Secretary shall regularly evaluate the impact of permitting enrollment in MSA plans under this part on selection (including adverse selection), use of preventive care, access to care, and the financial status of the Trust Funds under this title.

(C) REPORTS.—The Secretary shall submit to Congress periodic reports on the numbers of individuals enrolled in such plans and on the evaluation being conducted under subparagraph (B). [285]

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[283] P.L. 108-173, §233(b)(1), struck out "ON A DEMONSTRATION BASIS".

[284] P.L. 108-173, §233(b)(2), struck out "An individual is not eligible to enroll in an MSA plan under this part—

(i) on or after January 1, 2003, unless the enrollment is the continuation of such an enrollment in effect as of such date; or

(ii) as of any date if the number of such individuals so enrolled as of such date has reached 390,000.".

[285] P.L. 108-173, §233(b)(3), struck out "The Secretary shall submit such a report, by not later than March 1, 2002, on whether the time limitation under subparagraph (A)(i) should be extended or removed and whether to change the numerical limitation under subparagraph (A)(ii).".

(c) PROCESS FOR EXERCISING CHOICE.—

(1) IN GENERAL.—The Secretary shall establish a process through which elections described in subsection (a) are made and changed, including the form and manner in which such elections are made and changed. Such elections shall be made or changed only during coverage election periods specified under subsection (e) and shall become effective as provided in subsection (f).

(2) COORDINATION THROUGH MEDICARE+CHOICE ORGANIZATIONS.—

(A) ENROLLMENT.—Such process shall permit an individual who wishes to elect a Medicare+Choice plan offered by a Medicare+Choice organization to make such election through the filing of an appropriate election form with the organization.

(B) DISENROLLMENT.—Such process shall permit an individual, who has elected a Medicare+Choice plan offered by a Medicare+Choice organization and who wishes to terminate such election, to terminate such election through the filing of an appropriate election form with the organization.

(3) DEFAULT.—

(A) INITIAL ELECTION.—

(i) IN GENERAL.—Subject to clause (ii), an individual who fails to make an election during an initial election period under subsection (e)(1) is deemed to have chosen the original medicare fee–for–service program option.

(ii) SEAMLESS CONTINUATION OF COVERAGE.—The Secretary may establish procedures under which an individual who is enrolled in a health plan (other than Medicare+Choice plan) offered by a Medicare+Choice organization at the time of the initial election period and who fails to elect to receive coverage other than through the organization is deemed to have elected the Medicare+Choice plan offered by the organization (or, if the organization offers more than one such plan, such plan or plans as the Secretary identifies under such procedures).

(B) CONTINUING PERIODS.—An individual who has made (or is deemed to have made) an election under this section is considered to have continued to make such election until such time as—

(i) the individual changes the election under this section, or

(ii) the Medicare+Choice plan with respect to which such election is in effect is discontinued or, subject to subsection (b)(1)(B), no longer serves the area in which the individual resides.

(d) PROVIDING INFORMATION TO PROMOTE INFORMED CHOICE.—

(1) IN GENERAL.—The Secretary shall provide for activities under this subsection to broadly disseminate information to medicare beneficiaries (and prospective medicare beneficiaries) on the coverage options provided under this section in order to promote an active, informed selection among such options.

(2) PROVISION OF NOTICE.—

(A) OPEN SEASON NOTIFICATION.—At least 15 days before the beginning of each annual, coordinated election period (as defined in subsection (e)(3)(B)), the Secretary shall mail to each Medicare+Choice eligible individual residing in an area the following:

(i) GENERAL INFORMATION.—The general information described in paragraph (3).

(ii) LIST OF PLANS AND COMPARISON OF PLAN OPTIONS.—A list identifying the Medicare+Choice plans that are (or will be) available to residents of the area and information described in paragraph (4) concerning such plans. Such information shall be presented in a comparative form.

(iii) ADDITIONAL INFORMATION.—Any other information that the Secretary determines will assist the individual in making the election under this section. The mailing of such information shall be coordinated, to the extent practicable, with the mailing of any annual notice under section 1804.

(B) NOTIFICATION TO NEWLY ELIGIBLE MEDICARE+CHOICE ELIGIBLE INDIVIDUALS.—To the extent practicable, the Secretary shall, not later than 30 days before the beginning of the initial Medicare+Choice enrollment period for an individual described in subsection (e)(1), mail to the individual the information described in subparagraph (A).

(C) FORM.—The information disseminated under this paragraph shall be written and formatted using language that is easily understandable by medicare beneficiaries.

(D) PERIODIC UPDATING.—The information described in subparagraph (A) shall be updated on at least an annual basis to reflect changes in the availability of Medicare+Choice plans and the benefits and Medicare+Choice monthly basic and supplemental beneficiary premiums for such plans.

(3) GENERAL INFORMATION.—General information under this paragraph, with respect to coverage under this part during a year, shall include the following:

(A) BENEFITS UNDER ORIGINAL MEDICARE FEE–FOR–SERVICE PROGRAM OPTION.—A general description of the benefits covered under the original medicare fee–for–service program under parts A and B, including—

(i) covered items and services,

(ii) beneficiary cost sharing, such as deductibles, coinsurance, and copayment amounts, and (iii) any beneficiary liability for balance billing.

(B) ELECTION PROCEDURES—Information and instructions on how to exercise election options under this section.

(C) RIGHTS.—A general description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original medicare fee–for–service program and the Medicare+Choice programand the right to be protected against discrimination based on health status–related factors under section 1852(b).

(D) INFORMATION ON MEDIGAP AND MEDICARE SELECT.—A general description of the benefits, enrollment rights, and other requirements applicable to medicare supple-

mental policies under section 1882 and provisions relating to medicare select policies described in section 1882(t).

(E) POTENTIAL FOR CONTRACT TERMINATION.—The fact that a Medicare+Choice organization may terminate its contract, refuse to renew its contract, or reduce the service area included in its contract, under this part, and the effect of such a termination, nonrenewal, or service area reduction may have on individuals enrolled with the Medicare+Choice plan under this part.

(F)[286] Catastrophic coverage and single deductible.—In the case of an MA regional plan, a description of the catastrophic coverage and single deductible applicable under the plan.

(4) INFORMATION COMPARING PLAN OPTIONS.—Information under this paragraph, with respect to a Medicare+Choice plan for a year, shall include the following:

(A) BENEFITS.—The benefits covered under the plan, including the following:

(i) Covered items and services beyond those provided under the original medicare fee–for–service program.

(ii) Any beneficiary cost sharing, including information on the single deductible (if applicable) under section 1858(b)(1)[287].

(iii) Any maximum limitations on out–of–pocket expenses.

(iv) In the case of an MSA plan, differences in cost sharing, premiums, and balance billing under such a plan compared to under other Medicare+Choice plans.

(v) In the case of a Medicare+Choice private fee–for–service plan, differences in cost sharing, premiums, and balance billing under such a plan compared to under other Medicare+Choice plans.

(vi) The extent to which an enrollee may obtain benefits through out–of–network health care providers.

(vii) The extent to which an enrollee may select among in– network providers and the types of providers participating in the plan's network.

(viii) The organization's coverage of emergency and urgently needed care.

(B) PREMIUMS.—The Medicare+Choice monthly basic beneficiary premium and Medicare+Choice monthly supplemental beneficiary premium, if any, for the plan or, in the case of an MSA plan, the Medicare+Choice monthly MSA premium.

(C) SERVICE AREA.—The service area of the plan.

(D) QUALITY AND PERFORMANCE.—To the extent available, plan quality and performance indicators for the benefits under the plan (and how they compare to such indicators under the original medicare fee–for–service program under parts A and B in the area involved), including—

(i) disenrollment rates for medicare enrollees electing to receive benefits through the plan for the pre-

[286] P.L. 108-173, §221(l)(3)(B)(i), added subparagraph (F), effective December 8, 2003.

[287] P.L. 108-173, §221(l)(3)(B)(ii), inserted ", including information on the single deductible (if applicable) under section 1858(b)(1)".

vious 2 years (excluding disenrollment due to death or moving outside the plan's service area),

(ii) information on medicare enrollee satisfaction,

(iii) information on health outcomes, and

(iv) the recent record regarding compliance of the plan with requirements of this part (as determined by the Secretary).

(E)[288] SUPPLEMENTAL BENEFITS.—Supplemental health care benefits, including any reductions in cost-sharing under section 1852(a)(3) and the terms and conditions (including premiums) for such benefits.

(5) MAINTAINING A TOLL–FREE NUMBER AND INTERNET SITE.—The Secretary shall maintain a toll–free number for inquiries regarding Medicare+Choice options and the operation of this part in all areas in which Medicare+Choice plans are offered and an Internet site through which individuals may electronically obtain information on such options and Medicare+Choice plans.

(6) USE OF NON–FEDERAL ENTITIES.—The Secretary may enter into contracts with non–Federal entities to carry out activities under this subsection.

(7) PROVISION OF INFORMATION.—A Medicare+Choice organization shall provide the Secretary with such information on the organization and each Medicare+Choice plan it offers as may be required for the preparation of the information referred to in paragraph (2)(A).

(e) COVERAGE ELECTION PERIODS.—

(1) INITIAL CHOICE UPON ELIGIBILITY TO MAKE ELECTION IF MEDICARE+CHOICE PLANS AVAILABLE TO INDIVIDUAL.—If, at the time an individual first becomes entitled to benefits under part A and enrolled under part B, there is one or more Medicare+Choice plans offered in the area in which the individual resides, the individual shall make the election under this section during a period specified by the Secretary such that if the individual elects a Medicare+Choice plan during the period, coverage under the plan becomes effective as of the first date on which the individual may receive such coverage.

(2) OPEN ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.—Subject to paragraph (5)—

(A) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT THROUGH 2005[289].—At any time during the period beginning January 1, 1998, and ending on December 31, 2005[290], a Medicare+Choice eligible individual may change the election under subsection (a)(1).

(B) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 6 MONTHS DURING 2006[291].—

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[288] P.L. 108-173, §221(l)(3)(B)(iv), amended subparagraph (E) in its entirety. For subparagraph (E) as it formerly read, see Vol. II, Superseded Provisions, P.L. 108-173.

[289] P.L. 107-188, §532(a)(1), struck out "THROUGH 2001" and substituted "THROUGH 2004", applicable to information submitted for years beginning with 2003.

P.L. 108-173, §102(a)(1)(A), struck out "2004" and substituted "2005".

[290] P.L. 107-188, §532(a)(1), struck out "during 1998, 1999, 2000, and 2001" and substituted "during the period beginning January 1, 1998, and ending on December 31, 2004", applicable to information submitted for years beginning with 2003.

P.L. 108-173, §102(a)(1)(A), struck out "2004" and substituted "2005".

[291] P.L. 107-188, §532(a)(2), struck out "DURING 2002" and substituted "DURING 2005".

P.L. 108-173, §102(a)(1)(A), struck out "2005" and substituted "2006".

(i) IN GENERAL.—Subject to clause (ii), at any time during the first 6 months of 2006[292], or, if the individual first becomes a Medicare+Choice eligible individual during 2006[293], during the first 6 months during 2006[294] in which the individual is a Medicare+Choice eligible individual, a Medicare+Choice eligible individual may change the election under subsection (a)(1).

(ii) LIMITATION OF ONE CHANGE.—An individual may exercise the right under clause (i) only once. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under the first sentence of paragraph (4).

(C) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 3 MONTHS IN SUBSEQUENT YEARS.—

(i) IN GENERAL.—Subject to clause (ii), at any time during the first 3 months of a year after 2006[295], or, if the individual first becomes a Medicare+Choice eligible individual during a year after 2006[296], during the first 3 months of such year in which the individual is a Medicare+Choice eligible individual, a Medicare+Choice eligible individual may change the election under subsection (a)(1).

(ii) LIMITATION OF ONE CHANGE DURING OPEN ENROLLMENT PERIOD EACH YEAR.—An individual may exercise the right under clause (i) only once during the applicable 3–month period described in such clause in each year. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).

(D) CONTINUOUS OPEN ENROLLMENT FOR INSTITUTIONALIZED INDIVIDUALS.—At any time after 2005[297] in the case of a Medicare+Choice eligible individual who is institutionalized (as defined by the Secretary), the individual may elect under subsection (a)(1)—

(i) to enroll in a Medicare+Choice plan; or

(ii) to change the Medicare+Choice plan in which the individual is enrolled.

(3) ANNUAL, COORDINATED ELECTION PERIOD.—

(A) IN GENERAL.—Subject to paragraph (5), each individual who is eligible to make an election under this section may change such election during an annual, coordinated election period.

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[292] P.L. 107-188, §532(a)(3), struck out "2002" and substituted "2005".
P.L. 108-173, §102(a)(1)(A), struck out "2005" and substituted "2006".
[293] P.L. 107-188, §532(a)(3), struck out "2002" and substituted "2005".
P.L. 108-173, §102(a)(1)(A), struck out "2005" and substituted "2006".
[294] P.L. 107-188, §532(a)(3), struck out "2002" and substituted "2005".
P.L. 108-173, §102(a)(1)(A), struck out "2005" and substituted "2006".
[295] P.L. 107-188, §532(a)(3), struck out "2002" and substituted "2005".
P.L. 108-173, §102(a)(1)(A), struck out "2005" and substituted "2006".
[296] P.L. 107-188, §532(a)(3), struck out "2002" and substituted "2005".
P.L. 108-173, §102(a)(1)(A), struck out "2005" and substituted "2006".
[297] P.L. 107-188, §532(a)(4), struck out "2001" and substituted "2004".
P.L. 108-173, §102(a)(1)(A), struck out "2004" and substituted "2005".

(B) ANNUAL, COORDINATED ELECTION PERIOD.—For purposes of this section, the term annual, coordinated election period means, with respect to a year before 2003 and after 2005, the month of November before such year and with respect to 2003, 2004, and 2005, the period beginning on November 15 and ending on December 31 of the year before such year.[298]

(C) MEDICARE+CHOICE HEALTH INFORMATION FAIRS.—During the fall season of each year (beginning with 1999), in conjunction with the annual coordinated election period defined in subparagraph (B), the Secretary shall provide for a nationally coordinated educational and publicity campaign to inform Medicare+Choice eligible individuals about Medicare+Choice plans and the election process provided under this section.

(D) SPECIAL INFORMATION CAMPAIGN IN 1998.—During November 1998 the Secretary shall provide for an educational and publicity campaign to inform Medicare+Choice eligible individuals about the availability of Medicare+Choice plans, and eligible organizations with risk–sharing contracts under section 1876, offered in different areas and the election process provided under this section.

(4) SPECIAL ELECTION PERIODS.—Effective as of January 1, 2006[299], an individual may discontinue an election of a Medicare+Choice plan offered by a Medicare+Choice organization other than during an annual, coordinated election period and make a new election under this section if—

(A)(i) the certification of the organization or plan under this part has been terminated, or the organization or plan has notified the individual of an impending termination of such certification; or

(ii) the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the individual of an impending termination or discontinuation of such plan;

(B) the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances (specified by the Secretary, but not including termination of the individual's enrollment on the basis described in clause (i) or (ii) of subsection (g)(3)(B));

(C) the individual demonstrates (in accordance with guidelines established by the Secretary) that—

(i) the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual (including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are

[298] P.L. 107-188, §532(c)(1)(A), struck out "means, with respect to a calendar year (beginning with 2000), the month of November before such year." and substituted "means, with respect to a year before 2003 and after 2005, the month of November before such year and with respect to 2003, 2004, and 2005, the period beginning on November 15 and ending on December 31 of the year before such year.", applicable to the annual, coordinated election period for years beginning with 2003.

[299] P.L. 107-188, §532(a)(5), struck out "2002" and substituted "2005".
P.L. 108-173, §102(a)(1)(B), struck out "2005" and substituted "2006".

available under the plan or the failure to provide such covered care in accordance with applicable quality standards); or

(ii) the organization (or an agent or other entity acting on the organization's behalf) materially misrepresented the plan's provisions in marketing the plan to the individual; or

(D) the individual meets such other exceptional conditions as the Secretary may provide.

Effective as of January 1, 2006[300], an individual who, upon first becoming eligible for benefits under part A at age 65, enrolls in a Medicare+Choice plan under this part, the individual may discontinue the election of such plan, and elect coverage under the original fee—for—service plan, at any time during the 12—month period beginning on the effective date of such enrollment.

(5) SPECIAL RULES FOR MSA PLANS.—Notwithstanding the preceding provisions of this subsection, an individual—

(A) may elect an MSA plan only during—

(i) an initial open enrollment period described in paragraph (1), or[301]

(ii) an annual, coordinated election period described in paragraph (3)(B);[302]

(iii) [Stricken.[303]]

(B) subject to subparagraph (C), may not discontinue an election of an MSA plan except during the periods described in clause (ii) or (iii) of subparagraph (A) and under the first sentence of paragraph (4); and

(C) who elects an MSA plan during an annual, coordinated election period, and who never previously had elected such a plan, may revoke such election, in a manner determined by the Secretary, by not later than December 15 following the date of the election.

(6) OPEN ENROLLMENT PERIODS.—Subject to paragraph (5), a Medicare+Choice organization—

(A) shall accept elections or changes to elections during the initial enrollment periods described in paragraph (1), during the month of November 1998 and during the annual, coordinated election period under paragraph (3) for each subsequent year[304], and during special election periods described in the first sentence of paragraph (4); and

(B) may accept other changes to elections at such other times as the organization provides.

(f) EFFECTIVENESS OF ELECTIONS AND CHANGES OF ELECTIONS.—

(1) DURING INITIAL COVERAGE ELECTION PERIOD.—An election of coverage made during the initial coverage election period under subsection (e)(1)(A) shall take effect upon the date the individual becomes entitled to benefits under part A and enrolled under part B, except as the Secretary may provide (con-

[300] P.L. 107-188, §532(a)(5), struck out "2002" and substituted "2005".
P.L. 108-173, §102(a)(1)(A), struck out "2005" and substituted "2006".
[301] P.L. 108-173, §233(d)(1), added "or".
[302] P.L. 108-173, §233(d)(2), struck out ", or" and substituted a semicolon.
[303] P.L. 108-173, §233(d)(3); 117 Stat. 2209.
[304] P.L. 107-188, §532(c)(1)(B), struck out "each subsequent year (as provided in paragraph (3))" and substituted "during the annual, coordinated election period under paragraph (3) for each subsequent year", applicable to the annual, coordinated election period for years beginning with 2003.

sistent with section 1838) in order to prevent retroactive coverage.

(2) DURING CONTINUOUS OPEN ENROLLMENT PERIODS.—An election or change of coverage made under subsection (e)(2) shall take effect with the first day of the first calendar month following the date on which the election or change is made.

(3) ANNUAL, COORDINATED ELECTION PERIOD.—An election or change of coverage made during an annual, coordinated election period (as defined in subsection (e)(3)(B)) in a year shall take effect as of the first day of the following year.

(4) OTHER PERIODS.—An election or change of coverage made during any other period under subsection (e)(4) shall take effect in such manner as the Secretary provides in a manner consistent (to the extent practicable) with protecting continuity of health benefit coverage.

(g) GUARANTEED ISSUE AND RENEWAL.—

(1) IN GENERAL.—Except as provided in this subsection, a Medicare+Choice organization shall provide that at any time during which elections are accepted under this section with respect to a Medicare+Choice plan offered by the organization, the organization will accept without restrictions individuals who are eligible to make such election.

(2) PRIORITY.—If the Secretary determines that a Medicare+Choice organization, in relation to a Medicare+Choice plan it offers, has a capacity limit and the number of Medicare+Choice eligible individuals who elect the plan under this section exceeds the capacity limit, the organization may limit the election of individuals of the plan under this section but only if priority in election is provided—

(A) first to such individuals as have elected the plan at the time of the determination, and

(B) then to other such individuals in such a manner that does not discriminate, on a basis described in section 1852(b), among the individuals (who seek to elect the plan).

The preceding sentence shall not apply if it would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the medicare population in the service area of the plan.

(3) LIMITATION ON TERMINATION OF ELECTION.—

(A) IN GENERAL.—Subject to subparagraph (B), a Medicare+Choice organization may not for any reason terminate the election of any individual under this section for a Medicare+Choice plan it offers.

(B) BASIS FOR TERMINATION OF ELECTION.—A Medicare+Choice organization may terminate an individual's election under this section with respect to a Medicare+Choice plan it offers if—

(i) any Medicare+Choice monthly basic and supplemental beneficiary premiums required with respect to such plan are not paid on a timely basis (consistent with standards under section 1856 that provide for a grace period for late payment of such premiums),

(ii) the individual has engaged in disruptive behavior (as specified in such standards), or

(iii) the plan is terminated with respect to all individuals under this part in the area in which the individual resides.

(C) CONSEQUENCE OF TERMINATION.—

(i) TERMINATIONS FOR CAUSE.—Any individual whose election is terminated under clause (i) or (ii) of subparagraph (B) is deemed to have elected the original medicare fee–for–service program option described in subsection (a)(1)(A).

(ii) TERMINATION BASED ON PLAN TERMINATION OR SERVICE AREA REDUCTION.—Any individual whose election is terminated under subparagraph (B)(iii) shall have a special election period under subsection (e)(4)(A) in which to change coverage to coverage under another Medicare+Choice plan. Such an individual who fails to make an election during such period is deemed to have chosen to change coverage to the original medicare fee—for—service program option described in subsection (a)(1)(A).

(D) ORGANIZATION OBLIGATION WITH RESPECT TO ELECTION FORMS.—Pursuant to a contract under section 1857, each Medicare+Choice organization receiving an election form under subsection (c)(2) shall transmit to the Secretary (at such time and in such manner as the Secretary may specify) a copy of such form or such other information respecting the election as the Secretary may specify.

(h) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—

(1) SUBMISSION.—No marketing material or application form may be distributed by a Medicare+Choice organization to (or for the use of) Medicare+Choice eligible individuals unless—

(A) at least 45 days (or 10 days in the case described in paragraph (5)) before the date of distribution the organization has submitted the material or form to the Secretary for review, and

(B) the Secretary has not disapproved the distribution of such material or form.

(2) REVIEW.—The standards established under section 1856 shall include guidelines for the review of any material or form submitted and under such guidelines the Secretary shall disapprove (or later require the correction of) such material or form if the material or form is materially inaccurate or misleading or otherwise makes a material misrepresentation.

(3) DEEMED APPROVAL (1–STOP SHOPPING).—In the case of material or form that is submitted under paragraph (1)(A) to the Secretary or a regional office of the Department of Health and Human Services and the Secretary or the office has not disapproved the distribution of marketing material or form under paragraph (1)(B) with respect to a Medicare+Choice plan in an area, the Secretary is deemed not to have disapproved such distribution in all other areas covered by the plan and organization except with regard to that portion of such material or form that is specific only to an area involved.

(4) PROHIBITION OF CERTAIN MARKETING PRACTICES.—Each Medicare+Choice organization shall conform to fair marketing standards, in relation to Medicare+Choice plans offered under

this part, included in the standards established under section 1856. Such standards—

(A) shall not permit a Medicare+Choice organization to provide for cash or other monetary rebates as an inducement for enrollment or otherwise, and

(B) may include a prohibition against a Medicare+Choice organization (or agent of such an organization) completing any portion of any election form used to carry out elections under this section on behalf of any individual.

(5) SPECIAL TREATMENT OF MARKETING MATERIAL FOLLOWING MODEL MARKETING LANGUAGE.—In the case of marketing material of an organization that uses, without modification, proposed model language specified by the Secretary, the period specified in paragraph (1)(A) shall be reduced from 45 days to 10 days.

(i) EFFECT OF ELECTION OF MEDICARE+CHOICE PLAN OPTION.—

(1) PAYMENTS TO ORGANIZATIONS.—Subject to sections 1852(a)(5), 1853(a)(4),[305] 1853(g), 1853(h), 1886(d)(11), and 1886(h)(3)(D), payments under a contract with a Medicare+Choice organization under section 1853(a) with respect to an individual electing a Medicare+Choice plan offered by the organization shall be instead of the amounts which (in the absence of the contract) would otherwise be payable under parts A and B for items and services furnished to the individual.

(2) ONLY ORGANIZATION ENTITLED TO PAYMENT.— Subject to sections 1853(a)(4),[306] 1853(e), 1853(g), 1853(h), 1857(f)(2), 1858(h),[307] 1886(d)(11), and 1886(h)(3)(D), only the Medicare+Choice organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.

BENEFITS AND BENEFICIARY PROTECTIONS[308]

SEC. 1852. [42 U.S.C. 1395w–22] (a) BASIC BENEFITS.—

(1) IN GENERAL.—Except as provided in section 1859(b)(3) for MSA plans and except as provided in paragraph (6) for MA regional plans[309], each Medicare+Choice plan shall provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this title and part A of title XI—

(A) those items and services (other than hospice care) for which benefits are available under parts A and B to individuals residing in the area served by the plan, and

(B) additional benefits required under section 1854(f)(1)(A).

(2) SATISFACTION OF REQUIREMENT.—

[305] P.L. 108-173, §237(b)(2)(A)(i), inserted "1853(a)(4),".
[306] P.L. 108-173, §237(b)(2)(A)(ii), inserted "1853(a)(4),".
[307] P.L. 108-173, §221(d)(5), inserted "1858(h),".
[308] P.L. 108-173, §§221 and 222, amends §1852 in several places; however, P.L. 108-173, §223(a) provides that these amendments shall apply with respect to plan years beginning on or after January 1, 2006.

P.L. 108-173, §223(b), provides that the Secretary shall revise the regulations previously promulgated to carry out the provisions of P.L. 108-173.

[309] P.L. 108–173, §221(d)(3)(A), inserted "and except as provided in paragraph (6) for MA regional plans".

(A) IN GENERAL.—A Medicare+Choice plan (other than an MSA plan) offered by a Medicare+Choice organization satisfies paragraph (1)(A), with respect to benefits for items and services furnished other than through a provider or other person that has a contract with the organization offering the plan, if the plan provides payment in an amount so that—

(i) the sum of such payment amount and any cost sharing provided for under the plan, is equal to at least

(ii) the total dollar amount of payment for such items and services as would otherwise be authorized under parts A and B (including any balance billing permitted under such parts).

(B) REFERENCE TO RELATED PROVISIONS.—For provision relating to—

(i) limitations on balance billing against Medicare+Choice organizations for non–contract providers, see sections 1852(k) and 1866(a)(1)(O), and

(ii) limiting actuarial value of enrollee liability for covered benefits, see section 1854(e).

(C) ELECTION OF UNIFORM COVERAGE POLICY.—In the case of a Medicare+Choice organization that offers a Medicare+Choice plan in an area in which more than one local coverage determination[310] is applied with respect to different parts of the area, the organization may elect to have the local coverage determination[311] for the part of the area that is most beneficial to Medicare+Choice enrollees (as identified by the Secretary) apply with respect to all Medicare+Choice enrollees enrolled in the plan.

(3) SUPPLEMENTAL BENEFITS.—

(A) BENEFITS INCLUDED SUBJECT TO SECRETARY'S APPROVAL.—Each Medicare+Choice organization may provide to individuals enrolled under this part, other than under an MSA plan (without affording those individuals an option to decline the coverage), supplemental health care benefits that the Secretary may approve. The Secretary shall approve any such supplemental benefits unless the Secretary determines that including such supplemental benefits would substantially discourage enrollment by Medicare+Choice eligible individuals with the organization.

(B) AT ENROLLEES OPTION.—

(i) IN GENERAL.—Subject to clause (ii), a Medicare+Choice organization may provide to individuals enrolled under this part supplemental health care benefits that the individuals may elect, at their option, to have covered.

(ii) SPECIAL RULE FOR MSA PLANS.—A Medicare+Choice organization may not provide, under an MSA plan, supplemental health care benefits that cover the deductible described in section 1859(b)(2)(B). In applying the previous sentence, health benefits de-

[310] P.L. 108–173, §948(b)(2), struck out "policy" and substituted "determination".
[311] P.L. 108–173, §948(b)(2), struck out "policy" and substituted "determination".

scribed in section 1882(u)(2)(B) shall not be treated as covering such deductible.

(C) APPLICATION TO MEDICARE+CHOICE PRIVATE FEE–FOR–SERVICE PLANS.—Nothing in this paragraph shall be construed as preventing a Medicare+Choice private fee–for–service plan from offering supplemental benefits that include payment for some or all of the balance billing amounts permitted consistent with section 1852(k) and coverage of additional services that the plan finds to be medically necessary.

(4) ORGANIZATION AS SECONDARY PAYER.— Notwithstanding any other provision of law, a Medicare+Choice organization may (in the case of the provision of items and services to an individual under a Medicare+Choice plan under circumstances in which payment under this title is made secondary pursuant to section 1862(b)(2)) charge or authorize the provider of such services to charge, in accordance with the charges allowed under a law, plan, or policy described in such section—

(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or

(B) such individual to the extent that the individual has been paid under such law, plan, or policy for such services.

(5) NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—If there is a national coverage determination or legislative change in benefits required to be provided under this part made in the period beginning on the date of an announcement under section 1853(b) and ending on the date of the next announcement under such section and the Secretary projects that the determination will result in a significant change in the costs to a Medicare+Choice organization of providing the benefits that are the subject of such national coverage determination and that such change in costs was not incorporated in the determination of the annual Medicare+Choice capitation rate under section 1853 included in the announcement made at the beginning of such period, then, unless otherwise required by law—

(A) such determination or legislative change in benefits shall not apply to contracts under this part until the first contract year that begins after the end of such period, and

(B) if such coverage determination or legislative change provides for coverage of additional benefits or coverage under additional circumstances, section 1851(i)(1) shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period.

The projection under the previous sentence shall be based on an analysis by the Chief Actuary of the Centers for Medicare and Medicaid Services[312] of the actuarial costs associated with the coverage determination or legislative change in benefits.

(6)[313] SPECIAL BENEFIT RULES FOR REGIONAL PLANS.—In the case of an MA plan that is an MA regional plan, benefits under

[312] P.L. 108–173, §900(e)(1)(F), struck out "Health Care Financing Administration" and substituted "Centers for Medicare and Medicaid Services".

[313] P.L. 108–173, §221(d)(3)(B), added paragraph (6), effective December 8, 2003.

the plan shall include the benefits described in paragraphs (1) and (2) of section 1858(b).

(b) ANTIDISCRIMINATION.—

(1) BENEFICIARIES.—

(A) IN GENERAL.—A Medicare+Choice organization may not deny, limit, or condition the coverage or provision of benefits under this part, for individuals permitted to be enrolled with the organization under this part, based on any health status–related factor described in section 2702(a)(1) of the Public Health Service Act.

(B) CONSTRUCTION.—Subparagraph (A) shall not be construed as requiring a Medicare+Choice organization to enroll individuals who are determined to have end–stage renal disease, except as provided under section 1851(a)(3)(B).

(2) PROVIDERS.—A Medicare+Choice organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan.

(c) DISCLOSURE REQUIREMENTS.—

(1) DETAILED DESCRIPTION OF PLAN PROVISIONS.—A Medicare+Choice organization shall disclose, in clear, accurate, and standardized form to each enrollee with a Medicare+Choice plan offered by the organization under this part at the time of enrollment and at least annually thereafter, the following information regarding such plan:

(A) SERVICE AREA.—The plan's service area.

(B) BENEFITS.—Benefits offered under the plan, including information described in section 1851(d)(3)(A) and exclusions from coverage and, if it is an MSA plan, a comparison of benefits under such a plan with benefits under other Medicare+Choice plans.

(C) ACCESS.—The number, mix, and distribution of plan providers, out–of–network coverage (if any) provided by the plan, and any point–of–service option (including the supplemental premium for such option).

(D) OUT–OF–AREA COVERAGE.—Out–of–area coverage provided by the plan.

(E) EMERGENCY COVERAGE.—Coverage of emergency services, including—

(i) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

(ii) the process and procedures of the plan for obtaining emergency services; and

(iii) the locations of (I) emergency departments, and (II) other settings, in which plan physicians and hospitals provide emergency services and post–stabilization care.

(F) SUPPLEMENTAL BENEFITS.—Supplemental benefits available from the organization offering the plan, including—

(i) whether the supplemental benefits are optional,

(ii) the supplemental benefits covered, and

(iii) the Medicare+Choice monthly supplemental beneficiary premium for the supplemental benefits.

(G) PRIOR AUTHORIZATION RULES.—Rules regarding prior authorization or other review requirements that could result in nonpayment.

(H) PLAN GRIEVANCE AND APPEALS PROCEDURES.— All plan appeal or grievance rights and procedures.

(I)[314] QUALITY ASSURANCE PROGRAM.—A description of the organization's quality assurance program under subsection (e).

(2) DISCLOSURE UPON REQUEST.—Upon request of a Medicare+Choice eligible individual, a Medicare+Choice organization must provide the following information to such individual:

(A) The general coverage information and general comparative plan information made available under clauses (i) and (ii) of section 1851(d)(2)(A).

(B) Information on procedures used by the organization to control utilization of services and expenditures.

(C) Information on the number of grievances, redeterminations, and appeals and on the disposition in the aggregate of such matters.

(D) An overall summary description as to the method of compensation of participating physicians.

(d) ACCESS TO SERVICES.—

(1) IN GENERAL.—A Medicare+Choice organization offering a Medicare+Choice plan may select the providers from whom the benefits under the plan are provided so long as—

(A) the organization makes such benefits available and accessible to each individual electing the plan within the plan service area with reasonable promptness and in a manner which assures continuity in the provision of benefits;

(B) when medically necessary the organization makes such benefits available and accessible 24 hours a day and 7 days a week;

(C) the plan provides for reimbursement with respect to services which are covered under subparagraphs (A) and (B) and which are provided to such an individual other than through the organization, if—

(i) the services were not emergency services (as defined in paragraph (3)), but (I) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition, and (II) it was not reasonable given the circumstances to obtain the services through the organization,

(ii) the services were renal dialysis services and were provided other than through the organization be-

[314] P.L. 108–173, §722(b), amends §1852(c)(1)(I) effective January 1, 2006.

cause the individual was temporarily out of the plan's service area, or

(iii) the services are maintenance care or post– stabilization care covered under the guidelines established under paragraph (2);

(D) the organization provides access to appropriate providers, including credentialed specialists, for medically necessary treatment and services; and

(E) coverage is provided for emergency services (as defined in paragraph (3)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization.

(2) GUIDELINES RESPECTING COORDINATION OF POST– STABILIZATION CARE.—A Medicare+Choice plan shall comply with such guidelines as the Secretary may prescribe relating to promoting efficient and timely coordination of appropriate maintenance and post—stabilization care of an enrollee after the enrollee has been determined to be stable under section 1867.

(3) DEFINITION OF EMERGENCY SERVICES.—In this subsection—

(A) IN GENERAL.—The term emergency services means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

(i) are furnished by a provider that is qualified to furnish such services under this title, and

(ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (B)).

(B) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON.—The term emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

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

(4) ASSURING ACCESS TO SERVICES IN MEDICARE+CHOICE PRIVATE FEE–FOR–SERVICE PLANS.—In addition to any other requirements under this part, in the case of a Medicare+Choice private fee–for–service plan, the organization offering the plan must demonstrate to the Secretary that the organization has sufficient number and range of health care professionals and providers willing to provide services under the terms of the plan. The Secretary shall find that an organization has met such requirement with respect to any category of health care professional or provider if, with respect to that category of provider—

(A) the plan has established payment rates for covered services furnished by that category of provider that are not less than the payment rates provided for under part A, part B, or both, for such services, or

(B) the plan has contracts or agreements (other than deemed contracts or agreements under subsection (j)(6))[315] with a sufficient number and range of providers within such category to provide covered services under the terms of the plan, or a combination of both. The previous sentence shall not be construed as restricting the persons from whom enrollees under such a plan may obtain covered benefits, except that, if a plan entirely meets such requirement with respect to a category of health care professional or provider on the basis of subparagraph (B), it may provide for a higher beneficiary copayment in the case of health care professionals and providers of that category who do not have contracts or agreements (other than deemed contracts or agreements under subsection (j)(6)) to provide covered services under the terms of the plan.[316]

(e) QUALITY IMPROVEMENT[317] Program.—

(1)[318] IN GENERAL.—Each MA organization shall have an ongoing quality improvement program for the purpose of improving the quality of care provided to enrollees in each MA plan (other than MSA plans)[319] offered by such organization (other than an MA private fee-for-service plan or an MSA plan).

(2)[320] CHRONIC CARE IMPROVEMENT PROGRAMS.—As part of the quality improvement program under paragraph (1), each MA organization shall have a chronic care improvement program. Each chronic care improvement program shall have a method for monitoring and identifying enrollees with multiple or sufficiently severe chronic conditions that meet criteria established by the organization for participation under the program.

(3)[321] DATA.—

(A) COLLECTION, ANALYSIS, AND REPORTING.—

(i) IN GENERAL.—Except as provided in clauses (ii) and (iii) with respect to plans described in such clauses and subject to subparagraph (B), as part of the quality improvement program under paragraph (1), each MA organization shall provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality.

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[315] P.L. 108–173, §211(j)(1), inserted "(other than deemed contracts or agreements under subsection (j)(6))".

[316] P.L. 108–173, §211(j)(2), inserted ", except that, if a plan entirely meets such requirement with respect to a category of health care professional or provider on the basis of subparagraph (B), it may provide for a higher beneficiary copayment in the case of health care professionals and providers of that category who do not have contracts or agreements (other than deemed contracts or agreements under subsection (j)(6)) to provide covered services under the terms of the plan".

[317] P.L. 108–173, §722(a)(1), struck out "ASSURANCE" and substituted "IMPROVEMENT", applicable with respect to contract years beginning on and after January 1, 2006.

[318] P.L. 108–173, §722(a)(2), amended paragraph (1) in its entirety. For paragraph (1) as it formerly read, see Vol. II, Superseded Provisions, P.L. 108-173, applicable with respect to contract years beginning on and after January 1, 2006.

[319] P.L. 108–173, §233(a)(1), inserted "(other than MSA plans)", applicable on and after December 8, 2003 but not applicable to contract years beginning on or after January 1, 2006.

[320] P.L. 108–173, §722(a)(2), amended paragraph (2) in its entirety. For paragraph (2) as it formerly read, see Vol. II, Superseded Provisions, P.L. 108-173, applicable with respect to contract years beginning on and after January 1, 2006.

[321] P.L. 108–173, §722(a)(2), amended paragraph (3) in its entirety. For paragraph (3) as it formerly read, see Vol. II, Superseded Provisions, P.L. 108-173, applicable with respect to contract years beginning on and after January 1, 2006.

(ii) APPLICATION TO MA REGIONAL PLANS.—The Secretary shall establish as appropriate by regulation requirements for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality for MA organizations with respect to MA regional plans. Such requirements may not exceed the requirements under this subparagraph with respect to MA local plans that are preferred provider organization plans.

(iii) APPLICATION TO PREFERRED PROVIDER ORGANIZATIONS.—Clause (i) shall apply to MA organizations with respect to MA local plans that are preferred provider organization plans only insofar as services are furnished by providers or services, physicians, and other health care practitioners and suppliers that have contracts with such organization to furnish services under such plans.

(iv) DEFINITION OF PREFERRED PROVIDER ORGANIZATION PLAN.—In this subparagraph, the term "preferred provider organization plan" means an MA plan that—

(I) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan;

(II) provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and

(III) is offered by an organization that is not licensed or organized under State law as a health maintenance organization.

(B) LIMITATIONS.—

(i) TYPES OF DATA.—The Secretary shall not collect under subparagraph (A) data on quality, outcomes, and beneficiary satisfaction to facilitate consumer choice and program administration other than the types of data that were collected by the Secretary as of November 1, 2003.

(ii) CHANGES IN TYPES OF DATA.—Subject to subclause (iii), the Secretary may only change the types of data that are required to be submitted under subparagraph (A) after submitting to Congress a report on the reasons for such changes that was prepared in consultation with MA organizations and private accrediting bodies.

(iii) CONSTRUCTION.—Nothing in the subsection shall be construed as restricting the ability of the Secretary to carry out the duties under section 1851(d)(4)(D).

(4) TREATMENT OF ACCREDITATION.—

(A) IN GENERAL.—The Secretary shall provide that a Medicare+Choice organization is deemed to meet all the requirements described in any specific clause of subparagraph (B) if the organization is accredited (and periodically reaccredited) by a private accrediting organization under a process that the Secretary has determined assures that the accrediting organization applies and enforces standards

that meet or exceed the standards established under section 1856 to carry out the requirements in such clause.

(B) REQUIREMENTS DESCRIBED.—The provisions described in this subparagraph are the following:

(i) Paragraphs (1) and (2) of this subsection (relating to quality assurance programs).

(ii) Subsection (b) (relating to antidiscrimination).

(iii) Subsection (d) (relating to access to services).

(iv) Subsection (h) (relating to cofidentiality and accuracy of enrollee records).

(v) Subsection (i) (relating to information on advance directives).

(vi) Subsection (j) (relating to provider participation rules).

(C) TIMELY ACTION ON APPLICATIONS.—The Secretary shall determine, within 210 days after the date the Secretary receives an application by a private accrediting organization and using the criteria specified in section 1865(b)(2), whether the process of the private accrediting organization meets the requirements with respect to any specific clause in subparagraph (B) with respect to which the application is made. The Secretary may not deny such an application on the basis that it seeks to meet the requirements with respect to only one, or more than one, such specific clause.

(D) CONSTRUCTION.—Nothing in this paragraph shall be construed as limiting the authority of the Secretary under section 1857, including the authority to terminate contracts with Medicare+Choice organizations under subsection (c)(2) of such section.

(5) REPORT TO CONGRESS.—

(A) IN GENERAL.—Not later than 2 years after the date of the enactment of this paragraph, and biennially thereafter, the Secretary shall submit to Congress a report regarding how quality assurance programs conducted under this subsection focus on racial and ethnic minorities.

(B) CONTENTS OF REPORT.—Each such report shall include the following:

(i) A description of the means by which such programs focus on such racial and ethnic minorities.

(ii) An evaluation of the impact of such programs on eliminating health disparities and on improving health outcomes, continuity and coordination of care, management of chronic conditions, and consumer satisfaction.

(iii) Recommendations on ways to reduce clinical outcome disparities among racial and ethnic minorities.

(f) GRIEVANCE MECHANISM.—Each Medicare+Choice organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and enrollees with Medicare+Choice plans of the organization under this part.

(g) COVERAGE DETERMINATIONS, RECONSIDERATIONS, AND APPEALS.—

(1) DETERMINATIONS BY ORGANIZATION.—

(A) IN GENERAL.—A Medicare+Choice organization shall have a procedure for making determinations regarding whether an individual enrolled with the plan of the organization under this part is entitled to receive a health service under this section and the amount (if any) that the individual is required to pay with respect to such service. Subject to paragraph (3), such procedures shall provide for such determination to be made on a timely basis.

(B) EXPLANATION OF DETERMINATION.—Such a determination that denies coverage, in whole or in part, shall be in writing and shall include a statement in understandable language of the reasons for the denial and a description of the reconsideration and appeals processes.

(2) RECONSIDERATIONS.—

(A) IN GENERAL.—The organization shall provide for reconsideration of a determination described in paragraph (1)(B) upon request by the enrollee involved. The reconsideration shall be within a time period specified by the Secretary, but shall be made, subject to paragraph (3), not later than 60 days after the date of the receipt of the request for reconsideration.

(B) PHYSICIAN DECISION ON CERTAIN RECONSIDERATIONS.—A reconsideration relating to a determination to deny coverage based on a lack of medical necessity shall be made only by a physician with appropriate expertise in the field of medicine which necessitates treatment who is other than a physician involved in the initial determination.

(3) EXPEDITED DETERMINATIONS AND RECONSIDERATIONS.—

(A) RECEIPT OF REQUESTS.—

(i) ENROLLEE REQUESTS.—An enrollee in a Medicare+Choice plan may request, either in writing or orally, an expedited determination under paragraph (1) or an expedited reconsideration under paragraph (2) by the Medicare+Choice organization.

(ii) PHYSICIAN REQUESTS.—A physician, regardless whether the physician is affiliated with the organization or not, may request, either in writing or orally, such an expedited determination or reconsideration.

(B) ORGANIZATION PROCEDURES.—

(i) IN GENERAL.—The Medicare+Choice organization shall maintain procedures for expediting organization determinations and reconsiderations when, upon request of an enrollee, the organization determines that the application of the normal time frame for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

(ii) EXPEDITION REQUIRED FOR PHYSICIAN REQUESTS.—In the case of a request for an expedited determination or reconsideration made under subparagraph (A)(ii), the organization shall expedite the determination or reconsideration if the request indicates that the application of the normal time frame for mak-

ing a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

(iii) TIMELY RESPONSE.—In cases described in clauses (i) and (ii), the organization shall notify the enrollee (and the physician involved, as appropriate) of the determination or reconsideration under time limitations established by the Secretary, but not later than 72 hours of the time of receipt of the request for the determination or reconsideration (or receipt of the information necessary to make the determination or reconsideration), or such longer period as the Secretary may permit in specified cases.

(4) INDEPENDENT REVIEW OF CERTAIN COVERAGE DENIALS .—The Secretary shall contract with an independent, outside entity to review and resolve in a timely manner reconsiderations that affirm denial of coverage, in whole or in part. The provisions of section 1869(c)(5) shall apply to independent outside entities under contract with the Secretary under this paragraph.

(5) APPEALS.—An enrollee with a Medicare+Choice plan of a Medicare+Choice organization under this part who is dissatisfied by reason of the enrollee's failure to receive any health service to which the enrollee believes the enrollee is entitled and at no greater charge than the enrollee believes the enrollee is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 205(b), and in any such hearing the Secretary shall make the organization a party. If the amount in controversy is $1,000 or more, the individual or organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and both the individual and the organization shall be entitled to be parties to that judicial review. In applying subsections (b) and (g) of section 205 as provided in this paragraph, and in applying section 205(l) thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively. The provisions of section 1869(b)(1)(E)(iii) shall apply with respect to dollar amounts specified in the first 2 sentences of this paragraph in the same manner as they apply to the dollar amounts specified in section 1869(b)(1)(E)(i).[322]

(h) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—Insofar as a Medicare+Choice organization maintains medical records or other health information regarding enrollees under this part, the Medicare+Choice organization shall establish procedures—

(1) to safeguard the privacy of any individually identifiable enrollee information;

[322] P.L. 108–173, §940(b)(2)(A), added "The provisions of section 1869(b)(1)(E)(iii) shall apply with respect to dollar amounts specified in the first 2 sentences of this paragraph in the same manner as they apply to the dollar amounts specified in section 1869(b)(1)(E)(i).".

(2) to maintain such records and information in a manner that is accurate and timely; and

(3) to assure timely access of enrollees to such records and information.

(i) INFORMATION ON ADVANCE DIRECTIVES.—Each Medicare+Choice organization shall meet the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).

(j) RULES REGARDING PROVIDER PARTICIPATION.—

(1) PROCEDURES.—Insofar as a Medicare+Choice organization offers benefits under a Medicare+Choice plan through agreements with physicians, the organization shall establish reasonable procedures relating to the participation (under an agreement between a physician and the organization) of physicians under such a plan. Such procedures shall include—

(A) providing notice of the rules regarding participation,

(B) providing written notice of participation decisions that are adverse to physicians, and

(C) providing a process within the organization for appealing such adverse decisions, including the presentation of information and views of the physician regarding such decision.

(2) CONSULTATION IN MEDICAL POLICIES.—A Medicare+Choice organization shall consult with physicians who have entered into participation agreements with the organization regarding the organization's medical policy, quality, and medical management procedures.

(3) PROHIBITING INTERFERENCE WITH PROVIDER ADVICE TO ENROLLEES.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), a Medicare+Choice organization (in relation to an individual enrolled under a Medicare+Choice plan offered by the organization under this part) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the professional is acting within the lawful scope of practice.

(B) CONSCIENCE PROTECTION.—Subparagraph (A) shall not be construed as requiring a Medicare+Choice plan to provide, reimburse for, or provide coverage of a counseling or referral service if the Medicare+Choice organization offering the plan—

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

(ii) in the manner and through the written instrumentalities such Medicare+Choice organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the organization or plan adopts a change in policy regarding such a counseling or referral service.

(C) CONSTRUCTION.—Nothing in subparagraph (B) shall be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974.

(D) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this paragraph, the term health care professional means a physician (as defined in section 1861(r)) or other health care professional if coverage for the professional's services is provided under the Medicare+Choice plan for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech–language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse–midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

(4) LIMITATIONS ON PHYSICIAN INCENTIVE PLANS.—

(A) IN GENERAL.—No Medicare+Choice organization may operate any physician incentive plan (as defined in subparagraph (B)) unless the following requirements are met:

(i) No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization.

(ii) If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the organization—

(I) provides stop—loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or group, and

(II) conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the organization to determine the degree of access of such individuals to services provided by the organization and satisfaction with the quality of such services.]

(iii) The organization provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this subparagraph.]

(B) PHYSICIAN INCENTIVE PLAN DEFINED.—In this paragraph, the term physician incentive plan means any compensation arrangement between a Medicare+Choice organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting

services provided with respect to individuals enrolled with the organization under this part.

(5) LIMITATION ON PROVIDER INDEMNIFICATION.— A Medicare+Choice organization may not provide (directly or indirectly) for a health care professional, provider of services, or other entity providing health care services (or group of such professionals, providers, or entities) to indemnify the organization against any liability resulting from a civil action brought for any damage caused to an enrollee with a Medicare+Choice plan of the organization under this part by the organization's denial of medically necessary care.

(6) SPECIAL RULES FOR MEDICARE+CHOICE PRIVATE FEE–FOR–SERVICE PLANS.—For purposes of applying this part (including subsection (k)(1)) and section 1866(a)(1)(O), a hospital (or other provider of services), a physician or other health care professional, or other entity furnishing health care services is treated as having an agreement or contract in effect with a Medicare+Choice organization (with respect to an individual enrolled in a Medicare+Choice private fee–for–service plan it offers), if—

(A) the provider, professional, or other entity furnishes services that are covered under the plan to such an enrollee; and

(B) before providing such services, the provider, professional, or other entity—

(i) has been informed of the individual's enrollment under the plan, and

(ii) either—

(I) has been informed of the terms and conditions of payment for such services under the plan, or

(II) is given a reasonable opportunity to obtain information concerning such terms and conditions,

in a manner reasonably designed to effect informed agreement by a provider. The previous sentence shall only apply in the absence of an explicit agreement between such a provider, professional, or other entity and the Medicare+Choice organization.

(7)[323] PROMOTION OF E-PRESCRIBING BY MA PLANS.—

(A) IN GENERAL.—An MA-PD plan may provide for a separate payment or otherwise provide for a differential payment for a participating physician that prescribes covered part D drugs in accordance with an electronic prescription drug program that meets standards established under section 1860D-4(e).

(B) CONSIDERATIONS.—Such payment may take into consideration the costs of the physician in implementing such a program and may also be increased for those participating physicians who significantly increase—

(i) formulary compliance;

(ii) lower cost, therapeutically equivalent alternatives;

(iii) reductions in adverse drug interactions; and

[323] P.L. 108–173, §102(b), added paragraph (7).

(iv) efficiencies in filing prescriptions through reduced administrative costs.

(C) STRUCTURE.—Additional or increased payments under this subsection may be structured in the same manner as medication therapy management fees are structured under section 1860D-4(c)(2)(E).

(k) TREATMENT OF SERVICES FURNISHED BY CERTAIN PROVIDERS.—

(1) IN GENERAL.—Except as provided in paragraph (2), a physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for services furnished to an individual enrolled under this part with a Medicare+Choice organization described in section 1851(a)(2)(A) or with an organization offering an MSA plan[324] shall accept as payment in full for covered services under this title that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled. Any penalty or other provision of law that applies to such a payment with respect to an individual entitled to benefits under this title (but not enrolled with a Medicare+Choice organization under this part) also applies with respect to an individual so enrolled.

(2) APPLICATION TO MEDICARE+CHOICE PRIVATE FEE– FOR–SERVICE PLANS.—

(A) BALANCE BILLING LIMITS UNDER MEDICARE+CHOICE PRIVATE FEE–FOR–SERVICE PLANS IN CASE OF CONTRACT PROVIDERS.—

(i) IN GENERAL.—In the case of an individual enrolled in a Medicare+Choice private fee–for–service plan under this part, a physician, provider of services, or other entity that has a contract (including through the operation of subsection (j)(6)) establishing a payment rate for services furnished to the enrollee shall accept as payment in full for covered services under this title that are furnished to such an individual an amount not to exceed (including any deductibles, coinsurance, copayments, or balance billing otherwise permitted under the plan) an amount equal to 115 percent of such payment rate.

(ii) PROCEDURES TO ENFORCE LIMITS.—The Medicare+Choice organization that offers such a plan shall establish procedures, similar to the procedures described in section 1848(g)(1)(A), in order to carry out the previous sentence.

(iii) ASSURING ENFORCEMENT.—If the Medicare+Choice organization fails to establish and enforce procedures required under clause (ii), the organization is subject to intermediate sanctions under section 1857(g).

(B) ENROLLEE LIABILITY FOR NONCONTRACT PROVIDERS.—For provision—

(i) establishing minimum payment rate in the case of noncontract providers under a Medicare+Choice private fee–for– service plan, see section 1852(a)(2); or

[324] P.L. 108–173, §233(c), inserted "or with an organization offering an MSA plan".

(ii) limiting enrollee liability in the case of covered services furnished by such providers, see paragraph (1) and section 1866(a)(1)(O).

(C) INFORMATION ON BENEFICIARY LIABILITY.—

(i) IN GENERAL.—Each Medicare+Choice organization that offers a Medicare+Choice private fee–for–service plan shall provide that enrollees under the plan who are furnished services for which payment is sought under the plan are provided an appropriate explanation of benefits (consistent with that provided under parts A and B and, if applicable, under medicare supplemental policies) that includes a clear statement of the amount of the enrollee's liability (including any liability for balance billing consistent with this subsection) with respect to payments for such services.

(ii) ADVANCE NOTICE BEFORE RECEIPT OF INPATIENT HOSPITAL SERVICES AND CERTAIN OTHER SERVICES.—In addition, such organization shall, in its terms and conditions of payments to hospitals for inpatient hospital services and for other services identified by the Secretary for which the amount of the balance billing under subparagraph (A) could be substantial, require the hospital to provide to the enrollee, before furnishing such services and if the hospital imposes balance billing under subparagraph (A)—

(I) notice of the fact that balance billing is permitted under such subparagraph for such services, and

(II) a good faith estimate of the likely amount of such balance billing (if any), with respect to such services, based upon the presenting condition of the enrollee.

(l)[325] RETURN TO HOME SKILLED NURSING FACILITIES FOR COVERED POST–HOSPITAL EXTENDED CARE SERVICES.—

(1) ENSURING RETURN TO HOME SNF.—

(A) IN GENERAL.—In providing coverage of post–hospital extended care services, a Medicare+Choice plan shall provide for such coverage through a home skilled nursing facility if the following conditions are met:

(i) ENROLLEE ELECTION.—The enrollee elects to receive such coverage through such facility.

(ii) SNF AGREEMENT.—The facility has a contract with the Medicare+Choice organization for the provision of such services, or the facility agrees to accept substantially similar payment under the same terms and conditions that apply to similarly situated skilled nursing facilities that are under contract with the Medicare+Choice organization for the provision of such services and through which the enrollee would otherwise receive such services.

(B) MANNER OF PAYMENT TO HOME SNF.—The organization shall provide payment to the home skilled nursing fa-

[325] See Vol. II, P.L. 106–554, §1(a)(6) [621(c)], with respect to the effects on Medicare+Choice organizations.

cility consistent with the contract or the agreement described in subparagraph (A)(ii), as the case may be.

(2) NO LESS FAVORABLE COVERAGE.—The coverage provided under paragraph (1) (including scope of services, cost–sharing, and other criteria of coverage) shall be no less favorable to the enrollee than the coverage that would be provided to the enrollee with respect to a skilled nursing facility the post– hospital extended care services of which are otherwise covered under the Medicare+Choice plan.

(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to do the following:

(A) To require coverage through a skilled nursing facility that is not otherwise qualified to provide benefits under part A for medicare beneficiaries not enrolled in a Medicare+Choice plan.

(B) To prevent a skilled nursing facility from refusing to accept, or imposing conditions upon the acceptance of, an enrollee for the receipt of post– hospital extended care services.

(4) DEFINITIONS.—In this subsection:

(A) HOME SKILLED NURSING FACILITY.—The term "home skilled nursing facility" means, with respect to an enrollee who is entitled to receive post–hospital extended care services under a Medicare+Choice plan, any of the following skilled nursing facilities:

(i) SNF RESIDENCE AT TIME OF ADMISSION.—The skilled nursing facility in which the enrollee resided at the time of admission to the hospital preceding the receipt of such post–hospital extended care services.

(ii) SNF IN CONTINUING CARE RETIREMENT COMMUNITY.—A skilled nursing facility that is providing such services through a continuing care retirement community (as defined in subparagraph (B)) which provided residence to the enrollee at the time of such admission.

(iii) SNF RESIDENCE OF SPOUSE AT TIME OF DISCHARGE.—The skilled nursing facility in which the spouse of the enrollee is residing at the time of discharge from such hospital.

(B) CONTINUING CARE RETIREMENT COMMUNITY.—The term "continuing care retirement community" means, with respect to an enrollee in a Medicare+Choice plan, an arrangement under which housing and health–related services are provided (or arranged) through an organization for the enrollee under an agreement that is effective for the life of the enrollee or for a specified period.

PAYMENTS TO MEDICARE+CHOICE ORGANIZATIONS [326]

SEC. 1853. [42 U.S.C. 1395w–23] (a) PAYMENTS TO ORGANIZATIONS.—

[326] See Vol. II, P.L. 106–113, §1000(a)(6) [511(b)], with respect to a MEDPAC study and report that evaluates the methodology used in developing the risk factors used in adjusting the Medicare+Choice capitation rate; [511(c)], with respect to a study and report regarding encounter data; and [552(a)], with respect to certain Medicare Advisory Commission studies and reports.

(1) MONTHLY PAYMENTS.—

(A) IN GENERAL.—Under a contract under section 1857 and subject to subsections (e), (g) and (i) and section 1859(e)(4), the Secretary shall make monthly payments under this section in advance to each Medicare+Choice organization, with respect to coverage of an individual under this part in a Medicare+Choice payment area for a month, in an amount equal to 1/12 of the annual Medicare+Choice capitation rate (as calculated under subsection (c)) with respect to that individual for that area, reduced by the amount of any reduction elected under section 1854(f)(1)(E) and adjusted for such risk factors as age, disability status, gender, institutional status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such factors, if such changes will improve the determination of actuarial equivalence.

(B) SPECIAL RULE FOR END–STAGE RENAL DISEASE.—The Secretary shall establish separate rates of payment to a Medicare+Choice organization with respect to classes of individuals determined to have end–stage renal disease and enrolled in a Medicare+Choice plan of the organization. Such rates of payment shall be actuarially equivalent to rates paid other enrollees in the Medicare+Choice payment area (or such other area as specified by the Secretary). In accordance with regulations, the Secretary shall provide for the application of the seventh sentence of section 1881(b)(7) to payments under this section covering the provision of renal dialysis treatment in the same manner as such sentence applies to composite rate payments described in such sentence. In establishing such rates, the Secretary shall provide for appropriate adjustments to increase each rate to reflect the demonstration rate (including the risk adjustment methodology associated with such rate) of the social health maintenance organization end–stage renal disease capitation demonstrations (established by section 2355 of the Deficit Reduction Act of 1984, as amended by section 13567(b) of the Omnibus Budget Reconciliation Act of 1993), and shall compute such rates by taking into account such factors as renal treatment modality, age, and the underlying cause of the end–stage renal disease.

(2) ADJUSTMENT TO REFLECT NUMBER OF ENROLLEES.—

(A) IN GENERAL.—The amount of payment under this subsection may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled with an organization under this part and the

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See Vol. II, P.L. 106–554, §1(a)(6) [601(b)], with respect to a special rule for January and February of 2001; [602(b)], with respect to application of special rule for January and February of 2001; [604], with respect to transition to revised Medicare+Choice payment rates; [605(c)], with respect to the publication of appropriate adjustments; and [609], with respect to a report on inclusion of certain costs of the Department of Veterans Affairs and military facility services in calculating Medicare+Choice payment rates.

P.L. 108-173, §§221 and 222, amends §1853 in several places; however, P.L. 108-173, §223(a) provides that these amendments shall apply with respect to plan years beginning on or after January 1, 2006.

P.L. 108-173, §223(b), provides that the Secretary shall revise the regulations previously promulgated to carry out the provisions of P.L. 108-173.

number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

(B) SPECIAL RULE FOR CERTAIN ENROLLEES.—

(i) IN GENERAL.—Subject to clause (ii), the Secretary may make retroactive adjustments under subparagraph (A) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with a Medicare+Choice organization under a plan operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the organization under this part, except that for purposes of making such retroactive adjustments under this subparagraph, such period may not exceed 90 days.

(ii) EXCEPTION.—No adjustment may be made under clause (i) with respect to any individual who does not certify that the organization provided the individual with the disclosure statement described in section 1852(c) at the time the individual enrolled with the organization.

(3) ESTABLISHMENT OF RISK ADJUSTMENT FACTORS.—

(A) REPORT.—The Secretary shall develop, and submit to Congress by not later than March 1, 1999, a report on the method of risk adjustment of payment rates under this section, to be implemented under subparagraph (C), that accounts for variations in per capita costs based on health status. Such report shall include an evaluation of such method by an outside, independent actuary of the actuarial soundness of the proposal.

(B) DATA COLLECTION.—In order to carry out this paragraph, the Secretary shall require Medicare+Choice organizations (and eligible organizations with risk–sharing contracts under section 1876) to submit data regarding inpatient hospital services for periods beginning on or after July 1, 1997, and data regarding other services and other information as the Secretary deems necessary for periods beginning on or after July 1, 1998. The Secretary may not require an organization to submit such data before January 1, 1998.

(C) INITIAL IMPLEMENTATION.—IN GENERAL.—(i) The Secretary shall first provide for implementation of a risk adjustment methodology that accounts for variations in per capita costs based on health status and other demographic factors for payments by no later than January 1, 2000.

(ii) PHASE–IN.—Except as provided in clause (iv)[327], such risk adjustment methodology shall be implemented in a phased–in manner so that the methodology insofar as it makes adjustments to capitation rates for health status applies to—

(I) 10 percent of 1/12 of the annual Medicare+Choice capitation rate in 2000 and each succeeding year through 2003;

[327] P.L. 108–173, §736(d)(1)(A), struck out "clause (iii)" and substituted "clause (iv)".

(II) 30 percent of such capitation rate in 2004;

(III) 50 percent of such capitation rate in 2005;

(IV) 75 percent of such capitation rate in 2006; and

(V) 100 percent of such capitation rate in 2007 and succeeding years.

(iii) DATA FOR RISK ADJUSTMENT METHODOLOGY.—Such risk adjustment methodology for 2004 and each succeeding year, shall be based on data from inpatient hospital and ambulatory settings.

(iv)[328] FULL IMPLEMENTATION OF RISK ADJUSTMENT FOR CONGESTIVE HEART FAILURE ENROLLEES FOR 2001.—

(I) EXEMPTION FROM PHASE–IN.— Subject to subclause (II), the Secretary shall fully implement the risk adjustment methodology described in clause (i) with respect to each individual who has had a qualifying congestive heart failure inpatient diagnosis (as determined by the Secretary under such risk adjustment methodology) during the period beginning on July 1, 1999, and ending on June 30, 2000, and who is enrolled in a coordinated care plan that is the only coordinated care plan offered on January 1, 2001, in the service area of the individual.

(II) PERIOD OF APPLICATION.— Subclause (I) shall only apply during the 1–year period beginning on January 1, 2001.

(D) UNIFORM APPLICATION TO ALL TYPES OF PLANS.—Subject to section 1859(e)(4), the methodology shall be applied uniformly without regard to the type of plan.

(4) CONTINUED COMPUTATION AND PUBLICATION OF COUNTY–SPECIFIC PER CAPITA FEE–FOR–SERVICE EXPENDITURE INFORMATION[329].— The Secretary, through the Chief Actuary of the Health Care Financing Administration, shall provide for the computation and publication, on an annual basis beginning with 2001 at the time of publication of the annual Medicare+Choice capitation rates under paragraph (1), of the following information for the original medicare fee–for–service program under parts A and B (exclusive of individuals eligible for coverage under section 226A) for each Medicare+Choice payment area for the second calendar year ending before the date of publication:

(A) Total expenditures per capita per month, computed separately for part A and for part B.

(B) The expenditures described in subparagraph (A) reduced by the best estimate of the expenditures (such as graduate medical education and disproportionate share hospital payments) not related to the payment of claims.

(C) The average risk factor for the covered population based on diagnoses reported for medicare inpatient services, using the same methodology as is expected to be applied in making payments under subsection (a).

[328] P.L. 108–173, §736(d)(1)(B), redesignated the former clause (iii) as clause (iv).

[329] See Vol. II, P.L. 106–113, §514(b), with respect to a special rule for 2001.

(D) Such average risk factor based on diagnoses for inpatient and other sites of service, using the same methodology as is expected to be applied in making payments under subsection (a).

(4)[330] PAYMENT RULE FOR FEDERALLY QUALIFIED HEALTH CENTER SERVICES.—If an individual who is enrolled with an MA plan under this part receives a service from a federally qualified health center that has a written agreement with the MA organization that offers such plan for providing such a service (including any agreement required under section 1857(e)(3))—

(A) the Secretary shall pay the amount determined under section 1833(a)(3)(B) directly to the federally qualified health center not less frequently than quarterly; and

(B) the Secretary shall not reduce the amount of the monthly payments under this subsection as a result of the application of subparagraph (A).

(b)[331] ANNUAL ANNOUNCEMENT OF PAYMENT RATES.—

(1) ANNUAL ANNOUNCEMENT.—The Secretary shall annually determine, and shall announce (in a manner intended to provide notice to interested parties) for years before 2004 and after 2005 not later than March 1 before the calendar year concerned and for 2004 and 2005 not later than the second Monday in May before the respective calendar year[332]—

(A) the annual Medicare+Choice capitation rate for each Medicare+Choice payment area for the year, and

(B) the risk and other factors to be used in adjusting such rates under subsection (a)(1)(A) of this section for payments for months in that year.

(2) ADVANCE NOTICE OF METHODOLOGICAL CHANGES.—At least 45 days before making the announcement under paragraph (1) for a year, the Secretary shall provide for notice to Medicare+Choice organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

(3) EXPLANATION OF ASSUMPTIONS.—In each announcement made under paragraph (1), the Secretary shall include an explanation of the assumptions and changes in methodology used in the announcement in sufficient detail so that Medicare+Choice organizations can compute monthly adjusted Medicare+Choice capitation rates for individuals in each Medicare+Choice payment area which is in whole or in part within the service area of such an organization.

(c) CALCULATION OF ANNUAL MEDICARE+CHOICE CAPITATION RATES.—

(1) IN GENERAL.—For purposes of this part, subject to paragraphs (6)(C) and (7), each annual Medicare+Choice capitation rate, for a Medicare+Choice payment area that is an MA local

[330] P.L. 108–173, §237(b)(1), added paragraph (4).

[331] See Vol. II, P.L. 105–33, §4002(i), with respect to publication of new capitation rates.

[332] P.L. 107–188, §532(d)(1), struck out "not later than March 1 before the calendar year concerned" and substituted "for years before 2004 and after 2005 not later than March 1 before the calendar year concerned and for 2004 and 2005 not later than the second Monday in May before the respective calendar year", applicable to announcements for years after 2003.

area[333] for a contract year consisting of a calendar year, is equal to the largest of the amounts specified in the following subparagraph (A), (B), (C), or (D)[334]:

(A) BLENDED CAPITATION RATE.—For a year before 2005, the sum[335] of—

(i) the area–specific percentage (as specified under paragraph (2) for the year) of the annual area–specific Medicare+Choice capitation rate for the Medicare+Choice payment area, as determined under paragraph (3) for the year, and

(ii) the national percentage (as specified under paragraph (2) for the year) of the input–price–adjusted annual national Medicare+Choice capitation rate, as determined under paragraph (4) for the year, multiplied (for a year other than 2004)[336] by the budget neutrality adjustment factor determined under paragraph (5).

(B) MINIMUM AMOUNT.—12 multiplied by the following amount:

(i) For 1998, $367 (but not to exceed, in the case of an area outside the 50 States and the District of Columbia, 150 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area).

(ii) For 1999 and 2000, the minimum amount determined under clause (i) or this clause, respectively, for the preceding year, increased by the national per capita Medicare+Choice growth percentage described in paragraph (6)(A) applicable to 1999 or 2000, respectively.

(iii)(I) Subject to subclause (II), for 2001, for any area in a Metropolitan Statistical Area with a population of more than 250,000, $525, and for any other area $475.

(II) In the case of an area outside the 50 States and the District of Columbia, the amount specified in this clause shall not exceed 120 percent of the amount determined under clause (ii) for such area for 2000.

(iv) For 2002, 2003, and 2004[337], the minimum amount specified in this clause (or clause (iii)) for the preceding year increased by the national per capita Medicare+Choice growth percentage, described in paragraph (6)(A) for that succeeding year.

(C) MINIMUM PERCENTAGE INCREASE.—

(i) For 1998, 102 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the Medicare+Choice payment area.

(ii) For 1999 and 2000, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

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[333] P.L. 108–173, §221(d)(4), inserted "that is an MA local area".

[334] P.L. 108–173, §211(a)(2), struck out "or (C)" and substituted "(C), or (D)".

[335] P.L. 108–173, §211(c)(1)(A), struck out "The sum" and substituted "For a year before 2005, the sum".

[336] P.L. 108–173, §211(b)(1), inserted "(for a year other than 2004)".

[337] P.L. 108–173, §211(c)(1)(B), struck out "and each succeeding year" and substituted ", 2003, and 2004".

(iii) For 2001, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for 2000.

(iv) For 2002 and 2003[338], 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

(v)[339] For 2004 and each succeeding year, the greater of—

(I) 102 percent of the annual MA capitation rate under this paragraph for the area for the previous year; or

(II) the annual MA capitation rate under this paragraph for the area for the previous year increased by the national per capita MA growth percentage, described in paragraph (6) for that succeeding year, but not taking into account any adjustment under paragraph (6)(C) for a year before 2004.

(D)[340] 100 PERCENT OF FEE-FOR-SERVICE COSTS.—

(i) IN GENERAL.—For each year specified in clause (ii), the adjusted average per capita cost for the year involved, determined under section 1876(a)(4) and adjusted as appropriate for the purpose of risk adjustment, for the MA payment area for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1886(h).

(ii) PERIODIC REBASING.—The provisions of clause (i) shall apply for 2004 and for subsequent years as the Secretary shall specify (but not less than once every 3 years).

(iii) INCLUSION OF COSTS OF VA AND DOD MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the adjusted average per capita cost under clause (i) for a year, such cost shall be adjusted to include the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.

(2) AREA–SPECIFIC AND NATIONAL PERCENTAGES.—For purposes of paragraph (1)(A)—

(A) for 1998, the area–specific percentage is 90 percent and the national percentage is 10 percent,

(B) for 1999, the area–specific percentage is 82 percent and the national percentage is 18 percent,

(C) for 2000, the area–specific percentage is 74 percent and the national percentage is 26 percent,

(D) for 2001, the area–specific percentage is 66 percent and the national percentage is 34 percent,

[338] P.L. 108–173, §211(c)(1)(C), struck out "and each succeeding year" and substituted "and 2003".

[339] P.L. 108–173, §211(c)(1)(D), added clause (v), effective December 8, 2003.

[340] P.L. 108–173, §211(a)(1), added subparagraph (D), effective December 8, 2003.

(E) for 2002, the area–specific percentage is 58 percent and the national percentage is 42 percent, and

(F) for a year after 2002, the area–specific percentage is 50 percent and the national percentage is 50 percent.

(3) ANNUAL AREA–SPECIFIC MEDICARE+CHOICE CAPITATION RATE.—

(A) IN GENERAL.—For purposes of paragraph (1)(A), subject to subparagraphs (B) and (E)[341], the annual area– specific Medicare+Choice capitation rate for a Medicare+Choice payment area—

(i) for 1998 is, subject to subparagraph (D), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area, increased by the national per capita Medicare+Choice growth percentage for 1998 (described in paragraph (6)(A)); or

(ii) for a subsequent year is the annual area–specific Medicare+Choice capitation rate for the previous year determined under this paragraph for the area, increased by the national per capita Medicare+Choice growth percentage for such subsequent year.

(B) REMOVAL OF MEDICAL EDUCATION FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—

(i) IN GENERAL.—In determining the area–specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 1998), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to exclude from the rate the applicable percent (specified in clause (ii)) of the payment adjustments described in subparagraph (C).

(ii) APPLICABLE PERCENT.—For purposes of clause (i), the applicable percent for—

(I) 1998 is 20 percent,

(II) 1999 is 40 percent,

(III) 2000 is 60 percent,

(IV) 2001 is 80 percent, and

(V) a succeeding year is 100 percent.

(C) PAYMENT ADJUSTMENT.—

(i) IN GENERAL.—Subject to clause (ii), the payment adjustments described in this subparagraph are payment adjustments which the Secretary estimates were payable during 1997—

(I) for the indirect costs of medical education under section 1886(d)(5)(B), and

(II) for direct graduate medical education costs under section 1886(h).

(ii) TREATMENT OF PAYMENTS COVERED UNDER STATE HOSPITAL REIMBURSEMENT SYSTEM.—To the extent that the Secretary estimates that an annual per capita rate of payment for 1997 described in clause (i) reflects payments to hospitals reimbursed under section 1814(b)(3), the Secretary shall estimate a payment adjustment that is comparable to the payment adjustment that would have been made under clause (i) if

[341] P.L. 108–173, §211(d)(1), inserted "subparagraphs (B) and (E)".

the hospitals had not been reimbursed under such section.

(D) TREATMENT OF AREAS WITH HIGHLY VARIABLE PAYMENT RATES.—In the case of a Medicare+Choice payment area for which the annual per capita rate of payment determined under section 1876(a)(1)(C) for 1997 varies by more than 20 percent from such rate for 1996, for purposes of this subsection the Secretary may substitute for such rate for 1997 a rate that is more representative of the costs of the enrollees in the area.

(E)[342] INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific MA capitation rate under subparagraph (A) for a year (beginning with 2004), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.

(4) INPUT–PRICE–ADJUSTED ANNUAL NATIONAL MEDICARE+CHOICE CAPITATION RATE.—

(A) IN GENERAL.—For purposes of paragraph (1)(A), the input–price–adjusted annual national Medicare+Choice capitation rate for a Medicare+Choice payment area for a year is equal to the sum, for all the types of medicare services (as classified by the Secretary), of the product (for each such type of service) of—

(i) the national standardized annual Medicare+Choice capitation rate (determined under subparagraph (B)) for the year,

(ii) the proportion of such rate for the year which is attributable to such type of services, and

(iii) an index that reflects (for that year and that type of services) the relative input price of such services in the area compared to the national average input price of such services.

In applying clause (iii), the Secretary may, subject to subparagraph (C), apply those indices under this title that are used in applying (or updating) national payment rates for specific areas and localities.

(B) NATIONAL STANDARDIZED ANNUAL MEDICARE+CHOICE CAPITATION RATE.—In subparagraph (A)(i), the national standardized annual Medicare+Choice capitation rate for a year is equal to—

(i) the sum (for all Medicare+Choice payment areas) of the product of—

(I) the annual area–specific Medicare+Choice capitation rate for that year for the area under paragraph (3), and

(II) the average number of medicare beneficiaries residing in that area in the year,

[342] P.L. 108–173, §211(d)(2), added subparagraph (E), effective December 8, 2003.

multiplied by the average of the risk factor weights used to adjust payments under subsection (a)(1)(A) for such beneficiaries in such area; divided by

(ii) the sum of the products described in clause (i)(II) for all areas for that year.

(C) SPECIAL RULES FOR 1998.—In applying this paragraph for 1998—

(i) medicare services shall be divided into 2 types of services: part A services and part B services;

(ii) the proportions described in subparagraph (A)(ii)—

(I) for part A services shall be the ratio (expressed as a percentage) of the national average annual per capita rate of payment for part A for 1997 to the total national average annual per capita rate of payment for parts A and B for 1997, and

(II) for part B services shall be 100 percent minus the ratio described in subclause (I);

(iii) for part A services, 70 percent of payments attributable to such services shall be adjusted by the index used under section 1886(d)(3)(E) to adjust payment rates for relative hospital wage levels for hospitals located in the payment area involved;

(iv) for part B services—

(I) 66 percent of payments attributable to such services shall be adjusted by the index of the geographic area factors under section 1848(e) used to adjust payment rates for physicians services furnished in the payment area, and

(II) of the remaining 34 percent of the amount of such payments, 40 percent shall be adjusted by the index described in clause (iii); and

(v) the index values shall be computed based only on the beneficiary population who are 65 years of age or older and who are not determined to have end stage renal disease.

The Secretary may continue to apply the rules described in this subparagraph (or similar rules) for 1999.

(5) PAYMENT ADJUSTMENT BUDGET NEUTRALITY FACTOR.—For purposes of paragraph (1)(A), for each year, (other than 2004)[343] the Secretary shall determine a budget neutrality adjustment factor so that the aggregate of the payments under this part (other than those attributable to subsections (a)(3)(C)(iv)[344], (a)(4), and (i)[345] shall equal the aggregate payments that would have been made under this part if payment were based entirely on area–specific capitation rates.

(6) NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE DEFINED.—

(A) IN GENERAL.—In this part, the national per capita Medicare+Choice growth percentage for a year is the per-

[343] P.L. 108–173, §211(b)(2), inserted "(other than 2004)".

[344] P.L. 108–173, §736(d)(1)(C), struck out "(a)(3)(C)(iii)" and substituted "(a)(3)(C)(iv)".

[345] P.L. 108–173, §211(b)(2), struck out "subsections (a)(3)(C)(iii) and (i)" and substituted "subsections (a)(3)(C)(iii), (a)(4), and (i)".

centage determined by the Secretary, by March 1st before the beginning of the year involved, to reflect the Secretary's estimate of the projected per capita rate of growth in expenditures under this title for an individual entitled to benefits under part A and enrolled under part B, reduced by the number of percentage points specified in subparagraph (B) for the year. Separate determinations may be made for aged enrollees, disabled enrollees, and enrollees with end– stage renal disease.

(B) ADJUSTMENT.—The number of percentage points specified in this subparagraph is—

(i) for 1998, 0.8 percentage points,
(ii) for 1999, 0.5 percentage points,
(iii) for 2000, 0.5 percentage points,
(iv) for 2001, 0.5 percentage points,
(v) for 2002, 0.3 percentage points, and
(vi) for a year after 2002, 0 percentage points.

(C) ADJUSTMENT FOR OVER OR UNDER PROJECTION OF NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE.—Beginning with rates calculated for 1999, before computing rates for a year as described in paragraph (1), the Secretary shall adjust all area–specific and national Medicare+Choice capitation rates (and beginning in 2000, the minimum amount) for the previous year for the differences between the projections of the national per capita Medicare+Choice growth percentage for that year and previous years and the current estimate of such percentage for such years, except that for purposes of paragraph (1)(C)(v)(II), no such adjustment shall be made for a year before 2004[346].

(7) ADJUSTMENT FOR NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—If the Secretary makes a determination with respect to coverage under this title or there is a change in benefits required to be provided under this part that the Secretary projects will result in a significant increase in the costs to Medicare+Choice of providing benefits under contracts under this part (for periods after any period described in section 1852(a)(5)), the Secretary shall adjust appropriately the payments to such organizations under this part. Such projection and adjustment shall be based on an analysis by the Chief Actuary of the Centers for Medicare and Medicaid Services[347] of the actuarial costs associated with the new benefits.

(d) MA PAYMENT AREA; MA LOCAL AREA; MA REGION DEFINED[348].—

(1) IN GENERAL.—In this part, except as provided in paragraph (3), the term Medicare+Choice payment area means a county, or equivalent area specified by the Secretary.

(2) RULE FOR ESRD BENEFICIARIES.—In the case of individuals who are determined to have end stage renal disease, the

[346] P.L. 108–173, §211(c)(2), inserted ", except that for purposes of paragraph (1)(C)(v)(II), no such adjustment shall be made for a year before 2004".

[347] P.L. 108–173, §900(e)(1)(G)(ii), struck out "Health Care Financing Administration" and substituted "Centers for Medicare and Medicaid Services".

[348] P.L. 108–173, §221(d)(1)(A), amended the heading in its entirety. For the heading as it formerly read, see Vol. II, Superseded Provisions, P.L. 108-173.

Medicare+Choice payment area shall be a State or such other payment area as the Secretary specifies.

(3) GEOGRAPHIC ADJUSTMENT.—

(A) IN GENERAL.—Upon written request of the chief executive officer of a State for a contract year (beginning after 1998) made by not later than February 1 of the previous year, the Secretary shall make a geographic adjustment to a Medicare+Choice payment area in the State otherwise determined under paragraph (1)—

(i) to a single statewide Medicare+Choice payment area,

(ii) to the metropolitan based system described in subparagraph (C), or

(iii) to consolidating into a single Medicare+Choice payment area noncontiguous counties (or equivalent areas described in paragraph (1)) within a State.

Such adjustment shall be effective for payments for months beginning with January of the year following the year in which the request is received.

(B) BUDGET NEUTRALITY ADJUSTMENT.—In the case of a State requesting an adjustment under this paragraph, the Secretary shall initially (and annually thereafter) adjust the payment rates otherwise established under this section for Medicare+Choice payment areas in the State in a manner so that the aggregate of the payments under this section in the State shall not exceed the aggregate payments that would have been made under this section for Medicare+Choice payment areas in the State in the absence of the adjustment under this paragraph.

(C) METROPOLITAN BASED SYSTEM.—The metropolitan based system described in this subparagraph is one in which—

(i) all the portions of each metropolitan statistical area in the State or in the case of a consolidated metropolitan statistical area, all of the portions of each primary metropolitan statistical area within the consolidated area within the State, are treated as a single Medicare+Choice payment area, and

(ii) all areas in the State that do not fall within a metropolitan statistical area are treated as a single Medicare+Choice payment area.

(D) AREAS.—In subparagraph (C), the terms metropolitan statistical area, consolidated metropolitan statistical area, and primary metropolitan statistical area mean any area designated as such by the Secretary of Commerce.

(e) SPECIAL RULES FOR INDIVIDUALS ELECTING MSA PLANS.—

(1) IN GENERAL.—If the amount of the Medicare+Choice monthly MSA premium (as defined in section 1854(b)(2)(C)) for an MSA plan for a year is less than 1/12 of the annual Medicare+Choice capitation rate applied under this section for the area and year involved, the Secretary shall deposit an amount equal to 100 percent of such difference in a Medicare+Choice MSA established (and, if applicable, designated) by the individual under paragraph (2).

(2) ESTABLISHMENT AND DESIGNATION OF MEDICARE+CHOICE MEDICAL SAVINGS ACCOUNT AS REQUIREMENT FOR PAYMENT OF

CONTRIBUTION.—In the case of an individual who has elected coverage under an MSA plan, no payment shall be made under paragraph (1) on behalf of an individual for a month unless the individual—

(A) has established before the beginning of the month (or by such other deadline as the Secretary may specify) a Medicare+Choice MSA (as defined in section 138(b)(2) of the Internal Revenue Code of 1986), and

(B) if the individual has established more than one such Medicare+Choice MSA, has designated one of such accounts as the individual's Medicare+Choice MSA for purposes of this part. Under rules under this section, such an individual may change the designation of such account under subparagraph (B) for purposes of this part.

(3) LUMP–SUM DEPOSIT OF MEDICAL SAVINGS ACCOUNT CONTRIBUTION.—In the case of an individual electing an MSA plan effective beginning with a month in a year, the amount of the contribution to the Medicare+Choice MSA on behalf of the individual for that month and all successive months in the year shall be deposited during that first month. In the case of a termination of such an election as of a month before the end of a year, the Secretary shall provide for a procedure for the recovery of deposits attributable to the remaining months in the year.

(f) PAYMENTS FROM TRUST FUNDS[349].—The payment to a Medicare+Choice organization under this section for individuals enrolled under this part with the organization and payments to a Medicare+Choice MSA under subsection (e)(1) shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines reflects the relative weight that benefits under part A and under part B represents of the actuarial value of the total benefits under this title. Payments to MA organizations for statutory drug benefits provided under this title are made from the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund.[350] Monthly payments otherwise payable under this section for October 2000 shall be paid on the first business day of such month. Monthly payments otherwise payable under this section for October 2001 shall be paid on the last business day of September 2001. Monthly payments otherwise payable under this section for October 2006 shall be paid on the first business day of October 2006.

(g) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS.—In the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B)), a rehabilitation hospital described in section 1886(d)(1)(B)(ii) or a distinct part rehabilitation unit described in the matter following clause (v) of section 1886(d)(1)(B), or a long-term care hospital (described in section 1886(d)(1)(B)(iv))[351] as of the effective date of the individual's—

[349] P.L. 108–173, §101(e)(3)(D)(i), struck out "Trust Fund" and substituted "Trust Funds".

[350] P.L. 108–173, §101(e)(3)(D)(ii), added "Payments to MA organizations for statutory drug benefits provided under this title are made from the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund.", effective December 8, 2003.

[351] P.L. 108–173, §211(e)(1)(A), inserted ", a rehabilitation hospital described in section 1886(d)(1)(B)(ii) or a distinct part rehabilitation unit described in the matter following clause

(1) election under this part of a Medicare+Choice plan offered by a Medicare+Choice organization—

(A) payment for such services until the date of the individual's discharge shall be made under this title through the Medicare+Choice plan or the original medicare fee–for–service program option described in section 1851(a)(1)(A) (as the case may be) elected before the election with such organization,

(B) the elected organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge, and

(C) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this part; or

(2) termination of election with respect to a Medicare+Choice organization under this part—

(A) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge,

(B) payment for such services during the stay shall not be made under section 1886(d) or other payment provision under this title for inpatient services for the type of facility, hospital, or unit involved, described in the matter preceding paragraph (1), as the case may be,[352] or by any succeeding Medicare+Choice organization, and

(C) the terminated organization shall not receive any payment with respect to the individual under this part during the period the individual is not enrolled.

(h) SPECIAL RULE FOR HOSPICE CARE.—

(1) INFORMATION.—A contract under this part shall require the Medicare+Choice organization to inform each individual enrolled under this part with a Medicare+Choice plan offered by the organization about the availability of hospice care if—

(A) a hospice program participating under this title is located within the organization's service area; or

(B) it is common practice to refer patients to hospice programs outside such service area.

(2) PAYMENT.—If an individual who is enrolled with a Medicare+Choice organization under this part makes an election under section 1812(d)(1) to receive hospice care from a particular hospice program—

(A) payment for the hospice care furnished to the individual shall be made to the hospice program elected by the individual by the Secretary;

(B) payment for other services for which the individual is eligible notwithstanding the individual's election of hospice care under section 1812(d)(1), including services not related to the individual's terminal illness, shall be made by the Secretary to the Medicare+Choice organization or the provider or supplier of the service instead of payments calculated under subsection (a); and

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(v) of section 1886(d)(1)(B), or a long-term care hospital (described in section 1886(d)(1)(B)(iv))", applicable to contract years beginning on or after January 1, 2004.

[352] P.L. 108–173, §211(e)(1)(B), inserted "or other payment provision under this title for inpatient services for the type of facility, hospital, or unit involved, described in the matter preceding paragraph (1), as the case may be,", applicable to contract years beginning on or after January 1, 2004.

(C) the Secretary shall continue to make monthly payments to the Medicare+Choice organization in an amount equal to the value of the additional benefits required under section 1854(f)(1)(A).

(i) NEW ENTRY BONUS.—

(1) IN GENERAL.—Subject to paragraphs (2) and (3), in the case of Medicare+Choice payment area in which a Medicare+Choice plan has not been offered since 1997 (or in which all organizations that offered a plan since such date have filed notice with the Secretary, as of October 13, 1999, that they will not be offering such a plan as of January 1, 2000, or filed notice with the Secretary as of October 3, 2000, that they will not be offering such a plan as of January 1, 2001), the amount of the monthly payment otherwise made under this section shall be increased—

(A) only for the first 12 months in which any Medicare+Choice plan is offered in the area, by 5 percent of the total monthly payment otherwise computed for such payment area; and

(B) only for the subsequent 12 months, by 3 percent of the total monthly payment otherwise computed for such payment area.

(2) PERIOD OF APPLICATION.—Paragraph (1) shall only apply to payment for Medicare+Choice plans which are first offered in a Medicare+Choice payment area during the 2–year period beginning on January 1, 2000.

(3) LIMITATION TO ORGANIZATION OFFERING FIRST PLAN IN AN AREA.—Paragraph (1) shall only apply to payment to the first Medicare+Choice organization that offers a Medicare+Choice plan in each Medicare+Choice payment area, except that if more than one such organization first offers such a plan in an area on the same date, paragraph (1) shall apply to payment for such organizations.

(4) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as affecting the calculation of the annual Medicare+Choice capitation rate under subsection (c) for any payment area or as applying to payment for any period not described in such paragraph and paragraph (2).

(5) OFFERED DEFINED.—In this subsection, the term "offered" means, with respect to a Medicare+Choice plan as of a date, that a Medicare+Choice eligible individual may enroll with the plan on that date, regardless of when the enrollment takes effect or when the individual obtains benefits under the plan.

PREMIUMS [353]

SEC. 1854. [42 U.S.C. 1395w–24] (a) SUBMISSION OF PROPOSED PREMIUMS AND RELATED INFORMATION.—

(1) IN GENERAL.—Not later than the second Monday in September of 2002, 2003, and 2004 (or July 1 of each other

[353] P.L. 108-173, §222, amends §1854 in several places; however, P.L. 108-173, §223(a) provides that these amendments shall apply with respect to plan years beginning on or after January 1, 2006.

P.L. 108-173, §223(b), provides that the Secretary shall revise the regulations previously promulgated to carry out the provisions of P.L. 108-173.

year)[354], each Medicare+Choice organization shall submit to the Secretary, in a form and manner specified by the Secretary and for each Medicare+Choice plan for the service area (or segment of such an area if permitted under subsection (h)) in which it intends to be offered in the following year—

(A) the information described in paragraph (2), (3), or (4) for the type of plan involved; and

(B) the enrollment capacity (if any) in relation to the plan and area.

(2) INFORMATION REQUIRED FOR COORDINATED CARE PLANS.—For a Medicare+Choice plan described in section 1851(a)(2)(A), the information described in this paragraph is as follows:

(A) BASIC (AND ADDITIONAL) BENEFITS.—For benefits described in section 1852(a)(1)(A)—

(i) the adjusted community rate (as defined in subsection (f)(3));

(ii) the Medicare+Choice monthly basic beneficiary premium (as defined in subsection (b)(2)(A));

(iii) a description of deductibles, coinsurance, and copayments applicable under the plan and the actuarial value of such deductibles, coinsurance, and copayments, described in subsection (e)(1)(A); and

(iv) if required under subsection (f)(1), a description of the additional benefits to be provided pursuant to such subsection and the value determined for such proposed benefits under such subsection.

(B) SUPPLEMENTAL BENEFITS.—For benefits described in section 1852(a)(3)—

(i) the adjusted community rate (as defined in subsection (f)(3));

(ii) the Medicare+Choice monthly supplemental beneficiary premium (as defined in subsection (b)(2)(B)); and

(iii) a description of deductibles, coinsurance, and copayments applicable under the plan and the actuarial value of such deductibles, coinsurance, and copayments, described in subsection (e)(2).

(3) REQUIREMENTS FOR MSA PLANS.—For an MSA plan described, the information described in this paragraph is as follows:

(A) BASIC (AND ADDITIONAL) BENEFITS.—For benefits described in section 1852(a)(1)(A), the amount of the Medicare+Choice monthly MSA premium.

(B) SUPPLEMENTAL BENEFITS.—For benefits described in section 1852(a)(3), the amount of the Medicare+Choice monthly supplementary beneficiary premium.

(4) REQUIREMENTS FOR PRIVATE FEE–FOR–SERVICE PLANS.—For a Medicare+Choice plan described in section 1851(a)(2)(C) for benefits described in section 1852(a)(1)(A), the information described in this paragraph is as follows:

(A) BASIC (AND ADDITIONAL) BENEFITS.—For benefits described in section 1852(a)(1)(A)—

[354] P.L. 107-188, §532(b)(1), struck out "Not later than July 1 of each year" and substituted "Not later than the second Monday in September of 2002, 2003, and 2004 (or July 1 of each other year)", applicable to information submitted for years beginning with 2003.

(i) the adjusted community rate (as defined in subsection (f)(3));

(ii) the amount of the Medicare+Choice monthly basic beneficiary premium;

(iii) a description of the deductibles, coinsurance, and copayments applicable under the plan, and the actuarial value of such deductibles, coinsurance, and copayments, as described in subsection (e)(4)(A); and

(iv) if required under subsection (f)(1), a description of the additional benefits to be provided pursuant to such subsection and the value determined for such proposed benefits under such subsection.

(B) SUPPLEMENTAL BENEFITS.—For benefits described in section 1852(a)(3), the amount of the Medicare+Choice monthly supplemental beneficiary premium (as defined in subsection (b)(2)(B)).

(5) REVIEW.—

(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall review the adjusted community rates, the amounts of the basic and supplemental premiums, and values filed under this subsection and shall approve or disapprove such rates, amounts, and values so submitted. The Chief Actuary of the Centers for Medicare and Medicaid Services [355] shall review the actuarial assumptions and data used by the Medicare+Choice organization with respect to such rates, amounts, and values so submitted to determine the appropriateness of such assumptions and data.

(B) EXCEPTION.—The Secretary shall not review, approve, or disapprove the amounts submitted under paragraph (3) or subparagraphs (A)(ii) and (B) of paragraph (4).

(b) MONTHLY PREMIUM CHARGED.—

(1) IN GENERAL.—

(A) RULE FOR OTHER THAN MSA PLANS.—The monthly amount of the premium charged to an individual enrolled in a Medicare+Choice plan (other than an MSA plan) offered by a Medicare+Choice organization shall be equal to the sum of the Medicare+Choice monthly basic beneficiary premium and the Medicare+Choice monthly supplementary beneficiary premium (if any).

(B) MSA PLANS.—The monthly amount of the premium charged to an individual enrolled in an MSA plan offered by a Medicare+Choice organization shall be equal to the Medicare+Choice monthly supplemental beneficiary premium (if any).

(2) PREMIUM TERMINOLOGY DEFINED.—For purposes of this part:

(A) THE MEDICARE+CHOICE MONTHLY BASIC BENEFICIARY PREMIUM.—The term "Medicare+Choice monthly basic beneficiary premium" means, with respect to a Medicare+Choice plan, the amount authorized to be charged under subsection (e)(1) of this section for the plan,

[355] P.L. 108-173, §900(e)(1)(H), struck out "Health Care Financing Administration" and substituted "Centers for Medicare and Medicaid Services".

or, in the case of a Medicare+Choice private fee-for-service plan, the amount filed under subsection (a)(4)(A)(ii).

(B) MEDICARE+CHOICE MONTHLY SUPPLEMENTAL BENEFICIARY PREMIUM.—The term Medicare+Choice monthly supplemental beneficiary premium means, with respect to a Medicare+Choice plan, the amount authorized to be charged under subsection (e)(2) for the plan or, in the case of a MSA plan or Medicare+Choice private fee-for-service plan, the amount filed under paragraph (3)(B) or (4)(B) of subsection (a).

(C) MEDICARE+CHOICE MONTHLY MSA PREMIUM.—The term Medicare+Choice monthly MSA premium means, with respect to a Medicare+Choice plan, the amount of such premium filed under subsection (a)(3)(A) for the plan.

(c) UNIFORM PREMIUM.—The Medicare+Choice monthly basic and supplemental beneficiary premium, the Medicare+Choice monthly MSA premium charged under subsection (b) of a Medicare+Choice organization under this part may not vary among individuals enrolled in the plan.

(d) TERMS AND CONDITIONS OF IMPOSING PREMIUMS.—Each Medicare+Choice organization shall permit the payment of Medicare+Choice monthly basic and supplemental beneficiary premiums on a monthly basis, may terminate election of individuals for a Medicare+Choice plan for failure to make premium payments only in accordance with section 1851(g)(3)(B)(i), and may not provide for cash or other monetary rebates as an inducement for enrollment or otherwise.

(e) LIMITATION ON ENROLLEE LIABILITY.—

(1) FOR BASIC AND ADDITIONAL BENEFITS.—In no event may—

(A) the Medicare+Choice monthly basic beneficiary premium (multiplied by 12) and the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with a Medicare+Choice plan described in section 1851(a)(2)(A) of an organization with respect to required benefits described in section 1852(a)(1)(A) and additional benefits (if any) required under subsection (f)(1)(A) for a year, exceed

(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals entitled to benefits under part A and enrolled under part B if they were not members of a Medicare+Choice organization for the year.

(2) FOR SUPPLEMENTAL BENEFITS.—If the Medicare+Choice organization provides to its members enrolled under this part in a Medicare+Choice plan described in section 1851(a)(2)(A) with respect to supplemental benefits described in section 1852(a)(3), the sum of the Medicare+Choice monthly supplemental beneficiary premium (multiplied by 12) charged and the actuarial value of its deductibles, coinsurance, and copayments charged with respect to such benefits may not exceed the adjusted community rate for such benefits (as defined in subsection (f)(3)).

(3) DETERMINATION ON OTHER BASIS.—If the Secretary determines that adequate data are not available to determine the actuarial value under paragraph (1)(A) or (2), the Secretary may determine such amount with respect to all individuals in

same geographic area, the State, or in the United States, eligible to enroll in the Medicare+Choice plan involved under this part or on the basis of other appropriate data.

(4) SPECIAL RULE FOR PRIVATE FEE–FOR–SERVICE PLANS.—With respect to a Medicare+Choice private fee–for–service plan (other than a plan that is an MSA plan), in no event may—

(A) the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with such a plan of an organization with respect to required benefits described in section 1852(a)(1), exceed

(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals entitled to benefits under part A and enrolled under part B if they were not members of a Medicare+Choice organization for the year.

(f) REQUIREMENT FOR ADDITIONAL BENEFITS.—

(1) REQUIREMENT.—

(A) IN GENERAL.—Each Medicare+Choice organization (in relation to a Medicare+Choice plan, other than an MSA plan, it offers) shall provide that if there is an excess amount (as defined in subparagraph (B)) for the plan for a contract year, subject to the succeeding provisions of this subsection, the organization shall provide to individuals such additional benefits (as the organization may specify) in a value which the Secretary determines is at least equal to the adjusted excess amount (as defined in subparagraph (C)).

(B) EXCESS AMOUNT.—For purposes of this paragraph, the excess amount, for an organization for a plan, is the amount (if any) by which—

(i) the average of the capitation payments made to the organization under section 1853 for the plan at the beginning of contract year, exceeds

(ii) the actuarial value of the required benefits described in section 1852(a)(1)(A) under the plan for individuals under this part, as determined based upon an adjusted community rate described in paragraph (3) (as reduced for the actuarial value of the coinsurance, copayments, and deductibles under parts A and B).

(C) ADJUSTED EXCESS AMOUNT.—For purposes of this paragraph, the adjusted excess amount, for an organization for a plan, is the excess amount reduced to reflect any amount withheld and reserved for the organization for the year under paragraph (2).

(D) UNIFORM APPLICATION.—This paragraph shall be applied uniformly for all enrollees for a plan.

(E)[356] PREMIUM REDUCTIONS.—

(i) IN GENERAL.—Subject to clause (ii), as part of providing any additional benefits required under subparagraph (A), a Medicare+Choice organization may elect a reduction in its payments under section

[356] P.L. 106-554, §1(a)(6) [606(a)(1)(B)], added this subparagraph (E), applicable to years beginning with 2003.

1853(a)(1)(A) with respect to a Medicare+Choice plan and the Secretary shall apply such reduction to reduce the premium under section 1839 of each enrollee in such plan as provided in section 1840(i).

(ii) AMOUNT OF REDUCTION.—The amount of the reduction under clause (i) with respect to any enrollee in a Medicare+Choice plan—

(I) may not exceed 125 percent of the premium described under section 1839(a)(3); and

(II) shall apply uniformly to each enrollee of the Medicare+Choice plan to which such reduction applies.

(F) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a Medicare+Choice organization from providing supplemental benefits (described in section 1852(a)(3)) that are in addition to the health care benefits otherwise required to be provided under this paragraph and from imposing a premium for such supplemental benefits.

(2) STABILIZATION FUND.—A Medicare+Choice organization may provide that a part of the value of an excess amount described in paragraph (1) be withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate) by the Secretary for subsequent annual contract periods, to the extent required to stabilize and prevent undue fluctuations in the additional benefits offered in those subsequent periods by the organization in accordance with such paragraph. Any of such value of the amount reserved which is not provided as additional benefits described in paragraph (1)(A) to individuals electing the Medicare+Choice plan of the organization in accordance with such paragraph prior to the end of such periods, shall revert for the use of such trust funds.

(3) ADJUSTED COMMUNITY RATE.—For purposes of this subsection, subject to paragraph (4), the term adjusted community rate for a service or services means, at the election of a Medicare+Choice organization, either—

(A) the rate of payment for that service or services which the Secretary annually determines would apply to an individual electing a Medicare+Choice plan under this part if the rate of payment were determined under a community rating system (as defined in section 1302(8) of the Public Health Service Act, other than subparagraph (C)), or

(B) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to such an individual, as the Secretary annually estimates is attributable to that service or services,

but adjusted for differences between the utilization characteristics of the individuals electing coverage under this part and the utilization characteristics of the other enrollees with the plan (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of individuals selecting other Medicare+Choice coverage, or Medicare+Choice eligible individuals in the area, in the State, or in the United States, eligible

to elect Medicare+Choice coverage under this part and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

(4) DETERMINATION BASED ON INSUFFICIENT DATA.—For purposes of this subsection, if the Secretary finds that there is insufficient enrollment experience to determine an average of the capitation payments to be made under this part at the beginning of a contract period or to determine (in the case of a newly operated provider—sponsored organization or other new organization) the adjusted community rate for the organization, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this part and may determine such a rate using data in the general commercial marketplace.

(g) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES.—No State may impose a premium tax or similar taxwith respect to payments to Medicare+Choice organizations under section 1853.

(h) PERMITTING USE OF SEGMENTS OF SERVICE AREAS.—The Secretary shall permit a Medicare+Choice organization to elect to apply the provisions of this section uniformly to separate segments of a service area (rather than uniformly to an entire service area) as long as such segments are composed of one or more Medicare+Choice payment areas.

ORGANIZATIONAL AND FINANCIAL REQUIREMENTS FOR MEDICARE+CHOICE ORGANIZATIONS; PROVIDER–SPONSORED ORGANIZATIONS

SEC. 1855. [42 U.S.C. 1395w–25] (a) ORGANIZED AND LICENSED UNDER STATE LAW.—

(1) IN GENERAL.—Subject to paragraphs (2) and (3), a Medicare+Choice organization shall be organized and licensed under State law as a risk—bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a Medicare+Choice plan.

(2) SPECIAL EXCEPTION FOR PROVIDER–SPONSORED ORGANIZATIONS.—

(A) IN GENERAL.—In the case of a provider—sponsored organization that seeks to offer a Medicare+Choice plan in a State, the Secretary shall waive the requirement of paragraph (1) that the organization be licensed in that State if—

(i) the organization files an application for such waiver with the Secretary by not later than November 1, 2002, and

(ii) the Secretary determines, based on the application and other evidence presented to the Secretary, that any of the grounds for approval of the application described in subparagraph (B), (C), or (D) has been met.

(B) FAILURE TO ACT ON LICENSURE APPLICATION ON A TIMELY BASIS.—The ground for approval of such a waiver application described in this subparagraph is that the State has failed to complete action on a licensing application of the organization within 90 days of the date of the State's receipt of a substantially complete application. No

period before the date of the enactment of this section shall be included in determining such 90–day period.

(C) DENIAL OF APPLICATION BASED ON DISCRIMINATORY TREATMENT.—The ground for approval of such a waiver application described in this subparagraph is that the State has denied such a licensing application and—

(i) the standards or review process imposed by the State as a condition of approval of the license imposes any material requirements, procedures, or standards (other than solvency requirements) to such organizations that are not generally applicable to other entities engaged in a substantially similar business, or

(ii) the State requires the organization, as a condition of licensure, to offer any product or plan other than a Medicare+Choice plan.

(D) DENIAL OF APPLICATION BASED ON APPLICATION OF SOLVENCY REQUIREMENTS.—With respect to waiver applications filed on or after the date of publication of solvency standards under section 1856(a), the ground for approval of such a waiver application described in this subparagraph is that the State has denied such a licensing application based (in whole or in part) on the organization's failure to meet applicable solvency requirements and—

(i) such requirements are not the same as the solvency standards established under section 1856(a); or

(ii) the State has imposed as a condition of approval of the license documentation or information requirements relating to solvency or other material requirements, procedures, or standards relating to solvency that are different from the requirements, procedures, and standards applied by the Secretary under subsection (d)(2).

For purposes of this paragraph, the term solvency requirements means requirements relating to solvency and other matters covered under the standards established under section 1856(a).

(E) TREATMENT OF WAIVER.—In the case of a waiver granted under this paragraph for a provider–sponsored organization with respect to a State—

(i) LIMITATION TO STATE.—The waiver shall be effective only with respect to that State and does not apply to any other State.

(ii) LIMITATION TO 36–MONTH PERIOD.—The waiver shall be effective only for a 36–month period and may not be renewed.

(iii) CONDITIONED ON COMPLIANCE WITH CONSUMER PROTECTION AND QUALITY STANDARDS.—The continuation of the waiver is conditioned upon the organization's compliance with the requirements described in subparagraph (G).

(iv) PREEMPTION OF STATE LAW.—Any provisions of law of that State which relate to the licensing of the organization and which prohibit the organization from providing coverage pursuant to a contract under this part shall be superseded.

(F) PROMPT ACTION ON APPLICATION.—The Secretary shall grant or deny such a waiver application within 60 days after the date the Secretary determines that a substantially complete waiver application has been filed. Nothing in this section shall be construed as preventing an organization which has had such a waiver application denied from submitting a subsequent waiver application.

(G) APPLICATION AND ENFORCEMENT OF STATE CONSUMER PROTECTION AND QUALITY STANDARDS.—

(i) IN GENERAL.—A waiver granted under this paragraph to an organization with respect to licensing under State law is conditioned upon the organization's compliance with all consumer protection and quality standards insofar as such standards—

(I) would apply in the State to the organization if it were licensed under State law;

(II) are generally applicable to other Medicare+Choice organizations and plans in the State; and

(III) are consistent with the standards established under this part. Such standards shall not include any standard preempted under section 1856(b)(3)(B).

(ii) INCORPORATION INTO CONTRACT.—In the case of such a waiver granted to an organization with respect to a State, the Secretary shall incorporate the requirement that the organization (and Medicare+Choice plans it offers) comply with standards under clause (i) as part of the contract between the Secretary and the organization under section 1857.

(iii) ENFORCEMENT.—In the case of such a waiver granted to an organization with respect to a State, the Secretary may enter into an agreement with the State under which the State agrees to provide for monitoring and enforcement activities with respect to compliance of such an organization and its Medicare+Choice plans with such standards. Such monitoring and enforcement shall be conducted by the State in the same manner as the State enforces such standards with respect to other Medicare+Choice organizations and plans, without discrimination based on the type of organization to which the standards apply. Such an agreement shall specify or establish mechanisms by which compliance activities are undertaken, while not lengthening the time required to review and process applications for waivers under this paragraph.

(H) REPORT.—By not later than December 31, 2001, the Secretary shall submit to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate a report regarding whether the waiver process under this paragraph should be continued after December 31, 2002. In making such recommendation, the Secretary shall consider, among other factors, the impact of such process on beneficiaries and on the long—term solvency of the program under this title.

(3) LICENSURE DOES NOT SUBSTITUTE FOR OR CONSTITUTE CERTIFICATION.—The fact that an organization is licensed in accordance with paragraph (1) does not deem the organization to meet other requirements imposed under this part.

(b) ASSUMPTION OF FULL FINANCIAL RISK.—The Medicare+Choice organization shall assume full financial risk on a prospective basis for the provision of the health care services for which benefits are required to be provided under section 1852(a)(1), except that the organization—

(1) may obtain insurance or make other arrangements for the cost of providing to any enrolled member such services the aggregate value of which exceeds such aggregate level as the Secretary specifies from time to time,

(2) may obtain insurance or make other arrangements for the cost of such services provided to its enrolled members other than through the organization because medical necessity required their provision before they could be secured through the organization,

(3) may obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for such fiscal year, and

(4) may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions.

(c) CERTIFICATION OF PROVISION AGAINST RISK OF INSOLVENCY FOR UNLICENSED PSOS.—

(1) IN GENERAL.—Each Medicare+Choice organization that is a provider–sponsored organization, that is not licensed by a State under subsection (a), and for which a waiver application has been approved under subsection (a)(2), shall meet standards established under section 1856(a) relating to the financial solvency and capital adequacy of the organization.

(2) CERTIFICATION PROCESS FOR SOLVENCY STANDARDS FOR PSOS.—The Secretary shall establish a process for the receipt and approval of applications of a provider–sponsored organization described in paragraph (1) for certification (and periodic recertification) of the organization as meeting such solvency standards. Under such process, the Secretary shall act upon such a certification application not later than 60 days after the date the application has been received.

(d) PROVIDER–SPONSORED ORGANIZATION DEFINED.—

(1) IN GENERAL.—In this part, the term provider–sponsored organization means a public or private entity—

(A) that is established or organized, and operated, by a health care provider, or group of affiliated health care providers,

(B) that provides a substantial proportion (as defined by the Secretary in accordance with paragraph (2)) of the health care items and services under the contract under this part directly through the provider or affiliated group of providers, and

(C) with respect to which the affiliated providers share, directly or indirectly, substantial financial risk with respect to the provision of such items and services and have at least a majority financial interest in the entity.

(2) SUBSTANTIAL PROPORTION.—In defining what is a substantial proportion for purposes of paragraph (1)(B), the Secretary—

(A) shall take into account the need for such an organization to assume responsibility for providing—

(i) significantly more than the majority of the items and services under the contract under this section through its own affiliated providers; and

(ii) most of the remainder of the items and services under the contract through providers with which the organization has an agreement to provide such items and services,

in order to assure financial stability and to address the practical considerations involved in integrating the delivery of a wide range of service providers;

(B) shall take into account the need for such an organization to provide a limited proportion of the items and services under the contract through providers that are neither affiliated with nor have an agreement with the organization; and

(C) may allow for variation in the definition of substantial proportion among such organizations based on relevant differences among the organizations, such as their location in an urban or rural area.

(3) AFFILIATION.—For purposes of this subsection, a provider is affiliated with another provider if, through contract, ownership, or otherwise—

(A) one provider, directly or indirectly, controls, is controlled by, or is under common control with the other,

(B) both providers are part of a controlled group of corporations under section 1563 of the Internal Revenue Code of 1986,

(C) each provider is a participant in a lawful combination under which each provider shares substantial financial risk in connection with the organization's operations, or

(D) both providers are part of an affiliated service group under section 414 of such Code.

(4) CONTROL.—For purposes of paragraph (3), control is presumed to exist if one party, directly or indirectly, owns, controls, or holds the power to vote, or proxies for, not less than 51 percent of the voting rights or governance rights of another.

(5) HEALTH CARE PROVIDER DEFINED.—In this subsection, the term health care provider means—

(A) any individual who is engaged in the delivery of health care services in a State and who is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, and

(B) any entity that is engaged in the delivery of health care services in a State and that, if it is required by State law or regulation to be licensed or certified by the State to

engage in the delivery of such services in the State, is so licensed.

(6) REGULATIONS.—The Secretary shall issue regulations to carry out this subsection.

ESTABLISHMENT OF STANDARDS

SEC. 1856. [42 U.S.C. 1395w–26] (a) ESTABLISHMENT OF SOLVENCY STANDARDS FOR PROVIDER–SPONSORED ORGANIZATIONS.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Secretary shall establish, on an expedited basis and using a negotiated rulemaking process under subchapter III of chapter 5 of title 5,United States Code, standards described in section 1855(c)(1) (relating to the financial solvency and capital adequacy of the organization) that entities must meet to qualify as provider–sponsored organizations under this part.

(B) FACTORS TO CONSIDER FOR SOLVENCY STANDARDS.—In establishing solvency standards under subparagraph (A) for provider–sponsored organizations, the Secretary shall consult with interested parties and shall take into account—

(i) the delivery system assets of such an organization and ability of such an organization to provide services directly to enrollees through affiliated providers,

(ii) alternative means of protecting against insolvency, including reinsurance, unrestricted surplus, letters of credit, guarantees, organizational insurance coverage, partnerships with other licensed entities, and valuation attributable to the ability of such an organization to meet its service obligations through direct delivery of care, and

(iii) any standards developed by the National Association of Insurance Commissioners specifically for risk–based health care delivery organizations.

(C) ENROLLEE PROTECTION AGAINST INSOLVENCY.—Such standards shall include provisions to prevent enrollees from being held liable to any person or entity for the Medicare+Choice organization's debts in the event of the organization's insolvency.

(2) PUBLICATION OF NOTICE.—In carrying out the rulemaking process under this subsection, the Secretary, after consultation with the National Association of Insurance Commissioners, the American Academy of Actuaries, organizations representative of medicare beneficiaries, and other interested parties, shall publish the notice provided for under section 564(a) of title 5, United States Code, by not later than 45 days after the date of the enactment of this section.

(3) TARGET DATE FOR PUBLICATION OF RULE.—As part of the notice under paragraph (2), and for purposes of this subsection, the target date for publication (referred to in section 564(a)(5) of such title) shall be April 1, 1998.

(4) ABBREVIATED PERIOD FOR SUBMISSION OF COMMENTS.—In applying section 564(c) of such title under this subsection, 15 days shall be substituted for 30 days.

(5) APPOINTMENT OF NEGOTIATED RULEMAKING COMMITTEE AND FACILITATOR.—The Secretary shall provide for—

(A) the appointment of a negotiated rulemaking committee under section 565(a) of such title by not later than 30 days after the end of the comment period provided for under section 564(c) of such title (as shortened under paragraph (4)), and

(B) the nomination of a facilitator under section 566(c) of such title by not later than 10 days after the date of appointment of the committee.

(6) PRELIMINARY COMMITTEE REPORT.—The negotiated rulemaking committee appointed under paragraph (5) shall report to the Secretary, by not later than January 1, 1998, regarding the committee's progress on achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before 1 month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress towards such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this subsection through such other methods as the Secretary may provide.

(7) FINAL COMMITTEE REPORT.—If the committee is not terminated under paragraph (6), the rulemaking committee shall submit a report containing a proposed rule by not later than 1 month before the target date of publication.

(8) INTERIM, FINAL EFFECT.—The Secretary shall publish a rule under this subsection in the Federal Register by not later than the target date of publication. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period (of not less than 60 days) for public comment. In connection with such rule, the Secretary shall specify the process for the timely review and approval of applications of entities to be certified as provider–sponsored organizations pursuant to such rules and consistent with this subsection.

(9) PUBLICATION OF RULE AFTER PUBLIC COMMENT.—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target date of publication.

(b) ESTABLISHMENT OF OTHER STANDARDS.—

(1) IN GENERAL.—The Secretary shall establish by regulation other standards (not described in subsection (a)) for Medicare+Choice organizations and plans consistent with, and to carry out, this part. The Secretary shall publish such regulations by June 1, 1998. In order to carry out this requirement in a timely manner, the Secretary may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

(2) USE OF CURRENT STANDARDS.—Consistent with the requirements of this part, standards established under this subsection shall be based on standards established under section 1876 to carry out analogous provisions of such section.

(3)[357] RELATION TO STATE LAWS.—The standards established under this part shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to MA plans which are offered by MA organizations under this part.

(4) PROHIBITION OF MIDYEAR IMPLEMENTATION OF SIGNIFICANT NEW REGULATORY REQUIREMENTS.—The Secretary may not implement, other than at the beginning of a calendar year, regulations under this section that impose new, significant regulatory requirements on a Medicare+Choice organization or plan.

CONTRACTS WITH MEDICARE+CHOICE ORGANIZATIONS

SEC. 1857. [42 U.S.C. 1395w–27] (a) IN GENERAL.—The Secretary shall not permit the election under section 1851 of a Medicare+Choice plan offered by a Medicare+Choice organization under this part, and no payment shall be made under section 1853 to an organization, unless the Secretary has entered into a contract under this section with the organization with respect to the offering of such plan. Such a contract with an organization may cover more than 1 Medicare+Choice plan. Such contract shall provide that the organization agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

(b) MINIMUM ENROLLMENT REQUIREMENTS.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary may not enter into a contract under this section with a Medicare+Choice organization unless the organization has—

(A) at least 5,000 individuals (or 1,500 individuals in the case of an organization that is a provider–sponsored organization) who are receiving health benefits through the organization, or

(B) at least 1,500 individuals (or 500 individuals in the case of an organization that is a provider–sponsored organization) who are receiving health benefits through the organization if the organization primarily serves individuals residing outside of urbanized areas.

(2) APPLICATION TO MSA PLANS.—In applying paragraph (1) in the case of a Medicare+Choice organization that is offering an MSA plan, paragraph (1) shall be applied by substituting covered lives for individuals.

(3) ALLOWING TRANSITION.—The Secretary may waive the requirement of paragraph (1) during the first 3 contract years with respect to an organization.

(c) CONTRACT PERIOD AND EFFECTIVENESS.—

(1) PERIOD.—Each contract under this section shall be for a term of at least 1 year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term.

(2) TERMINATION AUTHORITY.—In accordance with procedures established under subsection (h), the Secretary may at any

[357] P.L. 108-173, §232(a), amended paragraph (3) in its entirety. For §1856(b)(3) as it formerly read, see Vol. II, Superseded Provisions, P.L. 108-173.

time terminate any such contract if the Secretary determines that the organization—

(A) has failed substantially to carry out the contract;

(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this part; or

(C) no longer substantially meets the applicable conditions of this part.

(3) EFFECTIVE DATE OF CONTRACTS.—The effective date of any contract executed pursuant to this section shall be specified in the contract, except that in no case shall a contract under this section which provides for coverage under an MSA plan be effective before January 1999 with respect to such coverage.

(4) PREVIOUS TERMINATIONS.—IN GENERAL.—

(A) The Secretary may not enter into a contract with a Medicare+Choice organization if a previous contract with that organization under this section was terminated at the request of the organization within the preceding 2–year period, except as provided in subparagraph (B) and except in such other circumstances which warrant special consideration, as determined by the Secretary.

(B) EARLIER RE–ENTRY PERMITTED WHERE CHANGE IN PAYMENT POLICY.—Subparagraph (A) shall not apply with respect to the offering by a Medicare+Choice organization of a Medicare+Choice plan in a Medicare+Choice payment area if during the 6–month period beginning on the date the organization notified the Secretary of the intention to terminate the most recent previous contract, there was a legislative change enacted (or a regulatory change adopted) that has the effect of increasing payment amounts under section 1853 for that Medicare+Choice payment area.

(5) CONTRACTING AUTHORITY.—The authority vested in the Secretary by this part may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.

(d) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—

(1) PERIODIC AUDITING.—The Secretary shall provide for the annual auditing of the financial records (including data relating to medicare utilization and costs, including allowable costs under section 1858(c)[358]) of at least one–third of the Medicare+Choice organizations offering Medicare+Choice plans under this part. The Comptroller General shall monitor auditing activities conducted under this subsection.

(2) INSPECTION AND AUDIT.—Each contract under this section shall provide that the Secretary, or any person or organization designated by the Secretary—

(A) shall have the right to inspect or otherwise evaluate

(i) the quality, appropriateness, and timeliness of services

[358] P.L. 108–173, §222(l)(3)(C), struck out ", costs, and computation of the adjusted community rate" and substituted "and costs, including allowable costs under section 1858(c)" applicable with respect to plan years beginning on or after January 1, 2006.

performed under the contract, and (ii) the facilities of the organization when there is reasonable evidence of some need for such inspection, and

(B) shall have the right to audit and inspect any books and records of the Medicare+Choice organization that pertain (i) to the ability of the organization to bear the risk of potential financial losses, or (ii) to services performed or determinations of amounts payable under the contract.

(3) ENROLLEE NOTICE AT TIME OF TERMINATION.— Each contract under this section shall require the organization to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this title, to each individual enrolled with the organization under this part.

(4) DISCLOSURE.—

(A) IN GENERAL.—Each Medicare+Choice organization shall, in accordance with regulations of the Secretary, report to the Secretary financial information which shall include the following:

(i) Such information as the Secretary may require demonstrating that the organization has a fiscally sound operation.

(ii) A copy of the report, if any, filed with the Secretary[359] containing the information required to be reported under section 1124 by disclosing entities.

(iii) A description of transactions, as specified by the Secretary, between the organization and a party in interest. Such transactions shall include—

(I) any sale or exchange, or leasing of any property between the organization and a party in interest;

(II) any furnishing for consideration of goods, services (including management services), or facilities between the organization and a party in interest, but not including salaries paid to employees for services provided in the normal course of their employment and health services provided to members by hospitals and other providers and by staff, medical group (or groups), individual practice association (or associations), or any combination thereof; and

(III) any lending of money or other extension of credit between an organization and a party in interest.

The Secretary may require that information reported respecting an organization which controls, is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

(B) PARTY IN INTEREST DEFINED.—For the purposes of this paragraph, the term party in interest means—

(i) any director, officer, partner, or employee responsible for management or administration of a

[359] P.L. 108–173, §900(e)(1)(I), struck out "Health Care Financing Administration" and substituted "Secretary".

Medicare+Choice organization, any person who is directly or indirectly the beneficial owner of more than 5 percent of the equity of the organization, any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5 percent of the organization, and, in the case of a Medicare+Choice organization organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;

(ii) any entity in which a person described in clause (i)—

(I) is an officer or director;

(II) is a partner (if such entity is organized as a partnership);

(III) has directly or indirectly a beneficial interest of more than 5 percent of the equity; or

(IV) has a mortgage, deed of trust, note, or other interest valuing more than 5 percent of the assets of such entity;

(iii) any person directly or indirectly controlling, controlled by, or under common control with an organization; and

(iv) any spouse, child, or parent of an individual described in clause (i).

(C) ACCESS TO INFORMATION.—Each Medicare+Choice organization shall make the information reported pursuant to subparagraph (A) available to its enrollees upon reasonable request.

(5) LOAN INFORMATION.—The contract shall require the organization to notify the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties.

(e) ADDITIONAL CONTRACT TERMS.—

(1) IN GENERAL.—The contract shall contain such other terms and conditions not inconsistent with this part (including requiring the organization to provide the Secretary with such information) as the Secretary may find necessary and appropriate.

(2) COST–SHARING IN ENROLLMENT–RELATED COSTS.—

(A) IN GENERAL.—A Medicare+Choice organization and a PDP sponsor under part D[360] shall pay the fee established by the Secretary under subparagraph (B).

(B) AUTHORIZATION.—The Secretary is authorized to charge a fee to each Medicare+Choice organization with a contract under this part and each PDP sponsor with a contract under part D[361] that is equal to the organization's or sponsor's[362] pro rata share (as determined by the Secretary) of the aggregate amount of fees which the Secretary is directed to collect in a fiscal year. Any amounts collected shall be available without further appropriation to the Secretary for the purpose of carrying out section

[360] P.L. 108–173, §222(k)(1), inserted, "and a PDP sponsor under part D".

[361] P.L. 108–173, §222(k)(2)(A), inserted, "and each PDP sponsor with a contract under part D" applicable with respect to plan years beginning on or after January 1, 2006.

[362] P.L. 108–173, §222(k)(2)(B), inserted, "or sponsor's".

1851 (relating to enrollment and dissemination of information), section 1860D-1(c),[363] and section 4360 of the Omnibus Budget Reconciliation Act of 1990 (relating to the health insurance counseling and assistance program).

(C) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for the purposes described in subparagraph (B) for each fiscal year beginning with fiscal year 2001 and ending with fiscal year 2005[364] an amount equal to $100,000,000, and for each fiscal year beginning with fiscal year 2006 an amount equal to $200,000,000,[365] reduced by the amount of fees authorized to be collected under this paragraph and section 1860D-12(b)(3)(D)[366] for the fiscal year.[367]

(D) LIMITATION.—In any fiscal year the fees collected by the Secretary under subparagraph (B) shall not exceed the lesser of—

(i) the estimated costs to be incurred by the Secretary in the fiscal year in carrying out the activities described in section 1851 and section 1860D-1(c)[368] and section 4360 of the Omnibus Budget Reconciliation Act of 1990; or

(ii)(I) $200,000,000 in fiscal year 1998;

(II) $150,000,000 in fiscal year 1999;

(III) $100,000,000 in fiscal year 2000;[369]

(IV) the Medicare+Choice portion (as defined in subparagraph (E)) of $100,000,000 in fiscal year 2001 and each succeeding fiscal year before fiscal year 2006; and[370]

(V)[371] the applicable portion (as defined in subparagraph (F)) of $200,000,000 in fiscal year 2006 and each succeeding fiscal year.

(E) MEDICARE+CHOICE PORTION DEFINED.—In this paragraph, the term "Medicare+Choice portion" means, for a fiscal year, the ratio, as estimated by the Secretary, of—

(i) the average number of individuals enrolled in Medicare+Choice plans during the fiscal year, to

(ii) the average number of individuals entitled to benefits under part A, and enrolled under part B, during the fiscal year.

(F)[372] APPLICABLE PORTION DEFINED.—In this paragraph, the term "applicable portion" means, for a fiscal year—

(i) with respect to MA organizations, the Secretary's estimate of the total proportion of expenditures under this title that are attributable to expenditures made

[363] P.L. 108–173, §222(k)(2)(C), inserted, ", section 1860D-1(c),".

[364] P.L. 108–173, §222(k)(3)(A), inserted, "and ending with fiscal year 2005".

[365] P.L. 108–173, §222(k)(3)(B), inserted, "and for each fiscal year beginning with fiscal year 2006 an amount equal to $200,000,000,".

[366] P.L. 108–173, §222(k)(3)(C), inserted, "and section 1860D-12(b)(3)(D)".

[367] See Vol. II, P.L. 106–113, §522(b), for publication against a fee increase for a limited period.

[368] P.L. 108–173, §222(k)(4)(A), inserted, "and section 1860D-1(c)".

[369] P.L. 108–173, §222(k)(4)(B), struck out "and".

[370] P.L. 108–173, §222(k)(4)(C), inserted "each succeeding fiscal year before fiscal year 2006; and".

[371] P.L. 108–173, §222(k)(4)(D), added subclause (V) applicable with respect to plan years beginning on or after January 1, 2006.

[372] P.L. 108–173, §222(k)(5), added subparagraph (F) applicable with respect to plan years beginning on or after January 1, 2006.

under this part (including payments under part D that are made to such organizations); or

(ii) with respect to PDP sponsors, the Secretary's estimate of the total proportion of expenditures under this title that are attributable to expenditures made to such sponsors under part D.

(3)[373] AGREEMENTS WITH FEDERALLY QUALIFIED HEALTH CENTERS.—

(A) PAYMENT LEVELS AND AMOUNTS.—A contract under this section with an MA organization shall require the organization to provide, in any written agreement described in section 1853(a)(4) between the organization and a federally qualified health center, for a level and amount of payment to the federally qualified health center for services provided by such health center that is not less than the level and amount of payment that the plan would make for such services if the services had been furnished by a entity providing similar services that was not a federally qualified health center.

(B) COST-SHARING.—Under the written agreement referred to in subparagraph (A), a federally qualified health center must accept the payment amount referred to in such subparagraph plus the Federal payment provided for in section 1833(a)(3)(B) as payment in full for services covered by the agreement, except that such a health center may collect any amount of cost-sharing permitted under the contract under this section, so long as the amounts of any deductible, coinsurance, or copayment comply with the requirements under section 1854(e).

(f) PROMPT PAYMENT BY MEDICARE+CHOICE ORGANIZATION.—

(1) REQUIREMENT.—A contract under this part shall require a Medicare+Choice organization to provide prompt payment (consistent with the provisions of sections 1816(c)(2) and 1842(c)(2)) of claims submitted for services and supplies furnished to enrollees pursuant to the contract, if the services or supplies are not furnished under a contract between the organization and the provider or supplier (or in the case of a Medicare+Choice private fee–for–service plan, if a claim is submitted to such organization by an enrollee).

(2) SECRETARY'S OPTION TO BYPASS NONCOMPLYING ORGANIZATION.—In the case of a Medicare+Choice eligible organization which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with paragraph (1), the Secretary may provide for direct payment of the amounts owed to providers and suppliers (or, in the case of a Medicare+Choice private fee–for–service plan, amounts owed to the enrollees) for covered services and supplies furnished to individuals enrolled under this part under the contract. If the Secretary provides for the direct payments, the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the organization under this part to reflect the amount of the Secretary's payments (and the Secretary's costs in making the payments).

[373] P.L. 108–173, §237(c), added paragraph (3) applicable to services prvided on or after January 1, 2006. and contract years beginning on or after January 1, 2006.

(g) INTERMEDIATE SANCTIONS.—

(1) IN GENERAL.—If the Secretary determines that a Medicare+Choice organization with a contract under this section—

(A) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

(B) imposes premiums on individuals enrolled under this part in excess of the amount of the Medicare+Choice monthly basic and supplemental beneficiary premiums permitted under section 1854;

(C) acts to expel or to refuse to re–enroll an individual in violation of the provisions of this part;

(D) engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this part) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

(E) misrepresents or falsifies information that is furnished—

(i) to the Secretary under this part, or

(ii) to an individual or to any other entity under this part;

(F) fails to comply with the applicable requirements of section 1852(j)(3) or 1852(k)(2)(A)(ii); or

(G) 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;

the Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2).

(2) REMEDIES.—The remedies described in this paragraph are—

(A) civil money penalties of not more than $25,000 for each determination under paragraph (1) or, with respect to a determination under subparagraph (D) or (E)(i) of such paragraph, of not more than $100,000 for each such determination, plus, with respect to a determination under paragraph (1)(B), double the excess amount charged in violation of such paragraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under paragraph (1)(D), $15,000 for each individual not enrolled as a result of the practice involved,

(B) suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur, or

(C) suspension of payment to the organization under this part for individuals enrolled after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

(3) OTHER INTERMEDIATE SANCTIONS.—In the case of a Medicare+Choice organization for which the Secretary makes a determination under subsection (c)(2) the basis of which is not described in paragraph (1), the Secretary may apply the following intermediate sanctions:

(A) Civil money penalties of not more than $25,000 for each determination under subsection (c)(2) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

(B) Civil money penalties of not more than $10,000 for each week beginning after the initiation of civil money penalty procedures by the Secretary during which the deficiency that is the basis of a determination under subsection (c)(2) exists.

(C) Suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under subsection (c)(2) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.

(D) Civil monetary penalties of not more than $100,000, or such higher amount as the Secretary may establish by regulation, where the finding under subsection (c)(2)(A) is based on the organization's termination of its contract under this section other than at a time and in a manner provided for under subsection (a).

(4) CIVIL MONEY PENALTIES.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under paragraph (2) or (3) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).

(h) PROCEDURES FOR TERMINATION.—

(1) IN GENERAL.—The Secretary may terminate a contract with a Medicare+Choice organization under this section in accordance with formal investigation and compliance procedures established by the Secretary under which—

(A) the Secretary provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under subsection (c)(2); and

(B) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before terminating the contract.

(2) EXCEPTION FOR IMMINENT AND SERIOUS RISK TO HEALTH.—Paragraph (1) shall not apply if the Secretary determines that a delay in termination, resulting from compliance

with the procedures specified in such paragraph prior to termination, would pose an imminent and serious risk to the health of individuals enrolled under this part with the organization.

(i) MEDICARE+CHOICE PROGRAM COMPATIBILITY WITH EMPLOYER OR UNION GROUP HEALTH PLANS.—

(1) CONTRACTS WITH MA ORGANIZATIONS.—[374] To facilitate the offering of Medicare+Choice plans under contracts between Medicare+Choice organizations and employers, labor organizations, or the trustees of a fund established by one or more employers or labor organizations (or combination thereof) to furnish benefits to the entity's employees, former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations, the Secretary may waive or modify requirements that hinder the design of, the offering of, or the enrollment in such Medicare+Choice plans.

(2)[375] EMPLOYER SPONSORED MA PLANS.—To facilitate the offering of MA plans by employers, labor organizations, or the trustees of a fund established by one or more employers or labor organizations (or combination thereof) to furnish benefits to the entity's employees, former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations, the Secretary may waive or modify requirements that hinder the design of, the offering of, or the enrollment in such MA plans. Notwithstanding section 1851(g), an MA plan described in the previous sentence may restrict the enrollment of individuals under this part to individuals who are beneficiaries and participants in such plan.

SPECIAL RULES FOR MA REGIONAL PLANS.[376]

SEC. 1858. [42 U.S.C. 1395w–27a] (a) REGIONAL SERVICE AREA; ESTABLISHMENT OF MA REGIONS.—

(1) COVERAGE OF ENTIRE MA REGION.—The service area for an MA regional plan shall consist of an entire MA region established under paragraph (2) and the provisions of section 1854(h) shall not apply to such a plan.

(2) ESTABLISHMENT OF MA REGIONS.—

(A) MA REGION.—For purposes of this title, the term "MA region" means such a region within the 50 States and the District of Columbia as established by the Secretary under this paragraph.

(B) ESTABLISHMENT.—

(i) INITIAL ESTABLISHMENT.—Not later than January 1, 2005, the Secretary shall first establish and publish MA regions.

(ii) PERIODIC REVIEW AND REVISION OF SERVICE AREAS.—The Secretary may periodically review MA regions under this paragraph and, based on such review, may revise such regions if the Secretary determines such revision to be appropriate.

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[374] P.L. 108–173, §222(j)(1), inserted, "(1) CONTRACTS WITH MA ORGANIZATIONS.—".

[375] P.L. 108–173, §222(j)(2), added paragraph (2) to be applicable with respect to plan years beginning on or after Janaury 1, 2006.

[376] P.L. 108-173, §221(c)(1), added §1858 to be applicable with respect to plan years beginning on or after January 1, 2006.

P.L. 108-173, §223(b), provides that the Secretary shall revise the regulations previously promulgated to carry out part C of title XVIII to carry out the provisions of P.L. 108-173.

(C) REQUIREMENTS FOR MA REGIONS.—The Secretary shall establish, and may revise, MA regions under this paragraph in a manner consistent with the following:

(i) NUMBER OF REGIONS.—There shall be no fewer than 10 regions, and no more than 50 regions.

(ii) MAXIMIZING AVAILABILITY OF PLANS.—The regions shall maximize the availability of MA regional plans to all MA eligible individuals without regard to health status, especially those residing in rural areas.

(D) MARKET SURVEY AND ANALYSIS.—Before establishing MA regions, the Secretary shall conduct a market survey and analysis, including an examination of current insurance markets, to determine how the regions should be established.

(3) NATIONAL PLAN.—Nothing in this subsection shall be construed as preventing an MA regional plan from being offered in more than one MA region (including all regions).

(b) APPLICATION OF SINGLE DEDUCTIBLE AND CATASTROPHIC LIMIT ON OUT-OF-POCKET EXPENSES.—An MA regional plan shall include the following:

(1) SINGLE DEDUCTIBLE.—Any deductible for benefits under the original medicare fee-for-service program option shall be a single deductible (instead of a separate inpatient hospital deductible and a part B deductible) and may be applied differentially for in-network services and may be waived for preventive or other items and services.

(2) CATASTROPHIC LIMIT.—

(A) IN-NETWORK.—A catastrophic limit on out-of- pocket expenditures for in-network benefits under the original medicare fee-for-service program option.

(B) TOTAL.—A catastrophic limit on out-of-pocket expenditures for all benefits under the original medicare fee-for-service program option.

(c) PORTION OF TOTAL PAYMENTS TO AN ORGANIZATION SUBJECT TO RISK FOR 2006 AND 2007.—

(1) APPLICATION OF RISK CORRIDORS.—

(A) IN GENERAL.—This subsection shall only apply to MA regional plans offered during 2006 or 2007.

(B) NOTIFICATION OF ALLOWABLE COSTS UNDER THE PLAN.—In the case of an MA organization that offers an MA regional plan in an MA region in 2006 or 2007, the organization shall notify the Secretary, before such date in the succeeding year as the Secretary specifies, of—

(i) its total amount of costs that the organization incurred in providing benefits covered under the original medicare fee-for- service program option for all enrollees under the plan in the region in the year and the portion of such costs that is attributable to administrative expenses described in subparagraph (C); and

(ii) its total amount of costs that the organization incurred in providing rebatable integrated benefits (as defined in subparagraph (D)) and with respect to such benefits the portion of such costs that is attributable to administrative expenses described in subparagraph (C) and not described in clause (i) of this subparagraph.

(C) ALLOWABLE COSTS DEFINED.—For purposes of this subsection, the term "allowable costs" means, with respect to an MA regional plan for a year, the total amount of costs described in subparagraph (B) for the plan and year, reduced by the portion of such costs attributable to administrative expenses incurred in providing the benefits described in such subparagraph.

(D) REBATABLE INTEGRATED BENEFITS.—For purposes of this subsection, the term "rebatable integrated benefits" means such non-drug supplemental benefits under subclause (I) of section 1854(b)(1)(C)(ii) pursuant to a rebate under such section that the Secretary determines are integrated with the benefits described in subparagraph (B)(i).

(2) ADJUSTMENT OF PAYMENT.—

(A) NO ADJUSTMENT IF ALLOWABLE COSTS WITHIN 3 PERCENT OF TARGET AMOUNT.—If the allowable costs for the plan for the year are at least 97 percent, but do not exceed 103 percent, of the target amount for the plan and year, there shall be no payment adjustment under this subsection for the plan and year.

(B) INCREASE IN PAYMENT IF ALLOWABLE COSTS ABOVE 103 PERCENT OF TARGET AMOUNT .—

(i) COSTS BETWEEN 103 AND 108 PERCENT OF TARGET AMOUNT.—If the allowable costs for the plan for the year are greater than 103 percent, but not greater than 108 percent, of the target amount for the plan and year, the Secretary shall increase the total of the monthly payments made to the organization offering the plan for the year under section 1853(a) by an amount equal to 50 percent of the difference between such allowable costs and 103 percent of such target amount.

(ii) COSTS ABOVE 108 PERCENT OF TARGET AMOUNT.—If the allowable costs for the plan for the year are greater than 108 percent of the target amount for the plan and year, the Secretary shall increase the total of the monthly payments made to the organization offering the plan for the year under section 1853(a) by an amount equal to the sum of—

(I) 2.5 percent of such target amount; and

(II) 80 percent of the difference between such allowable costs and 108 percent of such target amount.

(C) REDUCTION IN PAYMENT IF ALLOWABLE COSTS BELOW 97 PERCENT OF TARGET AMOUNT .—

(i) COSTS BETWEEN 92 AND 97 PERCENT OF TARGET AMOUNT.—If the allowable costs for the plan for the year are less than 97 percent, but greater than or equal to 92 percent, of the target amount for the plan and year, the Secretary shall reduce the total of the monthly payments made to the organization offering the plan for the year under section 1853(a) by an amount (or otherwise recover from the plan an amount) equal to 50 percent of the difference between 97 percent of the target amount and such allowable costs.

(ii) COSTS BELOW 92 PERCENT OF TARGET AMOUNT.—If the allowable costs for the plan for the year are less than 92 percent of the target amount for the plan and year, the Secretary shall reduce the total of the monthly payments made to the organization offering the plan for the year under section 1853(a) by an amount (or otherwise recover from the plan an amount) equal to the sum of—

(I) 2.5 percent of such target amount; and

(II) 80 percent of the difference between 92 percent of such target amount and such allowable costs.

(D) TARGET AMOUNT DESCRIBED.—For purposes of this paragraph, the term "target amount" means, with respect to an MA regional plan offered by an organization in a year, an amount equal to—

(i) the sum of—

(I) the total monthly payments made to the organization for enrollees in the plan for the year that are attributable to benefits under the original medicare fee-for-service program option (as defined in section 1852(a)(1)(B));

(II) the total of the MA monthly basic beneficiary premium collectable for such enrollees for the year; and

(III) the total amount of the rebates under section 1854(b)(1)(C)(ii) that are attributable to rebatable integrated benefits; reduced by

(ii) the amount of administrative expenses assumed in the bid insofar as the bid is attributable to benefits described in clause (i)(I) or (i)(III).

(3) DISCLOSURE OF INFORMATION.—

(A) IN GENERAL.—Each contract under this part shall provide—

(i) that an MA organization offering an MA regional plan shall provide the Secretary with such information as the Secretary determines is necessary to carry out this subsection; and

(ii) that, pursuant to section 1857(d)(2)(B), the Secretary has the right to inspect and audit any books and records of the organization that pertain to the information regarding costs provided to the Secretary under paragraph (1)(B).

(B) RESTRICTION ON USE OF INFORMATION.— Information disclosed or obtained pursuant to the provisions of this subsection may be used by officers, employees, and contractors of the Department of Health and Human Services only for the purposes of, and to the extent necessary in, carrying out this subsection.

(d) ORGANIZATIONAL AND FINANCIAL REQUIREMENTS.—

(1) IN GENERAL.—In the case of an MA organization that is offering an MA regional plan in an MA region and—

(A) meets the requirements of section 1855(a)(1) with respect to at least one such State in such region; and

(B) with respect to each other State in such region in which it does not meet requirements, it demonstrates to

the satisfaction of the Secretary that it has filed the necessary application to meet such requirements, the Secretary may waive such requirement with respect to each State described in subparagraph (B) for such period of time as the Secretary determines appropriate for the timely processing of such an application by the State (and, if such application is denied, through the end of such plan year as the Secretary determines appropriate to provide for a transition).

(2) SELECTION OF APPROPRIATE STATE.—In applying paragraph (1) in the case of an MA organization that meets the requirements of section 1855(a)(1) with respect to more than one State in a region, the organization shall select, in a manner specified by the Secretary among such States, one State the rules of which shall apply in the case of the States described in paragraph (1)(B).

(e) STABILIZATION FUND.—

(1) ESTABLISHMENT.—The Secretary shall establish under this subsection an MA Regional Plan Stabilization Fund (in this subsection referred to as the "Fund") which shall be available for two purposes:

(A) PLAN ENTRY.—To provide incentives to have MA regional plans offered in each MA region under paragraph (3).

(B) PLAN RETENTION.—To provide incentives to retain MA regional plans in certain MA regions with below-national-average MA market penetration under paragraph (4).

(2) FUNDING.—

(A) INITIAL FUNDING.—

(i) IN GENERAL.—There shall be available to the Fund, for expenditures from the Fund during the period beginning on January 1, 2007, and ending on December 31, 2013, a total of $10,000,000,000.

(ii) PAYMENT FROM TRUST FUNDS.—Such amount shall be available to the Fund, as expenditures are made from the Fund, from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in the proportion specified in section 1853(f).

(B) ADDITIONAL FUNDING FROM SAVINGS.—

(i) IN GENERAL.—There shall also be made available to the Fund, 50 percent of savings described in clause (ii).

(ii) SAVINGS.—The savings described in this clause are 25 percent of the average per capita savings described in section 1854(b)(4)(C) for which monthly rebates are provided under section 1854(b)(1)(C) in the fiscal year involved that are attributable to MA regional plans.

(iii) AVAILABILITY.—Funds made available under this subparagraph shall be transferred into a special account in the Treasury from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in the proportion specified in section 1853(f) on a monthly basis.

(C) OBLIGATIONS.—Amounts in the Fund shall be available in advance of appropriations to MA regional plans in qualifying MA regions only in accordance with paragraph (5).

(D) ORDERING.—Expenditures from the Fund shall first be made from amounts made available under subparagraph (A).

(3) PLAN ENTRY FUNDING.—

(A) IN GENERAL.—Funding is available under this paragraph for a year only as follows:

(i) NATIONAL PLAN.—For a national bonus payment described in subparagraph (B) for the offering by a single MA organization of an MA regional plan in each MA region in the year, but only if there was not such a plan offered in each such region in the previous year. Funding under this clause is only available with respect to any individual MA organization for a single year, but may be made available to more than one such organization in the same year.

(ii) REGIONAL PLANS.—Subject to clause (iii), for an increased amount under subparagraph (C) for an MA regional plan offered in an MA region which did not have any MA regional plan offered in the prior year.

(iii) LIMITATION ON REGIONAL PLAN FUNDING IN CASE OF NATIONAL PLAN.—In no case shall there be any payment adjustment under subparagraph (C) for a year for which a national payment adjustment is made under subparagraph (B).

(B) NATIONAL BONUS PAYMENT.—The national bonus payment under this subparagraph shall—

(i) be available to an MA organization only if the organization offers MA regional plans in every MA region;

(ii) be available with respect to all MA regional plans of the organization regardless of whether any other MA regional plan is offered in any region; and

(iii) subject to amounts available under paragraph (5) for a year, be equal to 3 percent of the benchmark amount otherwise applicable for each MA regional plan offered by the organization.

(C) REGIONAL PAYMENT ADJUSTMENT.—

(i) IN GENERAL.—The increased amount under this subparagraph for an MA regional plan in an MA region for a year shall be an amount, determined by the Secretary, based on the bid submitted for such plan (or plans) and shall be available to all MA regional plans offered in such region and year. Such amount may be based on the mean, mode, or median, or other measure of such bids and may vary from region to region. The Secretary may not limit the number of plans or bids in a region.

(ii) MULTI-YEAR FUNDING.—

(I) IN GENERAL.—Subject to amounts available under paragraph (5), funding under this subparagraph shall be available for a period determined by the Secretary.

(II) REPORT.—If the Secretary determines that funding will be provided for a second consecutive year with respect to an MA region, the Secretary shall submit to the Congress a report that describes the underlying market dynamics in the region and that includes recommendations concerning changes in the payment methodology otherwise provided for MA regional plans under this part.

(iii) APPLICATION TO ALL PLANS IN A REGION.—Funding under this subparagraph with respect to an MA region shall be made available with respect to all MA regional plans offered in the region.

(iv) LIMITATION ON AVAILABILITY OF PLAN RETENTION FUNDING IN NEXT YEAR.—If an increased amount is made available under this subparagraph with respect to an MA region for a period determined by the Secretary under clause (ii)(I), in no case shall funding be available under paragraph (4) with respect to MA regional plans offered in the region in the year following such period.

(D) APPLICATION.—Any additional payment under this paragraph provided for an MA regional plan for a year shall be treated as if it were an addition to the benchmark amount otherwise applicable to such plan and year, but shall not be taken into account in the computation of any benchmark amount for any subsequent year.

(4) PLAN RETENTION FUNDING.—

(A) IN GENERAL.—Funding is available under this paragraph for a year with respect to MA regional plans offered in an MA region for the increased amount specified in subparagraph (B) but only if the region meets the requirements of subparagraphs (C) and (E).

(B) PAYMENT INCREASE.—The increased amount under this subparagraph for an MA regional plan in an MA region for a year shall be an amount, determined by the Secretary, that does not exceed the greater of—

(i) 3 percent of the benchmark amount applicable in the region; or

(ii) such amount as (when added to the benchmark amount applicable to the region) will result in the ratio of—

(I) such additional amount plus the benchmark amount computed under section 1854(b)(4)(B)(i) for the region and year, to the adjusted average per capita cost for the region and year, as estimated by the Secretary under section 1876(a)(4) and adjusted as appropriate for the purpose of risk adjustment; being equal to

(II) the weighted average of such benchmark amounts for all the regions and such year, to the average per capita cost for the United States and such year, as estimated by the Secretary under section 1876(a)(4) and adjusted as appropriate for the purpose of risk adjustment.

(C) REGIONAL REQUIREMENTS.—The requirements of this subparagraph for an MA region for a year are as follows:

(i) NOTIFICATION OF PLAN EXIT.—The Secretary has received notice (in such form and manner as the Secretary specifies) before a year that one or more MA regional plans that were offered in the region in the previous year will not be offered in the succeeding year.

(ii) REGIONAL PLANS AVAILABLE FROM FEWER THAN 2 MA ORGANIZATIONS IN THE REGION.—The Secretary determines that if the plans referred to in clause (i) are not offered in the year, fewer than 2 MA organizations will be offering MA regional plans in the region in the year involved.

(iii) PERCENTAGE ENROLLMENT IN MA REGIONAL PLANS BELOW NATIONAL AVERAGE.—For the previous year, the Secretary determines that the average percentage of MA eligible individuals residing in the region who are enrolled in MA regional plans is less than the average percentage of such individuals in the United States enrolled in such plans.

(D) APPLICATION.—Any additional payment under this paragraph provided for an MA regional plan for a year shall be treated as if it were an addition to the benchmark amount otherwise applicable to such plan and year, but shall not be taken into account in the computation of any benchmark amount for any subsequent year.

(E) 2-CONSECUTIVE-YEAR LIMITATION.—

(i) IN GENERAL.—In no case shall any funding be available under this paragraph in an MA region in a period of consecutive years that exceeds 2 years.

(ii) REPORT.—If the Secretary determines that funding will be provided under this paragraph for a second consecutive year with respect to an MA region, the Secretary shall submit to the Congress a report that describes the underlying market dynamics in the region and that includes recommendations concerning changes in the payment methodology otherwise provided for MA regional plans under this part.

(5) FUNDING LIMITATION.—

(A) IN GENERAL.—The total amount expended from the Fund as a result of the application of this subsection through the end of a calendar year may not exceed the amount available to the Fund as of the first day of such year. For purposes of this subsection, amounts that are expended under this title insofar as such amounts would not have been expended but for the application of this subsection shall be counted as amounts expended as a result of such application.

(B) APPLICATION OF LIMITATION.—The Secretary may obligate funds from the Fund for a year only if the Secretary determines (and the Chief Actuary of the Centers for Medicare and Medicaid Services and the appropriate budget officer certify) that there are available in the Fund at the beginning of the year sufficient amounts to cover all such obligations incurred during the year consistent with subparagraph (A). The Secretary shall take such steps, in connec-

tion with computing additional payment amounts under paragraphs (3) and (4) and including limitations on enrollment in MA regional plans receiving such payments, as will ensure that sufficient funds are available to make such payments for the entire year. Funds shall only be made available from the Fund pursuant to an apportionment made in accordance with applicable procedures.

(6) SECRETARY REPORTS.—Not later than April 1 of each year (beginning in 2008), the Secretary shall submit a report to Congress and the Comptroller General of the United States that includes—

(A) a detailed description of—

(i) the total amount expended as a result of the application of this subsection in the previous year compared to the total amount that would have been expended under this title in the year if this subsection had not been enacted;

(ii) the projections of the total amount that will be expended as a result of the application of this subsection in the year in which the report is submitted compared to the total amount that would have been expended under this title in the year if this subsection had not been enacted;

(iii) amounts remaining within the funding limitation specified in paragraph (5); and

(iv) the steps that the Secretary will take under paragraph (5)(B) to ensure that the application of this subsection will not cause expenditures to exceed the amount available in the Fund; and

(B) a certification from the Chief Actuary of the Centers for Medicare and Medicaid Services that the description provided under subparagraph (A) is reasonable, accurate, and based on generally accepted actuarial principles and methodologies.

(7) BIENNIAL GAO REPORTS.—Not later than January 1 of 2009, 2011, 2013, and 2015, the Comptroller General of the United States shall submit to the Secretary and Congress a report on the application of additional payments under this subsection. Each report shall include—

(A) an evaluation of—

(i) the quality of care provided to individuals enrolled in MA regional plans for which additional payments were made under this subsection;

(ii) the satisfaction of such individuals with benefits under such a plan;

(iii) the costs to the medicare program for payments made to such plans; and

(iv) any improvements in the delivery of health care services under such a plan;

(B) a comparative analysis of the performance of MA regional plans receiving payments under this subsection with MA regional plans not receiving such payments; and

(C) recommendations for such legislation or administrative action as the Comptroller General determines to be appropriate.

(f) COMPUTATION OF APPLICABLE MA REGION-SPECIFIC NON-DRUG MONTHLY BENCHMARK AMOUNTS.—

(1) COMPUTATION FOR REGIONS.—For purposes of section 1853(j)(2) and this section, subject to subsection (e), the term "MA region-specific non-drug monthly benchmark amount" means, with respect to an MA region for a month in a year, the sum of the 2 components described in paragraph (2) for the region and year. The Secretary shall compute such benchmark amount for each MA region before the beginning of each annual, coordinated election period under section 1851(e)(3)(B) for each year (beginning with 2006).

(2) 2 COMPONENTS.—For purposes of paragraph (1), the 2 components described in this paragraph for an MA region and a year are the following:

(A) STATUTORY COMPONENT.—The product of the following:

(i) STATUTORY REGION-SPECIFIC NON-DRUG AMOUNT.—The statutory region-specific non-drug amount (as defined in paragraph (3)) for the region and year.

(ii) STATUTORY NATIONAL MARKET SHARE.—The statutory national market share percentage, determined under paragraph (4) for the year.

(B) PLAN-BID COMPONENT.—The product of the following:

(i) WEIGHTED AVERAGE OF MA PLAN BIDS IN REGION.—The weighted average of the plan bids for the region and year (as determined under paragraph (5)(A)).

(ii) NON-STATUTORY MARKET SHARE.—1 minus the statutory national market share percentage, determined under paragraph (4) for the year.

(3) STATUTORY REGION-SPECIFIC NON-DRUG AMOUNT.—For purposes of paragraph (2)(A)(i), the term "statutory region-specific non-drug amount" means, for an MA region and year, an amount equal the sum (for each MA local area within the region) of the product of—

(A) MA area-specific non-drug monthly benchmark amount under section 1853(j)(1)(A) for that area and year; and

(B) the number of MA eligible individuals residing in the local area, divided by the total number of MA eligible individuals residing in the region.

(4) Computation of statutory market share percentage.—

(A) In general.—The Secretary shall determine for each year a statutory national market share percentage that is equal to the proportion of MA eligible individuals nationally who were not enrolled in an MA plan during the reference month.

(B) Reference month defined.—For purposes of this part, the term "reference month" means, with respect to a year, the most recent month during the previous year for which the Secretary determines that data are available to compute the percentage specified in subparagraph (A) and other relevant percentages under this part.

(5) DETERMINATION OF WEIGHTED AVERAGE MA BIDS FOR A REGION.—

(A) IN GENERAL.—For purposes of paragraph (2)(B)(i), the weighted average of plan bids for an MA region and a year is the sum, for MA regional plans described in subparagraph (D) in the region and year, of the products (for each such plan) of the following:

(i) MONTHLY MA STATUTORY NON-DRUG BID AMOUNT.—The unadjusted MA statutory non-drug monthly bid amount for the plan.

(ii) PLAN'S SHARE OF MA ENROLLMENT IN REGION.—The factor described in subparagraph (B) for the plan.

(B) PLAN'S SHARE OF MA ENROLLMENT IN REGION.—

(i) IN GENERAL.—Subject to the succeeding provisions of this subparagraph, the factor described in this subparagraph for a plan is equal to the number of individuals described in subparagraph (C) for such plan, divided by the total number of such individuals for all MA regional plans described in subparagraph (D) for that region and year.

(ii) SINGLE PLAN RULE.—In the case of an MA region in which only a single MA regional plan is being offered, the factor described in this subparagraph shall be equal to 1.

(iii) EQUAL DIVISION AMONG MULTIPLE PLANS IN YEAR IN WHICH PLANS ARE FIRST AVAILABLE.—In the case of an MA region in the first year in which any MA regional plan is offered, if more than one MA regional plan is offered in such year, the factor described in this subparagraph for a plan shall (as specified by the Secretary) be equal to—

(I) 1 divided by the number of such plans offered in such year; or

(II) a factor for such plan that is based upon the organization's estimate of projected enrollment, as reviewed and adjusted by the Secretary to ensure reasonableness and as is certified by the Chief Actuary of the Centers for Medicare and Medicaid Services.

(C) COUNTING OF INDIVIDUALS.—For purposes of subparagraph (B)(i), the Secretary shall count for each MA regional plan described in subparagraph (D) for an MA region and year, the number of individuals who reside in the region and who were enrolled under such plan under this part during the reference month.

(D) PLANS COVERED.—For an MA region and year, an MA regional plan described in this subparagraph is an MA regional plan that is offered in the region and year and was offered in the region in the reference month.

(g) ELECTION OF UNIFORM COVERAGE DETERMINATION.—Instead of applying section 1852(a)(2)(C) with respect to an MA regional plan, the organization offering the plan may elect to have a local coverage determination for the entire MA region be the local coverage determination applied for any part of such region (as selected by the organization).

(h) ASSURING NETWORK ADEQUACY.—

(1) IN GENERAL.—For purposes of enabling MA organizations that offer MA regional plans to meet applicable provider access

requirements under section 1852 with respect to such plans, the Secretary may provide for payment under this section to an essential hospital that provides inpatient hospital services to enrollees in such a plan where the MA organization offering the plan certifies to the Secretary that the organization was unable to reach an agreement between the hospital and the organization regarding provision of such services under the plan. Such payment shall be available only if—

(A) the organization provides assurances satisfactory to the Secretary that the organization will make payment to the hospital for inpatient hospital services of an amount that is not less than the amount that would be payable to the hospital under section 1886 with respect to such services; and

(B) with respect to specific inpatient hospital services provided to an enrollee, the hospital demonstrates to the satisfaction of the Secretary that the hospital's costs of such services exceed the payment amount described in subparagraph (A).

(2) PAYMENT AMOUNTS.—The payment amount under this subsection for inpatient hospital services provided by a subsection (d) hospital to an enrollee in an MA regional plan shall be, subject to the limitation of funds under paragraph (3), the amount (if any) by which—

(A) the amount of payment that would have been paid for such services under this title if the enrollees were covered under the original medicare fee-for-service program option and the hospital were a critical access hospital; exceeds

(B) the amount of payment made for such services under paragraph (1)(A).

(3) AVAILABLE AMOUNTS.—There shall be available for payments under this subsection—

(A) in 2006, $25,000,000; and

(B) in each succeeding year the amount specified in this paragraph for the preceding year increased by the market basket percentage increase (as defined in section 1886(b)(3)(B)(iii)) for the fiscal year ending in such succeeding year. Payments under this subsection shall be made from the Federal Hospital Insurance Trust Fund.

(4) ESSENTIAL HOSPITAL.—In this subsection, the term "essential hospital" means, with respect to an MA regional plan offered by an MA organization, a subsection (d) hospital (as defined in section 1886(d)) that the Secretary determines, based upon an application filed by the organization with the Secretary, is necessary to meet the requirements referred to in paragraph (1) for such plan.

DEFINITIONS; MISCELLANEOUS PROVISIONS [377]

SEC. 1859. [42 U.S.C. 1395w–28] (a) DEFINITIONS RELATING TO MEDICARE+CHOICE ORGANIZATIONS.—In this part—

[377] P.L. 108-173, §222, amends §1859 in several places; however, P.L. 108-173, §223(a) provides that these amendments shall apply with respect to plan years beginning on or after January 1, 2006.

P.L. 108-173, §223(b), provides that the Secretary shall revise the regulations previously promulgated to carry out the provisions of P.L. 108-173.

(1) MEDICARE+CHOICE ORGANIZATION.—The term Medicare+Choice organization means a public or private entity that is certified under section 1856 as meeting the requirements and standards of this part for such an organization.

(2) PROVIDER–SPONSORED ORGANIZATION.—The term provider–sponsored organization is defined in section 1855(d)(1).

(b) DEFINITIONS RELATING TO MEDICARE+CHOICE PLANS.—

(1) MEDICARE+CHOICE PLAN.—The term Medicare+Choice plan means health benefits coverage offered under a policy, contract, or plan by a Medicare+Choice organization pursuant to and in accordance with a contract under section 1857.

(2) MEDICARE+CHOICE PRIVATE FEE–FOR–SERVICE PLAN.—The term Medicare+Choice private fee–for–service plan means a Medicare+Choice plan that—

(A) reimburses hospitals, physicians, and other providers at a rate determined by the plan on a fee–for–service basis without placing the provider at financial risk;

(B) does not vary such rates for such a provider based on utilization relating to such provider; and

(C) does not restrict the selection of providers among those who are lawfully authorized to provide the covered services and agree to accept the terms and conditions of payment established by the plan.

(3) MSA PLAN.—

(A) IN GENERAL.—The term MSA plan means a Medicare+Choice plan that—

(i) provides reimbursement for at least the items and services described in section 1852(a)(1) in a year but only after the enrollee incurs countable expenses (as specified under the plan) equal to the amount of an annual deductible (described in subparagraph (B));

(ii) counts as such expenses (for purposes of such deductible) at least all amounts that would have been payable under parts A and B, and that would have been payable by the enrollee as deductibles, coinsurance, or copayments, if the enrollee had elected to receive benefits through the provisions of such parts; and

(iii) provides, after such deductible is met for a year and for all subsequent expenses for items and services referred to in clause (i) in the year, for a level of reimbursement that is not less than—

(I) 100 percent of such expenses, or

(II) 100 percent of the amounts that would have been paid (without regard to any deductibles or coinsurance) under parts A and B with respect to such expenses,

whichever is less.

(B) DEDUCTIBLE.—The amount of annual deductible under an MSA plan—

(i) for contract year 1999 shall be not more than $6,000; and

(ii) for a subsequent contract year shall be not more than the maximum amount of such deductible for the previous contract year under this subparagraph increased by the national per capita Medicare+Choice

growth percentage under section 1853(c)(6) for the year.

If the amount of the deductible under clause (ii) is not a multiple of $50, the amount shall be rounded to the nearest multiple of $50.

(4)[378] MA REGIONAL PLAN.—The term "MA regional plan" means an MA plan described in section 1851(a)(2)(A)(i)—

(A) that has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan;

(B) that provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and

(C) the service area of which is one or more entire MA regions.

(5) MA LOCAL PLAN.—The term "MA local plan" means an MA plan that is not an MA regional plan.

(6)[379] SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.—

(A) IN GENERAL.—The term "specialized MA plan for special needs individuals" means an MA plan that exclusively serves special needs individuals (as defined in subparagraph (B)).

(B) SPECIAL NEEDS INDIVIDUAL.—The term "special needs individual" means an MA eligible individual who—

(i) is institutionalized (as defined by the Secretary);

(ii) is entitled to medical assistance under a State plan under title XIX; or

(iii) meets such requirements as the Secretary may determine would benefit from enrollment in such a specialized MA plan described in subparagraph (A) for individuals with severe or disabling chronic conditions.

The Secretary may waive application of section 1851(a)(3)(B) in the case of an individual described in clause (i), (ii), or (iii) of this subparagraph and may apply rules similar to the rules of section 1894(c)(4) for continued eligibility of special needs individuals.

(c) OTHER REFERENCES TO OTHER TERMS.—

(1) MEDICARE+CHOICE ELIGIBLE INDIVIDUAL.—The term Medicare+Choice eligible individual is defined in section 1851(a)(3).

(2) MEDICARE+CHOICE PAYMENT AREA.—The term Medicare+Choice payment area is defined in section 1853(d).

(3) NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE.—The national per capita Medicare+Choice growth percentage is defined in section 1853(c)(6).

(4) MEDICARE+CHOICE MONTHLY BASIC BENEFICIARY PREMIUM; MEDICARE+CHOICE MONTHLY SUPPLEMENTAL BENEFICIARY PREMIUM.—The terms Medicare+Choice monthly basic beneficiary premium and Medicare+Choice monthly supplemental beneficiary premium are defined in section 1854(a)(2).

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[378] P.L. 108–173, §221(b)(1), added paragraphs (4) and (5) to be applicable with respect to plan years beginning on or later January 1, 2006.

[379] P.L. 108–173, §231(b), added paragraph (6). effective December 8, 2003. See Vol. II. P.L. 108-173, §231(f)(2), with respect to certain regulations.

(5)[380] MA LOCAL AREA.—The term "MA local area" is defined in section 1853(d)(2).

(d) COORDINATED ACUTE AND LONG–TERM CARE BENEFITS UNDER A MEDICARE+CHOICE PLAN.—Nothing in this part shall be construed as preventing a State from coordinating benefits under a medicaid plan under title XIX with those provided under a Medicare+Choice plan in a manner that assures continuity of a full–range of acute care and long–term care services to poor elderly or disabled individuals eligible for benefits under this title and under such plan.

(e) RESTRICTION ON ENROLLMENT FOR CERTAIN MEDICARE+CHOICE PLANS.—

(1) IN GENERAL.—In the case of a Medicare+Choice religious fraternal benefit society plan described in paragraph (2), notwithstanding any other provision of this part to the contrary and in accordance with regulations of the Secretary, the society offering the plan may restrict the enrollment of individuals under this part to individuals who are members of the church, convention, or group described in paragraph (3)(B) with which the society is affiliated.

(2) MEDICARE+CHOICE RELIGIOUS FRATERNAL BENEFIT SOCIETY PLAN DESCRIBED.—For purposes of this subsection, a Medicare+Choice religious fraternal benefit society plan described in this paragraph is a Medicare+Choice plan described in section 1851(a)(2) that—

(A) is offered by a religious fraternal benefit society described in paragraph (3) only to members of the church, convention, or group described in paragraph (3)(B); and

(B) permits all such members to enroll under the plan without regard to health status–related factors. Nothing in this subsection shall be construed as waiving any plan requirements relating to financial solvency.

(3) RELIGIOUS FRATERNAL BENEFIT SOCIETY DEFINED.—For purposes of paragraph (2)(A), a religious fraternal benefit society described in this section is an organization that—

(A) is described in section 501(c)(8) of the Internal Revenue Code of 1986 and is exempt from taxation under section 501(a) of such Act;

(B) is affiliated with, carries out the tenets of, and shares a religious bond with, a church or convention or association of churches or an affiliated group of churches;

(C) offers, in addition to a Medicare+Choice religious fraternal benefit society plan, health coverage to individuals not entitled to benefits under this title who are members of such church, convention, or group; and

(D) does not impose any limitation on membership in the society based on any health status–related factor.

(4) PAYMENT ADJUSTMENT.—Under regulations of the Secretary, in the case of individuals enrolled under this part under a Medicare+Choice religious fraternal benefit society plan described in paragraph (2), the Secretary shall provide for such adjustment to the payment amounts otherwise established under section 1854 as may be appropriate to assure an

[380] P.L. 108–173, §221(d)(2), added paragraph (5) to be applicable with respect to plan years beginning on or after January 1, 2006.

appropriate payment level, taking into account the actuarial characteristics and experience of such individuals.

(f)[381] RESTRICTION ON ENROLLMENT FOR SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.—In the case of a specialized MA plan for special needs individuals (as defined in subsection (b)(6)), notwithstanding any other provision of this part and in accordance with regulations of the Secretary and for periods before January 1, 2009, the plan may restrict the enrollment of individuals under the plan to individuals who are within one or more classes of special needs individuals.

Part D—Voluntary Prescription Drug Benefit Program[382]

Subpart 1—Part D Eligible Individuals and Prescription Drug Benefits

ELIGIBILITY, ENROLLMENT, AND INFORMATION

SEC. 1860D-1. [42 U.S.C. 1395w-101] (a) PROVISION OF QUALIFIED PRESCRIPTION DRUG COVERAGE THROUGH ENROLLMENT IN PLANS.—

(1) IN GENERAL.—Subject to the succeeding provisions of this part, each part D eligible individual (as defined in paragraph (3)(A)) is entitled to obtain qualified prescription drug coverage (described in section 1860D-2(a)) as follows:

(A) FEE-FOR-SERVICE ENROLLEES MAY RECEIVE COVERAGE THROUGH A PRESCRIPTION DRUG PLAN.—A part D eligible individual who is not enrolled in an MA plan may obtain qualified prescription drug coverage through enrollment in a prescription drug plan (as defined in section 1860D-41(a)(14)).

(B) MEDICARE ADVANTAGE ENROLLEES.—

(i) ENROLLEES IN A PLAN PROVIDING QUALIFIED PRESCRIPTION DRUG COVERAGE RECEIVE COVERAGE THROUGH THE PLAN.—A part D eligible individual who is enrolled in an MA-PD plan obtains such coverage through such plan.

(ii) LIMITATION ON ENROLLMENT OF MA PLAN ENROLLEES IN PRESCRIPTION DRUG PLANS.—Except as provided in clauses (iii) and (iv), a part D eligible individual who is enrolled in an MA plan may not enroll in a prescription drug plan under this part.

(iii) PRIVATE FEE-FOR-SERVICE ENROLLEES IN MA PLANS NOT PROVIDING QUALIFIED PRESCRIPTION DRUG COVERAGE PERMITTED TO ENROLL IN A PRESCRIPTION DRUG PLAN.—A part D eligible individual who is enrolled in an MA private fee-for-service plan (as defined in section 1859(b)(2)) that does not provide qualified prescription drug coverage may obtain qualified pre-

[381] P.L. 108–173, §231(c), added subsection (f), effective December 8, 2003.

[382] P.L. 108-173, §101(a)(2), added a new Part D, Subparts 1 through 5, §§1860b-1 - 1860b-42, effective December 8, 2003.

See Vol. II, P.L. 108-173, §101(b), with respect to the submission of a legislative proposal; §101(c), with respect to a study on transitioning Part B prescription drug coverage; §101(d), with respect to a report on progress in implementation of prescription drug benefit; §106, with respect to the State Pharmaceutical Assistance Transition commission; and §110, with respect to a conflict of interest study.

scription drug coverage through enrollment in a prescription drug plan.

(iv) ENROLLEES IN MSA A PLANS PERMITTED TO ENROLL IN A PRESCRIPTION DRUG PLAN.—A part D eligible individual who is enrolled in an MSA plan (as defined in section 1859(b)(3)) may obtain qualified prescription drug coverage through enrollment in a prescription drug plan.

(2) COVERAGE FIRST EFFECTIVE JANUARY 1, 2006.—Coverage under prescription drug plans and MA-PD plans shall first be effective on January 1, 2006.

(3) DEFINITIONS.—For purposes of this part:

(A) PART D ELIGIBLE INDIVIDUAL.—The term "part D eligible individual" means an individual who is entitled to benefits under part A or enrolled under part B.

(B) MA PLAN.—The term "MA plan" has the meaning given such term in section 1859(b)(1).

(C) MA-PD PLAN.—The term "MA-PD plan" means an MA plan that provides qualified prescription drug coverage.

(b) ENROLLMENT PROCESS FOR PRESCRIPTION DRUG PLANS.—

(1) ESTABLISHMENT OF PROCESS.—

(A) IN GENERAL.—The Secretary shall establish a process for the enrollment, disenrollment, termination, and change of enrollment of part D eligible individuals in prescription drug plans consistent with this subsection.

(B) APPLICATION OF MA RULES.—In establishing such process, the Secretary shall use rules similar to (and coordinated with) the rules for enrollment, disenrollment, termination, and change of enrollment with an MA-PD plan under the following provisions of section 1851:

(i) RESIDENCE REQUIREMENTS.—Section 1851(b)(1)(A), relating to residence requirements.

(ii) EXERCISE OF CHOICE.—Section 1851(c) (other than paragraph (3)(A) of such section), relating to exercise of choice.

(iii) COVERAGE ELECTION PERIODS.—Subject to paragraphs (2) and (3) of this subsection, section 1851(e) (other than subparagraphs (B) and (C) of paragraph (2) and the second sentence of paragraph (4) of such section), relating to coverage election periods, including initial periods, annual coordinated election periods, special election periods, and election periods for exceptional circumstances.

(iv) COVERAGE PERIODS.—Section 1851(f), relating to effectiveness of elections and changes of elections.

(v) GUARANTEED ISSUE AND RENEWAL.—Section 1851(g) (other than paragraph (2) of such section and clause (i) and the second sentence of clause (ii) of paragraph (3)(C) of such section), relating to guaranteed issue and renewal.

(vi) MARKETING MATERIAL AND APPLICATION FORMS.—Section 1851(h), relating to approval of marketing material and application forms. In applying clauses (ii), (iv), and (v) of this subparagraph, any reference to section 1851(e) shall be treated as a ref-

erence to such section as applied pursuant to clause (iii) of this subparagraph.

(C) SPECIAL RULE.—The process established under subparagraph (A) shall include, in the case of a part D eligible individual who is a full-benefit dual eligible individual (as defined in section 1935(c)(6)) who has failed to enroll in a prescription drug plan or an MA-PD plan, for the enrollment in a prescription drug plan that has a monthly beneficiary premium that does not exceed the premium assistance available under section 1860D-14(a)(1)(A)). If there is more than one such plan available, the Secretary shall enroll such an individual on a random basis among all such plans in the PDP region. Nothing in the previous sentence shall prevent such an individual from declining or changing such enrollment.

(2) INITIAL ENROLLMENT PERIOD.—

(A) PROGRAM INITIATION.—In the case of an individual who is a part D eligible individual as of November 15, 2005, there shall be an initial enrollment period that shall be the same as the annual, coordinated open election period described in section 1851(e)(3)(B)(iii), as applied under paragraph (1)(B)(iii).

(B) CONTINUING PERIODS.—In the case of an individual who becomes a part D eligible individual after November 15, 2005, there shall be an initial enrollment period which is the period under section 1851(e)(1), as applied under paragraph (1)(B)(iii) of this section, as if "entitled to benefits under part A or enrolled under part B" were substituted for "entitled to benefits under part A and enrolled under part B", but in no case shall such period end before the period described in subparagraph (A).

(3) ADDITIONAL SPECIAL ENROLLMENT PERIODS.—The Secretary shall establish special enrollment periods, including the following:

(A) INVOLUNTARY LOSS OF CREDITABLE PRESCRIPTION DRUG COVERAGE.—

(i) IN GENERAL.—In the case of a part D eligible individual who involuntarily loses creditable prescription drug coverage (as defined in section 1860D-13(b)(4)).

(ii) NOTICE.—In establishing special enrollment periods under clause (i), the Secretary shall take into account when the part D eligible individuals are provided notice of the loss of creditable prescription drug coverage.

(iii) FAILURE TO PAY PREMIUM.—For purposes of clause (i), a loss of coverage shall be treated as voluntary if the coverage is terminated because of failure to pay a required beneficiary premium.

(iv) REDUCTION IN COVERAGE.—For purposes of clause (i), a reduction in coverage so that the coverage no longer meets the requirements under section 1860D-13(b)(5) (relating to actuarial equivalence) shall be treated as an involuntary loss of coverage.

(B) ERRORS IN ENROLLMENT.—In the case described in section 1837(h) (relating to errors in enrollment), in the same manner as such section applies to part B.

(C) EXCEPTIONAL CIRCUMSTANCES.—In the case of part D eligible individuals who meet such exceptional conditions (in addition to those conditions applied under paragraph (1)(B)(iii)) as the Secretary may provide.

(D) MEDICAID COVERAGE.—In the case of an individual (as determined by the Secretary) who is a full-benefit dual eligible individual (as defined in section 1935(c)(6)).

(E) DISCONTINUANCE OF MA-PD ELECTION DURING FIRST YEAR OF ELIGIBILITY.—In the case of a part D eligible individual who discontinues enrollment in an MA-PD plan under the second sentence of section 1851(e)(4) at the time of the election of coverage under such sentence under the original medicare fee-for-service program.

(4) INFORMATION TO FACILITATE ENROLLMENT.—

(A) IN GENERAL.—Notwithstanding any other provision of law but subject to subparagraph (B), the Secretary may provide to each PDP sponsor and MA organization such identifying information about part D eligible individuals as the Secretary determines to be necessary to facilitate efficient marketing of prescription drug plans and MA-PD plans to such individuals and enrollment of such individuals in such plans.

(B) LIMITATION.—

(i) PROVISION OF INFORMATION.—The Secretary may provide the information under subparagraph (A) only to the extent necessary to carry out such subparagraph.

(ii) USE OF INFORMATION.—Such information provided by the Secretary to a PDP sponsor or an MA organization may be used by such sponsor or organization only to facilitate marketing of, and enrollment of part D eligible individuals in, prescription drug plans and MA-PD plans.

(5) REFERENCE TO ENROLLMENT PROCEDURES FOR MA-PD PLANS .—For rules applicable to enrollment, disenrollment, termination, and change of enrollment of part D eligible individuals in MA-PD plans, see section 1851.

(6) REFERENCE TO PENALTIES FOR LATE ENROLLMENT.—Section 1860D-13(b) imposes a late enrollment penalty for part D eligible individuals who—

(A) enroll in a prescription drug plan or an MA-PD plan after the initial enrollment period described in paragraph (2); and

(B) fail to maintain continuous creditable prescription drug coverage during the period of non-enrollment.

(c) PROVIDING INFORMATION TO BENEFICIARIES.—

(1) ACTIVITIES.—The Secretary shall conduct activities that are designed to broadly disseminate information to part D eligible individuals (and prospective part D eligible individuals) regarding the coverage provided under this part. Such activities shall ensure that such information is first made available at least 30 days prior to the initial enrollment period described in subsection (b)(2)(A).

(2) REQUIREMENTS.—The activities described in paragraph (1) shall—

(A) be similar to the activities performed by the Secretary under section 1851(d), including dissemination (including through the toll-free telephone number 1-800-MEDICARE) of comparative information for prescription drug plans and MA-PD plans; and

(B) be coordinated with the activities performed by the Secretary under such section and under section 1804.

(3) COMPARATIVE INFORMATION.—

(A) IN GENERAL.—Subject to subparagraph (B), the comparative information referred to in paragraph (2)(A) shall include a comparison of the following with respect to qualified prescription drug coverage:

(i) BENEFITS.—The benefits provided under the plan.

(ii) MONTHLY BENEFICIARY PREMIUM.—The monthly beneficiary premium under the plan.

(iii) QUALITY AND PERFORMANCE.—The quality and performance under the plan.

(iv) BENEFICIARY COST-SHARING.—The cost-sharing required of part D eligible individuals under the plan.

(v) CONSUMER SATISFACTION SURVEYS.—The results of consumer satisfaction surveys regarding the plan conducted pursuant to section 1860D-4(d).

(B) EXCEPTION FOR UNAVAILABILITY OF INFORMATION.—The Secretary is not required to provide comparative information under clauses (iii) and (v) of subparagraph (A) with respect to a plan—

(i) for the first plan year in which it is offered; and

(ii) for the next plan year if it is impracticable or the information is otherwise unavailable.

(4) INFORMATION ON LATE ENROLLMENT PENALTY.—The information disseminated under paragraph (1) shall include information concerning the methodology for determining the late enrollment penalty under section 1860D-13(b).

PRESCRIPTION DRUG BENEFITS

SEC. 1860D-2. [42 U.S.C. 1395w-102] (a) REQUIREMENTS.—

(1) IN GENERAL.—For purposes of this part and part C, the term "qualified prescription drug coverage" means either of the following:

(A) STANDARD PRESCRIPTION DRUG COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Standard prescription drug coverage (as defined in subsection (b)) and access to negotiated prices under subsection (d).

(B) ALTERNATIVE PRESCRIPTION DRUG COVERAGE WITH AT LEAST ACTUARIALLY EQUIVALENT BENEFITS AND ACCESS TO NEGOTIATED PRICES.—Coverage of covered part D drugs which meets the alternative prescription drug coverage requirements of subsection (c) and access to negotiated prices under subsection (d), but only if the benefit design of such coverage is approved by the Secretary, as provided under subsection (c).

(2) PERMITTING SUPPLEMENTAL PRESCRIPTION DRUG COVERAGE.—

(A) IN GENERAL.—Subject to subparagraph (B), qualified prescription drug coverage may include supplemental pre-

scription drug coverage consisting of either or both of the following:

(i) CERTAIN REDUCTIONS IN COST-SHARING.—

(I) IN GENERAL.—A reduction in the annual deductible, a reduction in the coinsurance percentage, or an increase in the initial coverage limit with respect to covered part D drugs, or any combination thereof, insofar as such a reduction or increase increases the actuarial value of benefits above the actuarial value of basic prescription drug coverage.

(II) CONSTRUCTION.—Nothing in this paragraph shall be construed as affecting the application of subsection (c)(3).

(ii) OPTIONAL DRUGS.—Coverage of any product that would be a covered part D drug but for the application of subsection (e)(2)(A).

(B) REQUIREMENT.—A PDP sponsor may not offer a prescription drug plan that provides supplemental prescription drug coverage pursuant to subparagraph (A) in an area unless the sponsor also offers a prescription drug plan in the area that only provides basic prescription drug coverage.

(3) BASIC PRESCRIPTION DRUG COVERAGE.—For purposes of this part and part C, the term "basic prescription drug coverage" means either of the following:

(A) Coverage that meets the requirements of paragraph (1)(A).

(B) Coverage that meets the requirements of paragraph (1)(B) but does not have any supplemental prescription drug coverage described in paragraph (2)(A).

(4) APPLICATION OF SECONDARY PAYOR PROVISIONS.—The provisions of section 1852(a)(4) shall apply under this part in the same manner as they apply under part C.

(5) CONSTRUCTION.—Nothing in this subsection shall be construed as changing the computation of incurred costs under subsection (b)(4).

(b) STANDARD PRESCRIPTION DRUG COVERAGE.—For purposes of this part and part C, the term "standard prescription drug coverage" means coverage of covered part D drugs that meets the following requirements:

(1) DEDUCTIBLE.—

(A) IN GENERAL.—The coverage has an annual deductible—

(i) for 2006, that is equal to $250; or

(ii) for a subsequent year, that is equal to the amount specified under this paragraph for the previous year increased by the percentage specified in paragraph (6) for the year involved.

(B) ROUNDING.—Any amount determined under subparagraph (A)(ii) that is not a multiple of $5 shall be rounded to the nearest multiple of $5.

(2) BENEFIT STRUCTURE.—

(A) 25 PERCENT COINSURANCE.—The coverage has coinsurance (for costs above the annual deductible specified in

paragraph (1) and up to the initial coverage limit under paragraph (3)) that is—

(i) equal to 25 percent; or

(ii) actuarially equivalent (using processes and methods established under section 1860D-11(c)) to an average expected payment of 25 percent of such costs.

(B) USE OF TIERS.—Nothing in this part shall be construed as preventing a PDP sponsor or an MA organization from applying tiered copayments under a plan, so long as such tiered copayments are consistent with subparagraph (A)(ii).

(3) INITIAL COVERAGE LIMIT.—

(A) IN GENERAL.—Except as provided in paragraph (4), the coverage has an initial coverage limit on the maximum costs that may be recognized for payment purposes (including the annual deductible)—

(i) for 2006, that is equal to $2,250; or

(ii) for a subsequent year, that is equal to the amount specified in this paragraph for the previous year, increased by the annual percentage increase described in paragraph (6) for the year involved.

(B) ROUNDING.—Any amount determined under subparagraph (A)(ii) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

(4) PROTECTION AGAINST HIGH OUT-OF-POCKET EXPENDITURES.—

(A) IN GENERAL.—

(i) IN GENERAL.—The coverage provides benefits, after the part D eligible individual has incurred costs (as described in subparagraph (C)) for covered part D drugs in a year equal to the annual out-of-pocket threshold specified in subparagraph (B), with cost-sharing that is equal to the greater of—

(I) a copayment of $2 for a generic drug or a preferred drug that is a multiple source drug (as defined in section 1927(k)(7)(A)(i)) and $5 for any other drug; or

(II) coinsurance that is equal to 5 percent.

(ii) ADJUSTMENT OF AMOUNT.—For a year after 2006, the dollar amounts specified in clause (i)(I) shall be equal to the dollar amounts specified in this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (6) for the year involved. Any amount established under this clause that is not a multiple of a 5 cents shall be rounded to the nearest multiple of 5 cents.

(B) ANNUAL OUT-OF-POCKET THRESHOLD.—

(i) IN GENERAL.—For purposes of this part, the "annual out-of-pocket threshold" specified in this subparagraph—

(I) for 2006, is equal to $3,600; or

(II) for a subsequent year, is equal to the amount specified in this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (6) for the year involved.

(ii) ROUNDING.—Any amount determined under clause (i)(II) that is not a multiple of $50 shall be rounded to the nearest multiple of $50.

(C) APPLICATION.—In applying subparagraph (A)—

(i) incurred costs shall only include costs incurred with respect to covered part D drugs for the annual deductible described in paragraph (1), for cost-sharing described in paragraph (2), and for amounts for which benefits are not provided because of the application of the initial coverage limit described in paragraph (3), but does not include any costs incurred for covered part D drugs which are not included (or treated as being included) in the plan's formulary; and

(ii) such costs shall be treated as incurred only if they are paid by the part D eligible individual (or by another person, such as a family member, on behalf of the individual), under section 1860D-14, or under a State Pharmaceutical Assistance Program and the part D eligible individual (or other person) is not reimbursed through insurance or otherwise, a group health plan, or other third-party payment arrangement (other than under such section or such a Program) for such costs.

(D) INFORMATION REGARDING THIRD-PARTY REIMBURSEMENT.—

(i) PROCEDURES FOR EXCHANGING INFORMATION.—In order to accurately apply the requirements of subparagraph (C)(ii), the Secretary is authorized to establish procedures, in coordination with the Secretary of the Treasury and the Secretary of Labor—

(I) for determining whether costs for part D eligible individuals are being reimbursed through insurance or otherwise, a group health plan, or other third-party payment arrangement; and

(II) for alerting the PDP sponsors and MA organizations that offer the prescription drug plans and MA-PD plans in which such individuals are enrolled about such reimbursement arrangements.

(ii) AUTHORITY TO REQUEST INFORMATION FROM ENROLLEES.—A PDP sponsor or an MA organization may periodically ask part D eligible individuals enrolled in a prescription drug plan or an MA-PD plan offered by the sponsor or organization whether such individuals have or expect to receive such third-party reimbursement. A material misrepresentation of the information described in the preceding sentence by an individual (as defined in standards set by the Secretary and determined through a process established by the Secretary) shall constitute grounds for termination of enrollment in any plan under section 1851(g)(3)(B) (and as applied under this part under section 1860D-1(b)(1)(B)(v)) for a period specified by the Secretary.

(5) CONSTRUCTION.—Nothing in this part shall be construed as preventing a PDP sponsor or an MA organization offering

an MA-PD plan from reducing to 0 the cost-sharing otherwise applicable to preferred or generic drugs.

(6) ANNUAL PERCENTAGE INCREASE.—The annual percentage increase specified in this paragraph for a year is equal to the annual percentage increase in average per capita aggregate expenditures for covered part D drugs in the United States for part D eligible individuals, as determined by the Secretary for the 12-month period ending in July of the previous year using such methods as the Secretary shall specify.

(c) ALTERNATIVE PRESCRIPTION DRUG COVERAGE REQUIREMENTS.—A prescription drug plan or an MA-PD plan may provide a different prescription drug benefit design from standard prescription drug coverage so long as the Secretary determines (consistent with section 1860D-11(c)) that the following requirements are met and the plan applies for, and receives, the approval of the Secretary for such benefit design:

(1) ASSURING AT LEAST ACTUARIALLY EQUIVALENT COVERAGE.—

(A) ASSURING EQUIVALENT VALUE OF TOTAL COVERAGE.—The actuarial value of the total coverage is at least equal to the actuarial value of standard prescription drug coverage.

(B) ASSURING EQUIVALENT UNSUBSIDIZED VALUE OF COVERAGE.—The unsubsidized value of the coverage is at least equal to the unsubsidized value of standard prescription drug coverage. For purposes of this subparagraph, the unsubsidized value of coverage is the amount by which the actuarial value of the coverage exceeds the actuarial value of the subsidy payments under section 1860D-15 with respect to such coverage.

(C) ASSURING STANDARD PAYMENT FOR COSTS AT INITIAL COVERAGE LIMIT.—The coverage is designed, based upon an actuarially representative pattern of utilization, to provide for the payment, with respect to costs incurred that are equal to the initial coverage limit under subsection (b)(3) for the year, of an amount equal to at least the product of—

(i) the amount by which the initial coverage limit described in subsection (b)(3) for the year exceeds the deductible described in subsection (b)(1) for the year; and

(ii) 100 percent minus the coinsurance percentage specified in subsection (b)(2)(A)(i).

(2) MAXIMUM REQUIRED DEDUCTIBLE.—The deductible under the coverage shall not exceed the deductible amount specified under subsection (b)(1) for the year.

(3) SAME PROTECTION AGAINST HIGH OUT-OF-POCKET EXPENDITURES.—The coverage provides the coverage required under subsection (b)(4).

(d) Access to negotiated prices.—

(1) ACCESS.—

(A) IN GENERAL.—Under qualified prescription drug coverage offered by a PDP sponsor offering a prescription drug plan or an MA organization offering an MA-PD plan, the sponsor or organization shall provide enrollees with access to negotiated prices used for payment for covered part

D drugs, regardless of the fact that no benefits may be payable under the coverage with respect to such drugs because of the application of a deductible or other cost-sharing or an initial coverage limit (described in subsection (b)(3)).

(B) NEGOTIATED PRICES.—For purposes of this part, negotiated prices shall take into account negotiated price concessions, such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations, for covered part D drugs, and include any dispensing fees for such drugs.

(C) MEDICAID-RELATED PROVISIONS.—The prices negotiated by a prescription drug plan, by an MA-PD plan with respect to covered part D drugs, or by a qualified retiree prescription drug plan (as defined in section 1860D-22(a)(2)) with respect to such drugs on behalf of part D eligible individuals, shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1927(c)(1)(C).

(2) DISCLOSURE.—A PDP sponsor offering a prescription drug plan or an MA organization offering an MA-PD plan shall disclose to the Secretary (in a manner specified by the Secretary) the aggregate negotiated price concessions described in paragraph (1)(B) made available to the sponsor or organization by a manufacturer which are passed through in the form of lower subsidies, lower monthly beneficiary prescription drug premiums, and lower prices through pharmacies and other dispensers. The provisions of section 1927(b)(3)(D) apply to information disclosed to the Secretary under this paragraph.

(3) AUDITS.—To protect against fraud and abuse and to ensure proper disclosures and accounting under this part and in accordance with section 1857(d)(2)(B) (as applied under section 1860D-12(b)(3)(C)), the Secretary may conduct periodic audits, directly or through contracts, of the financial statements and records of PDP sponsors with respect to prescription drug plans and MA organizations with respect to MA-PD plans.

(e) COVERED PART D DRUG DEFINED.—

(1) IN GENERAL.—Except as provided in this subsection, for purposes of this part, the term "covered part D drug" means—

(A) a drug that may be dispensed only upon a prescription and that is described in subparagraph (A)(i), (A)(ii), or (A)(iii) of section 1927(k)(2); or

(B) a biological product described in clauses (i) through (iii) of subparagraph (B) of such section or insulin described in subparagraph (C) of such section and medical supplies associated with the injection of insulin (as defined in regulations of the Secretary), and such term includes a vaccine licensed under section 351 of the Public Health Service Act and any use of a covered part D drug for a medically accepted indication (as defined in section 1927(k)(6)).

(2) EXCLUSIONS.—

(A) IN GENERAL.—Such term does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted

under section 1927(d)(2), other than subparagraph (E) of such section (relating to smoking cessation agents), or under section 1927(d)(3).

(B) MEDICARE COVERED DRUGS.—A drug prescribed for a part D eligible individual that would otherwise be a covered part D drug under this part shall not be so considered if payment for such drug as so prescribed and dispensed or administered with respect to that individual is available (or would be available but for the application of a deductible) under part A or B for that individual.

(3) APPLICATION OF GENERAL EXCLUSION PROVISIONS.—A prescription drug plan or an MA-PD plan may exclude from qualified prescription drug coverage any covered part D drug—

(A) for which payment would not be made if section 1862(a) applied to this part; or

(B) which is not prescribed in accordance with the plan or this part. Such exclusions are determinations subject to reconsideration and appeal pursuant to subsections (g) and (h), respectively, of section 1860D-4.

ACCESS TO A CHOICE OF QUALIFIED PRESCRIPTION DRUG COVERAGE

SEC. 1860D-3. [42 U.S.C. 1395w-103] (a) ASSURING ACCESS TO A CHOICE OF COVERAGE.—

(1) CHOICE OF AT LEAST TWO PLANS IN EACH AREA.—The Secretary shall ensure that each part D eligible individual has available, consistent with paragraph (2), a choice of enrollment in at least 2 qualifying plans (as defined in paragraph (3)) in the area in which the individual resides, at least one of which is a prescription drug plan. In any such case in which such plans are not available, the part D eligible individual shall be given the opportunity to enroll in a fallback prescription drug plan.

(2) REQUIREMENT FOR DIFFERENT PLAN SPONSORS.—The requirement in paragraph (1) is not satisfied with respect to an area if only one entity offers all the qualifying plans in the area.

(3) QUALIFYING PLAN DEFINED.—For purposes of this section, the term "qualifying plan" means—

(A) a prescription drug plan; or

(B) an MA-PD plan described in section 1851(a)(2)(A)(i) that provides—

(i) basic prescription drug coverage; or

(ii)qualified prescription drug coverage that provides supplemental prescription drug coverage so long as there is no MA monthly supplemental beneficiary premium applied under the plan, due to the application of a credit against such premium of a rebate under section 1854(b)(1)(C).

(b) FLEXIBILITY IN RISK ASSUMED AND APPLICATION OF FALLBACK PLAN.—In order to ensure access pursuant to subsection (a) in an area—

(1) the Secretary may approve limited risk plans under section 1860D-11(f) for the area; and

(2) only if such access is still not provided in the area after applying paragraph (1), the Secretary shall provide for the offering of a fallback prescription drug plan for that area under section 1860D-11(g).

BENEFICIARY PROTECTIONS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE

SEC. 1860D-4. [42 U.S.C. 1395w-104] (a) DISSEMINATION OF INFORMATION.—

(1) GENERAL INFORMATION.—

(A) APPLICATION OF MA INFORMATION.—A PDP sponsor shall disclose, in a clear, accurate, and standardized form to each enrollee with a prescription drug plan offered by the sponsor under this part at the time of enrollment and at least annually thereafter, the information described in section 1852(c)(1) relating to such plan, insofar as the Secretary determines appropriate with respect to benefits provided under this part, and including the information described in subparagraph (B).

(B) DRUG SPECIFIC INFORMATION.—The information described in this subparagraph is information concerning the following:

(i) Access to specific covered part D drugs, including access through pharmacy networks.

(ii) How any formulary (including any tiered formulary structure) used by the sponsor functions, including a description of how a part D eligible individual may obtain information on the formulary consistent with paragraph (3).

(iii) Beneficiary cost-sharing requirements and how a part D eligible individual may obtain information on such requirements, including tiered or other copayment level applicable to each drug (or class of drugs), consistent with paragraph (3).

(iv) The medication therapy management program required under subsection (c).

(2) DISCLOSURE UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of a part D eligible individual who is eligible to enroll in a prescription drug plan, the PDP sponsor offering such plan shall provide information similar (as determined by the Secretary) to the information described in subparagraphs (A), (B), and (C) of section 1852(c)(2) to such individual.

(3) PROVISION OF SPECIFIC INFORMATION.—

(A) RESPONSE TO BENEFICIARY QUESTIONS.—Each PDP sponsor offering a prescription drug plan shall have a mechanism for providing specific information on a timely basis to enrollees upon request. Such mechanism shall include access to information through the use of a toll-free telephone number and, upon request, the provision of such information in writing.

(B) AVAILABILITY OF INFORMATION ON CHANGES IN FORMULARY THROUGH THE INTERNET.—A PDP sponsor offering a prescription drug plan shall make available on a timely basis through an Internet website information on specific changes in the formulary under the plan (including

changes to tiered or preferred status of covered part D drugs).

(4) CLAIMS INFORMATION.—A PDP sponsor offering a prescription drug plan must furnish to each enrollee in a form easily understandable to such enrollees—

(A) an explanation of benefits (in accordance with section 1806(a) or in a comparable manner); and

(B) when prescription drug benefits are provided under this part, a notice of the benefits in relation to—

(i) the initial coverage limit for the current year; and

(ii) the annual out-of-pocket threshold for the current year. Notices under subparagraph (B) need not be provided more often than as specified by the Secretary and notices under subparagraph (B)(ii) shall take into account the application of section 1860D-2(b)(4)(C) to the extent practicable, as specified by the Secretary.

(b) ACCESS TO COVERED PART D DRUGS.—

(1) ASSURING PHARMACY ACCESS.—

(A) PARTICIPATION OF ANY WILLING PHARMACY.—A prescription drug plan shall permit the participation of any pharmacy that meets the terms and conditions under the plan.

(B) DISCOUNTS ALLOWED FOR NETWORK PHARMACIES.—For covered part D drugs dispensed through in-network pharmacies, a prescription drug plan may, notwithstanding subparagraph (A), reduce coinsurance or copayments for part D eligible individuals enrolled in the plan below the level otherwise required. In no case shall such a reduction result in an increase in payments made by the Secretary under section 1860D-15 to a plan.

(C) CONVENIENT ACCESS FOR NETWORK PHARMACIES.—

(i) IN GENERAL.—The PDP sponsor of the prescription drug plan shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access (consistent with rules established by the Secretary).

(ii) APPLICATION OF TRICARE STANDARDS.—The Secretary shall establish rules for convenient access to in-network pharmacies under this subparagraph that are no less favorable to enrollees than the rules for convenient access to pharmacies included in the statement of work of solicitation (#MDA906-03-R-0002) of the Department of Defense under the TRICARE Retail Pharmacy (TRRx) as of March 13, 2003.

(iii) ADEQUATE EMERGENCY ACCESS.—Such rules shall include adequate emergency access for enrollees.

(iv) CONVENIENT ACCESS IN LONG-TERM CARE FACILITIES.—Such rules may include standards with respect to access for enrollees who are residing in long-term care facilities and for pharmacies operated by the Indian Health Service, Indian tribes and tribal organizations, and urban Indian organizations (as defined in

section 4 of the Indian Health Care Improvement Act[383]).

(D) LEVEL PLAYING FIELD.—Such a sponsor shall permit enrollees to receive benefits (which may include a 90-day supply of drugs or biologicals) through a pharmacy (other than a mail order pharmacy), with any differential in charge paid by such enrollees.

(E) NOT REQUIRED TO ACCEPT INSURANCE RISK.—The terms and conditions under subparagraph (A) may not require participating pharmacies to accept insurance risk as a condition of participation.

(2) USE OF STANDARDIZED TECHNOLOGY.—

(A) IN GENERAL.—The PDP sponsor of a prescription drug plan shall issue (and reissue, as appropriate) such a card (or other technology) that may be used by an enrollee to assure access to negotiated prices under section 1860D-2(d).

(B) STANDARDS.—

(i) IN GENERAL.—The Secretary shall provide for the development, adoption, or recognition of standards relating to a standardized format for the card or other technology required under subparagraph (A). Such standards shall be compatible with part C of title XI and may be based on standards developed by an appropriate standard setting organization.

(ii) CONSULTATION.—In developing the standards under clause (i), the Secretary shall consult with the National Council for Prescription Drug Programs and other standard setting organizations determined appropriate by the Secretary.

(iii) IMPLEMENTATION.—The Secretary shall develop, adopt, or recognize the standards under clause (i) by such date as the Secretary determines shall be sufficient to ensure that PDP sponsors utilize such standards beginning January 1, 2006.

(3) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If a PDP sponsor of a prescription drug plan uses a formulary (including the use of tiered cost-sharing), the following requirements must be met:

(A) DEVELOPMENT AND REVISION BY A PHARMACY AND THERAPEUTIC (P AND T) COMMITTEE.—

(i) IN GENERAL.—The formulary must be developed and reviewed by a pharmacy and therapeutic committee. A majority of the members of such committee shall consist of individuals who are practicing physicians or practicing pharmacists (or both).

(ii) INCLUSION OF INDEPENDENT EXPERTS.—Such committee shall include at least one practicing physician and at least one practicing pharmacist, each of whom—

(I) is independent and free of conflict with respect to the sponsor and plan; and

(II) has expertise in the care of elderly or disabled persons.

[383] See Vol. II, P.L. 94-437.

(B) FORMULARY DEVELOPMENT.—In developing and reviewing the formulary, the committee shall—

(i) base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, outcomes research data, and on such other information as the committee determines to be appropriate; and

(ii) take into account whether including in the formulary (or in a tier in such formulary) particular covered part D drugs has therapeutic advantages in terms of safety and efficacy.

(C) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES AND CLASSES.—

(i) IN GENERAL.—The formulary must include drugs within each therapeutic category and class of covered part D drugs, although not necessarily all drugs within such categories and classes.

(ii) MODEL GUIDELINES.—The Secretary shall request the United States Pharmacopeia to develop, in consultation with pharmaceutical benefit managers and other interested parties, a list of categories and classes that may be used by prescription drug plans under this paragraph and to revise such classification from time to time to reflect changes in therapeutic uses of covered part D drugs and the additions of new covered part D drugs.

(iii) LIMITATION ON CHANGES IN THERAPEUTIC CLASSIFICATION.—The PDP sponsor of a prescription drug plan may not change the therapeutic categories and classes in a formulary other than at the beginning of each plan year except as the Secretary may permit to take into account new therapeutic uses and newly approved covered part D drugs.

(D) PROVIDER AND PATIENT EDUCATION.—The PDP sponsor shall establish policies and procedures to educate and inform health care providers and enrollees concerning the formulary.

(E) NOTICE BEFORE REMOVING DRUG FROM FORMULARY OR CHANGING PREFERRED OR TIER STATUS OF DRUG.—Any removal of a covered part D drug from a formulary and any change in the preferred or tiered cost-sharing status of such a drug shall take effect only after appropriate notice is made available (such as under subsection (a)(3)) to the Secretary, affected enrollees, physicians, pharmacies, and pharmacists.

(F) PERIODIC EVALUATION OF PROTOCOLS.—In connection with the formulary, the sponsor of a prescription drug plan shall provide for the periodic evaluation and analysis of treatment protocols and procedures. The requirements of this paragraph may be met by a PDP sponsor directly or through arrangements with another entity.

(c) COST AND UTILIZATION MANAGEMENT; QUALITY ASSURANCE; MEDICATION THERAPY MANAGEMENT PROGRAM.—

(1) IN GENERAL.—The PDP sponsor shall have in place, directly or through appropriate arrangements, with respect to covered part D drugs, the following:

(A) A cost-effective drug utilization management program, including incentives to reduce costs when medically appropriate, such as through the use of multiple source drugs (as defined in section 1927(k)(7)(A)(i)).

(B) Quality assurance measures and systems to reduce medication errors and adverse drug interactions and improve medication use.

(C) A medication therapy management program described in paragraph (2).

(D) A program to control fraud, abuse, and waste. Nothing in this section shall be construed as impairing a PDP sponsor from utilizing cost management tools (including differential payments) under all methods of operation.

(2) MEDICATION THERAPY MANAGEMENT PROGRAM.—

(A) DESCRIPTION.—

(i) IN GENERAL.—A medication therapy management program described in this paragraph is a program of drug therapy management that may be furnished by a pharmacist and that is designed to assure, with respect to targeted beneficiaries described in clause (ii), that covered part D drugs under the prescription drug plan are appropriately used to optimize therapeutic outcomes through improved medication use, and to reduce the risk of adverse events, including adverse drug interactions. Such a program may distinguish between services in ambulatory and institutional settings.

(ii) TARGETED BENEFICIARIES DESCRIBED.—Targeted beneficiaries described in this clause are part D eligible individuals who—

(I) have multiple chronic diseases (such as diabetes, asthma, hypertension, hyperlipidemia, and congestive heart failure);

(II) are taking multiple covered part D drugs; and

(III) are identified as likely to incur annual costs for covered part D drugs that exceed a level specified by the Secretary.

(B) ELEMENTS.—Such program may include elements that promote—

(i) enhanced enrollee understanding to promote the appropriate use of medications by enrollees and to reduce the risk of potential adverse events associated with medications, through beneficiary education, counseling, and other appropriate means;

(ii) increased enrollee adherence with prescription medication regimens through medication refill reminders, special packaging, and other compliance programs and other appropriate means; and

(iii) detection of adverse drug events and patterns of overuse and underuse of prescription drugs.

(C) DEVELOPMENT OF PROGRAM IN COOPERATION WITH LICENSED PHARMACISTS.—Such program shall be developed

in cooperation with licensed and practicing pharmacists and physicians.

(D) COORDINATION WITH CARE MANAGEMENT PLANS.—The Secretary shall establish guidelines for the coordination of any medication therapy management program under this paragraph with respect to a targeted beneficiary with any care management plan established with respect to such beneficiary under a chronic care improvement program under section 1807.

(E) CONSIDERATIONS IN PHARMACY FEES.—The PDP sponsor of a prescription drug plan shall take into account, in establishing fees for pharmacists and others providing services under such plan, the resources used, and time required to, implement the medication therapy management program under this paragraph. Each such sponsor shall disclose to the Secretary upon request the amount of any such management or dispensing fees. The provisions of section 1927(b)(3)(D) apply to information disclosed under this subparagraph.

(d) CONSUMER SATISFACTION SURVEYS.—In order to provide for comparative information under section 1860D-1(c)(3)(A)(v), the Secretary shall conduct consumer satisfaction surveys with respect to PDP sponsors and prescription drug plans in a manner similar to the manner such surveys are conducted for MA organizations and MA plans under part C.

(e)[384] ELECTRONIC PRESCRIPTION PROGRAM.—

(1) APPLICATION OF STANDARDS.—As of such date as the Secretary may specify, but not later than 1 year after the date of promulgation of final standards under paragraph (4)(D), prescriptions and other information described in paragraph (2)(A) for covered part D drugs prescribed for part D eligible individuals that are transmitted electronically shall be transmitted only in accordance with such standards under an electronic prescription drug program that meets the requirements of paragraph (2).

(2) PROGRAM REQUIREMENTS.—Consistent with uniform standards established under paragraph (3)—

(A) PROVISION OF INFORMATION TO PRESCRIBING HEALTH CARE PROFESSIONAL AND DISPENSING PHARMACIES AND PHARMACISTS.—An electronic prescription drug program shall provide for the electronic transmittal to the prescribing health care professional and to the dispensing pharmacy and pharmacist of the prescription and information on eligibility and benefits (including the drugs included in the applicable formulary, any tiered formulary structure, and any requirements for prior authorization) and of the following information with respect to the prescribing and dispensing of a covered part D drug:

(i) Information on the drug being prescribed or dispensed and other drugs listed on the medication history, including information on drug-drug interactions, warnings or cautions, and, when indicated, dosage adjustments.

[384] See Vol. II, P.L. 108-173, §108, with respect to grants to physicians to implement electronic prescription drug programs.

(ii) Information on the availability of lower cost, therapeutically appropriate alternatives (if any) for the drug prescribed.

(B) APPLICATION TO MEDICAL HISTORY INFORMATION.—Effective on and after such date as the Secretary specifies and after the establishment of appropriate standards to carry out this subparagraph, the program shall provide for the electronic transmittal in a manner similar to the manner under subparagraph (A) of information that relates to the medical history concerning the individual and related to a covered part D drug being prescribed or dispensed, upon request of the professional or pharmacist involved.

(C) LIMITATIONS.—Information shall only be disclosed under subparagraph (A) or (B) if the disclosure of such information is permitted under the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

(D) TIMING.—To the extent feasible, the information exchanged under this paragraph shall be on an interactive, real-time basis.

(3) Standards.—

(A) IN GENERAL.—The Secretary shall provide consistent with this subsection for the promulgation of uniform standards relating to the requirements for electronic prescription drug programs under paragraph (2).

(B) OBJECTIVES.—Such standards shall be consistent with the objectives of improving—

(i) patient safety;

(ii) the quality of care provided to patients; and

(iii) efficiencies, including cost savings, in the delivery of care.

(C) DESIGN CRITERIA.—Such standards shall—

(i) be designed so that, to the extent practicable, the standards do not impose an undue administrative burden on prescribing health care professionals and dispensing pharmacies and pharmacists;

(ii) be compatible with standards established under part C of title XI, standards established under subsection (b)(2)(B)(i), and with general health information technology standards; and

(iii) be designed so that they permit electronic exchange of drug labeling and drug listing information maintained by the Food and Drug Administration and the National Library of Medicine.

(D) PERMITTING USE OF APPROPRIATE MESSAGING.—Such standards shall allow for the messaging of information only if it relates to the appropriate prescribing of drugs, including quality assurance measures and systems referred to in subsection (c)(1)(B).

(E) PERMITTING PATIENT DESIGNATION OF DISPENSING PHARMACY.—

(i) IN GENERAL.—Consistent with clause (ii), such standards shall permit a part D eligible individual to designate a particular pharmacy to dispense a prescribed drug.

(ii) NO CHANGE IN BENEFITS.—Clause (i) shall not be construed as affecting—

(I) the access required to be provided to pharmacies by a prescription drug plan; or

(II) the application of any differences in benefits or payments under such a plan based on the pharmacy dispensing a covered part D drug.

(4) DEVELOPMENT, PROMULGATION, AND MODIFICATION OF STANDARDS.—

(A) INITIAL STANDARDS.—Not later than September 1, 2005, the Secretary shall develop, adopt, recognize, or modify initial uniform standards relating to the requirements for electronic prescription drug programs described in paragraph (2) taking into consideration the recommendations (if any) from the National Committee on Vital and Health Statistics (as established under section 306(k) of the Public Health Service Act (42 U.S.C. 242k(k))) under subparagraph (B).

(B) ROLE OF NCVHS.—The National Committee on Vital and Health Statistics shall develop recommendations for uniform standards relating to such requirements in consultation with the following:

(i) Standard setting organizations (as defined in section 1171(8))

(ii) Practicing physicians.

(iii) Hospitals.

(iv) Pharmacies.

(v) Practicing pharmacists.

(vi) Pharmacy benefit managers.

(vii) State boards of pharmacy.

(viii) State boards of medicine.

(ix) Experts on electronic prescribing.

(x) Other appropriate Federal agencies.

(C) PILOT PROJECT TO TEST INITIAL STANDARDS.—

(i) IN GENERAL.—During the 1-year period that begins on January 1, 2006, the Secretary shall conduct a pilot project to test the initial standards developed under subparagraph (A) prior to the promulgation of the final uniform standards under subparagraph (D) in order to provide for the efficient implementation of the requirements described in paragraph (2).

(ii) EXCEPTION.—Pilot testing of standards is not required under clause (i) where there already is adequate industry experience with such standards, as determined by the Secretary after consultation with effected standard setting organizations and industry users.

(iii) VOLUNTARY PARTICIPATION OF PHYSICIANS AND PHARMACIES.—In order to conduct the pilot project under clause (i), the Secretary shall enter into agreements with physicians, physician groups, pharmacies, hospitals, PDP sponsors, MA organizations, and other appropriate entities under which health care professionals electronically transmit prescriptions to dispensing pharmacies and pharmacists in accordance with such standards.

(iv) EVALUATION AND REPORT.—

(I) EVALUATION.—The Secretary shall conduct an evaluation of the pilot project conducted under clause (i).

(II) REPORT TO CONGRESS.—Not later than April 1, 2007, the Secretary shall submit to Congress a report on the evaluation conducted under subclause (I).

(D) FINAL STANDARDS.—Based upon the evaluation of the pilot project under subparagraph (C)(iv)(I) and not later than April 1, 2008, the Secretary shall promulgate uniform standards relating to the requirements described in paragraph (2).

(5) RELATION TO STATE LAWS.—The standards promulgated under this subsection shall supersede any State law or regulation that—

(A) is contrary to the standards or restricts the ability to carry out this part; and (B) pertains to the electronic transmission of medication history and of information on eligibility, benefits, and prescriptions with respect to covered part D drugs under this part.

(6) ESTABLISHMENT OF SAFE HARBOR.—The Secretary, in consultation with the Attorney General, shall promulgate regulations that provide for a safe harbor from sanctions under paragraphs (1) and (2) of section 1128B(b) and an exception to the prohibition under subsection (a)(1) of section 1877 with respect to the provision of nonmonetary remuneration (in the form of hardware, software, or information technology and training services) necessary and used solely to receive and transmit electronic prescription information in accordance with the standards promulgated under this subsection—

(A) in the case of a hospital, by the hospital to members of its medical staff;

(B) in the case of a group practice (as defined in section 1877(h)(4)), by the practice to prescribing health care professionals who are members of such practice; and

(C) in the case of a PDP sponsor or MA organization, by the sponsor or organization to pharmacists and pharmacies participating in the network of such sponsor or organization, and to prescribing health care professionals.

(f) GRIEVANCE MECHANISM.—Each PDP sponsor shall provide meaningful procedures for hearing and resolving grievances between the sponsor (including any entity or individual through which the sponsor provides covered benefits) and enrollees with prescription drug plans of the sponsor under this part in accordance with section 1852(f).

(g) COVERAGE DETERMINATIONS AND RECONSIDERATIONS.—

(1) APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.—A PDP sponsor shall meet the requirements of paragraphs (1) through (3) of section 1852(g) with respect to covered benefits under the prescription drug plan it offers under this part in the same manner as such requirements apply to an MA organization with respect to benefits it offers under an MA plan under part C.

(2) REQUEST FOR A DETERMINATION FOR THE TREATMENT OF TIERED FORMULARY DRUG.—In the case of a prescription drug

plan offered by a PDP sponsor that provides for tiered cost-sharing for drugs included within a formulary and provides lower cost-sharing for preferred drugs included within the formulary, a part D eligible individual who is enrolled in the plan may request an exception to the tiered cost-sharing structure. Under such an exception, a nonpreferred drug could be covered under the terms applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition either would not be as effective for the individual or would have adverse effects for the individual or both. A PDP sponsor shall have an exceptions process under this paragraph consistent with guidelines established by the Secretary for making a determination with respect to such a request. Denial of such an exception shall be treated as a coverage denial for purposes of applying subsection (h).

(h) APPEALS.—

(1) IN GENERAL.—Subject to paragraph (2), a PDP sponsor shall meet the requirements of paragraphs (4) and (5) of section 1852(g) with respect to benefits (including a determination related to the application of tiered cost-sharing described in subsection (g)(2)) in a manner similar (as determined by the Secretary) to the manner such requirements apply to an MA organization with respect to benefits under the original medicare fee-for-service program option it offers under an MA plan under part C. In applying this paragraph only the part D eligible individual shall be entitled to bring such an appeal.

(2) LIMITATION IN CASES ON NONFORMULARY DETERMINATIONS.—A part D eligible individual who is enrolled in a prescription drug plan offered by a PDP sponsor may appeal under paragraph (1) a determination not to provide for coverage of a covered part D drug that is not on the formulary under the plan only if the prescribing physician determines that all covered part D drugs on any tier of the formulary for treatment of the same condition would not be as effective for the individual as the nonformulary drug, would have adverse effects for the individual, or both.

(3) TREATMENT OF NONFORMULARY DETERMINATIONS.—If a PDP sponsor determines that a plan provides coverage for a covered part D drug that is not on the formulary of the plan, the drug shall be treated as being included on the formulary for purposes of section 1860D- 2(b)(4)(C)(i).

(i) PRIVACY, CONFIDENTIALITY, AND ACCURACY OF ENROLLEE RECORDS.—The provisions of section 1852(h) shall apply to a PDP sponsor and prescription drug plan in the same manner as it applies to an MA organization and an MA plan.

(j) TREATMENT OF ACCREDITATION.—Subparagraph (A) of section 1852(e)(4) (relating to treatment of accreditation) shall apply to a PDP sponsor under this part with respect to the following requirements, in the same manner as it applies to an MA organization with respect to the requirements in subparagraph (B) (other than clause (vii) thereof) of such section:

(1) Subsection (b) of this section (relating to access to covered part D drugs).

(2) Subsection (c) of this section (including quality assurance and medication therapy management).

(3) Subsection (i) of this section (relating to confidentiality and accuracy of enrollee records).

(k) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—

(1) IN GENERAL.—A PDP sponsor offering a prescription drug plan shall provide that each pharmacy that dispenses a covered part D drug shall inform an enrollee of any differential between the price of the drug to the enrollee and the price of the lowest priced generic covered part D drug under the plan that is therapeutically equivalent and bioequivalent and available at such pharmacy.

(2) TIMING OF NOTICE.—

(A) IN GENERAL.—Subject to subparagraph (B), the information under paragraph (1) shall be provided at the time of purchase of the drug involved, or, in the case of dispensing by mail order, at the time of delivery of such drug.

(B) WAIVER.—The Secretary may waive subparagraph (A) in such circumstances as the Secretary may specify.

Subpart 2—Prescription Drug Plans; PDP Sponsors; Financing

PDP REGIONS; SUBMISSION OF BIDS; PLAN APPROVAL[385]

SEC. 1860D-11. [42 U.S.C. 1395w-111] (a) ESTABLISHMENT OF PDP REGIONS; SERVICE AREAS.—

(1) COVERAGE OF ENTIRE PDP REGION.—The service area for a prescription drug plan shall consist of an entire PDP region established under paragraph (2).

(2) ESTABLISHMENT OF PDP REGIONS.—

(A) IN GENERAL.—The Secretary shall establish, and may revise, PDP regions in a manner that is consistent with the requirements for the establishment and revision of MA regions under subparagraphs (B) and (C) of section 1858(a)(2).

(B) RELATION TO MA REGIONS.—To the extent practicable, PDP regions shall be the same as MA regions under section 1858(a)(2). The Secretary may establish PDP regions which are not the same as MA regions if the Secretary determines that the establishment of different regions under this part would improve access to benefits under this part.

(C) AUTHORITY FOR TERRITORIES.—The Secretary shall establish, and may revise, PDP regions for areas in States that are not within the 50 States or the District of Columbia.

(3) NATIONAL PLAN.—Nothing in this subsection shall be construed as preventing a prescription drug plan from being offered in more than one PDP region (including all PDP regions).

(b) SUBMISSION OF BIDS, PREMIUMS, AND RELATED INFORMATION.—

(1) IN GENERAL.—A PDP sponsor shall submit to the Secretary information described in paragraph (2) with respect to each prescription drug plan it offers. Such information shall be submitted at the same time and in a similar manner to the

[385] See Vol. II, P.L. 108-173, §107(a), with respect to a study regarding regional variations in prescription drug spending.

manner in which information described in paragraph (6) of section 1854(a) is submitted by an MA organization under paragraph (1) of such section.

(2) INFORMATION DESCRIBED.—The information described in this paragraph is information on the following:

(A) COVERAGE PROVIDED.—The prescription drug coverage provided under the plan, including the deductible and other cost-sharing.

(B) ACTUARIAL VALUE.—The actuarial value of the qualified prescription drug coverage in the region for a part D eligible individual with a national average risk profile for the factors described in section 1860D-15(c)(1)(A) (as specified by the Secretary).

(C) BID.—Information on the bid, including an actuarial certification of—

(i) the basis for the actuarial value described in subparagraph (B) assumed in such bid;

(ii) the portion of such bid attributable to basic prescription drug coverage and, if applicable, the portion of such bid attributable to supplemental benefits;

(iii) assumptions regarding the reinsurance subsidy payments provided under section 1860D-15(b) subtracted from the actuarial value to produce such bid; and

(iv) administrative expenses assumed in the bid.

(D) SERVICE AREA.—The service area for the plan.

(E) LEVEL OF RISK ASSUMED.—

(i) IN GENERAL.—Whether the PDP sponsor requires a modification of risk level under clause (ii) and, if so, the extent of such modification. Any such modification shall apply with respect to all prescription drug plans offered by a PDP sponsor in a PDP region. This subparagraph shall not apply to an MA-PD plan.

(ii) RISK LEVELS DESCRIBED.—A modification of risk level under this clause may consist of one or more of the following:

(I) INCREASE IN FEDERAL PERCENTAGE ASSUMED IN INITIAL RISK CORRIDOR.—An equal percentage point increase in the percents applied under subparagraphs (B)(i), (B)(ii)(I), (C)(i), and (C)(ii)(I) of section 1860D-15(e)(2). In no case shall the application of previous sentence prevent the application of a higher percentage under section 1869D-15(e)(2)(B)(iii).

(II) INCREASE IN FEDERAL PERCENTAGE ASSUMED IN SECOND RISK CORRIDOR.—An equal percentage point increase in the percents applied under subparagraphs (B)(ii)(II) and (C)(ii)(II) of section 1860D-15(e)(2).

(III) DECREASE IN SIZE OF RISK CORRIDORS.—A decrease in the threshold risk percentages specified in section 1860D-15(e)(3)(C).

(F) ADDITIONAL INFORMATION.—Such other information as the Secretary may require to carry out this part.

(3) PAPERWORK REDUCTION FOR OFFERING OF PRESCRIPTION DRUG PLANS NATIONALLY OR IN MULTI-REGION AREAS.—The Sec-

retary shall establish requirements for information submission under this subsection in a manner that promotes the offering of such plans in more than one PDP region (including all regions) through the filing of consolidated information.

(c) ACTUARIAL VALUATION.—

(1) PROCESSES.—For purposes of this part, the Secretary shall establish processes and methods for determining the actuarial valuation of prescription drug coverage, including—

(A) an actuarial valuation of standard prescription drug coverage under section 1860D-2(b);

(B) actuarial valuations relating to alternative prescription drug coverage under section 1860D-2(c)(1);

(C) an actuarial valuation of the reinsurance subsidy payments under section 1860D-15(b);

(D) the use of generally accepted actuarial principles and methodologies; and

(E) applying the same methodology for determinations of actuarial valuations under subparagraphs (A) and (B).

(2) ACCOUNTING FOR DRUG UTILIZATION.—Such processes and methods for determining actuarial valuation shall take into account the effect that providing alternative prescription drug coverage (rather than standard prescription drug coverage) has on drug utilization.

(3) RESPONSIBILITIES.—

(A) PLAN RESPONSIBILITIES.—PDP sponsors and MA organizations are responsible for the preparation and submission of actuarial valuations required under this part for prescription drug plans and MA-PD plans they offer.

(B) USE OF OUTSIDE ACTUARIES.—Under the processes and methods established under paragraph (1), PDP sponsors offering prescription drug plans and MA organizations offering MA-PD plans may use actuarial opinions certified by independent, qualified actuaries to establish actuarial values.

(d) REVIEW OF INFORMATION AND NEGOTIATION.—

(1) REVIEW OF INFORMATION.—The Secretary shall review the information filed under subsection (b) for the purpose of conducting negotiations under paragraph (2).

(2) NEGOTIATION REGARDING TERMS AND CONDITIONS.—Subject to subsection (i), in exercising the authority under paragraph (1), the Secretary—

(A) has the authority to negotiate the terms and conditions of the proposed bid submitted and other terms and conditions of a proposed plan; and

(B) has authority similar to the authority of the Director of the Office of Personnel Management with respect to health benefits plans under chapter 89 of title 5, United States Code.

(e) APPROVAL OF PROPOSED PLANS.—

(1) IN GENERAL.—After review and negotiation under subsection (d), the Secretary shall approve or disapprove the prescription drug plan.

(2) REQUIREMENTS FOR APPROVAL.—The Secretary may approve a prescription drug plan only if the following requirements are met:

(A) COMPLIANCE WITH REQUIREMENTS.—The plan and the PDP sponsor offering the plan comply with the requirements under this part, including the provision of qualified prescription drug coverage.

(B) ACTUARIAL DETERMINATIONS.—The Secretary determines that the plan and PDP sponsor meet the requirements under this part relating to actuarial determinations, including such requirements under section 1860D-2(c).

(C) APPLICATION OF FEHBP STANDARD.—

(i) IN GENERAL.—The Secretary determines that the portion of the bid submitted under subsection (b) that is attributable to basic prescription drug coverage is supported by the actuarial bases provided under such subsection and reasonably and equitably reflects the revenue requirements (as used for purposes of section 1302(8)(C) of the Public Health Service Act) for benefits provided under that plan, less the sum (determined on a monthly per capita basis) of the actuarial value of the reinsurance payments under section 1860D-15(b).

(ii) SUPPLEMENTAL COVERAGE.—The Secretary determines that the portion of the bid submitted under subsection (b) that is attributable to supplemental prescription drug coverage pursuant to section 1860D-2(a)(2) is supported by the actuarial bases provided under such subsection and reasonably and equitably reflects the revenue requirements (as used for purposes of section 1302(8)(C) of the Public Health Service Act) for such coverage under the plan.

(D) PLAN DESIGN.—

(i) IN GENERAL.—The Secretary does not find that the design of the plan and its benefits (including any formulary and tiered formulary structure) are likely to substantially discourage enrollment by certain part D eligible individuals under the plan.

(ii) USE OF CATEGORIES AND CLASSES IN FORMULARIES.—The Secretary may not find that the design of categories and classes within a formulary violates clause (i) if such categories and classes are consistent with guidelines (if any) for such categories and classes established by the United States Pharmacopeia.

(f) APPLICATION OF LIMITED RISK PLANS.—

(1) CONDITIONS FOR APPROVAL OF LIMITED RISK PLANS.—The Secretary may only approve a limited risk plan (as defined in paragraph (4)(A)) for a PDP region if the access requirements under section 1860D-3(a) would not be met for the region but for the approval of such a plan (or a fallback prescription drug plan under subsection (g)).

(2) RULES.—The following rules shall apply with respect to the approval of a limited risk plan in a PDP region:

(A) LIMITED EXERCISE OF AUTHORITY.—Only the minimum number of such plans may be approved in order to meet the access requirements under section 1860D-3(a).

(B) MAXIMIZING ASSUMPTION OF RISK.—The Secretary shall provide priority in approval for those plans bearing

the highest level of risk (as computed by the Secretary), but the Secretary may take into account the level of the bids submitted by such plans.

(C) NO FULL UNDERWRITING FOR LIMITED RISK PLANS.—In no case may the Secretary approve a limited risk plan under which the modification of risk level provides for no (or a de minimis) level of financial risk.

(3) ACCEPTANCE OF ALL FULL RISK CONTRACTS.—There shall be no limit on the number of full risk plans that are approved under subsection (e).

(4) RISK-PLANS DEFINED.—For purposes of this subsection:

(A) LIMITED RISK PLAN.—The term "limited risk plan" means a prescription drug plan that provides basic prescription drug coverage and for which the PDP sponsor includes a modification of risk level described in subparagraph (E) of subsection (b)(2) in its bid submitted for the plan under such subsection. Such term does not include a fallback prescription drug plan.

(B) FULL RISK PLAN.—The term "full risk plan" means a prescription drug plan that is not a limited risk plan or a fallback prescription drug plan.

(g) GUARANTEEING ACCESS TO COVERAGE.—

(1) SOLICITATION OF BIDS.—

(A) IN GENERAL.—Separate from the bidding process under subsection (b), the Secretary shall provide for a process for the solicitation of bids from eligible fallback entities (as defined in paragraph (2)) for the offering in all fallback service areas (as defined in paragraph (3)) in one or more PDP regions of a fallback prescription drug plan (as defined in paragraph (4)) during the contract period specified in paragraph (5)).

(B) ACCEPTANCE OF BIDS.—

(i) IN GENERAL.—Except as provided in this subparagraph, the provisions of subsection (e) shall apply with respect to the approval or disapproval of fallback prescription drug plans. The Secretary shall enter into contracts under this subsection with eligible fallback entities for the offering of fallback prescription drug plans so approved in fallback service areas.

(ii) LIMITATION OF 1 PLAN FOR ALL FALLBACK SERVICE AREAS IN A PDP REGION.—With respect to all fallback service areas in any PDP region for a contract period, the Secretary shall approve the offering of only 1 fallback prescription drug plan.

(iii) COMPETITIVE PROCEDURES.—Competitive procedures (as defined in section 4(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(5))) shall be used to enter into a contract under this subsection. The provisions of subsection (d) of section 1874A shall apply to a contract under this section in the same manner as they apply to a contract under such section.

(iv) TIMING.—The Secretary shall approve a fallback prescription drug plan for a PDP region in a manner so that, if there are any fallback service areas in the region for a year, the fallback prescription drug plan

is offered at the same time as prescription drug plans would otherwise be offered.

(v) NO NATIONAL FALLBACK PLAN.—The Secretary shall not enter into a contract with a single fallback entity for the offering of fallback plans throughout the United States.

(2) ELIGIBLE FALLBACK ENTITY.—For purposes of this section, the term "eligible fallback entity" means, with respect to all fallback service areas in a PDP region for a contract period, an entity that—

(A) meets the requirements to be a PDP sponsor (or would meet such requirements but for the fact that the entity is not a risk-bearing entity); and

(B) does not submit a bid under section 1860D-11(b) for any prescription drug plan for any PDP region for the first year of such contract period. For purposes of subparagraph (B), an entity shall be treated as submitting a bid with respect to a prescription drug plan if the entity is acting as a subcontractor of a PDP sponsor that is offering such a plan. The previous sentence shall not apply to entities that are subcontractors of an MA organization except insofar as such organization is acting as a PDP sponsor with respect to a prescription drug plan.

(3) FALLBACK SERVICE AREA.—For purposes of this subsection, the term "fallback service area" means, for a PDP region with respect to a year, any area within such region for which the Secretary determines before the beginning of the year that the access requirements of the first sentence of section 1860D-3(a) will not be met for part D eligible individuals residing in the area for the year.

(4) FALLBACK PRESCRIPTION DRUG PLAN.—For purposes of this part, the term "fallback prescription drug plan" means a prescription drug plan that—

(A) only offers the standard prescription drug coverage and access to negotiated prices described in section 1860D-2(a)(1)(A) and does not include any supplemental prescription drug coverage; and

(B) meets such other requirements as the Secretary may specify.

(5) PAYMENTS UNDER THE CONTRACT.—

(A) IN GENERAL.—A contract entered into under this subsection shall provide for—

(i) payment for the actual costs (taking into account negotiated price concessions described in section 1860D-2(d)(1)(B)) of covered part D drugs provided to part D eligible individuals enrolled in a fallback prescription drug plan offered by the entity; and

(ii) payment of management fees that are tied to performance measures established by the Secretary for the management, administration, and delivery of the benefits under the contract.

(B) PERFORMANCE MEASURES.—The performance measures established by the Secretary pursuant to subparagraph (A)(ii) shall include at least measures for each of the following:

(i) COSTS.—The entity contains costs to the Medicare Prescription Drug Account and to part D eligible individuals enrolled in a fallback prescription drug plan offered by the entity through mechanisms such as generic substitution and price discounts.

(ii) QUALITY PROGRAMS.—The entity provides such enrollees with quality programs that avoid adverse drug reactions and overutilization and reduce medical errors.

(iii) CUSTOMER SERVICE.—The entity provides timely and accurate delivery of services and pharmacy and beneficiary support services.

(iv) BENEFIT ADMINISTRATION AND CLAIMS ADJUDICATION.—The entity provides efficient and effective benefit administration and claims adjudication.

(6) MONTHLY BENEFICIARY PREMIUM.—Except as provided in section 1860D-13(b) (relating to late enrollment penalty) and subject to section 1860D-14 (relating to low-income assistance), the monthly beneficiary premium to be charged under a fallback prescription drug plan offered in all fallback service areas in a PDP region shall be uniform and shall be equal to 25.5 percent of an amount equal to the Secretary's estimate of the average monthly per capita actuarial cost, including administrative expenses, under the fallback prescription drug plan of providing coverage in the region, as calculated by the Chief Actuary of the Centers for Medicare and Medicaid Services. In calculating such administrative expenses, the Chief Actuary shall use a factor that is based on similar expenses of prescription drug plans that are not fallback prescription drug plans.

(7) GENERAL CONTRACT TERMS AND CONDITIONS.—

(A) IN GENERAL.—Except as may be appropriate to carry out this section, the terms and conditions of contracts with eligible fallback entities offering fallback prescription drug plans under this subsection shall be the same as the terms and conditions of contracts under this part for prescription drug plans.

(B) PERIOD OF CONTRACT.—

(i) IN GENERAL.—Subject to clause (ii), a contract approved for a fallback prescription drug plan for fallback service areas for a PDP region under this section shall be for a period of 3 years (except as may be renewed after a subsequent bidding process).

(ii) LIMITATION.—A fallback prescription drug plan may be offered under a contract in an area for a year only if that area is a fallback service area for that year.

(C) ENTITY NOT PERMITTED TO MARKET OR BRAND FALLBACK PRESCRIPTION DRUG PLANS.—An eligible fallback entity with a contract under this subsection may not engage in any marketing or branding of a fallback prescription drug plan.

(h) ANNUAL REPORT ON USE OF LIMITED RISK PLANS AND FALLBACK PLANS.—The Secretary shall submit to Congress an annual report that describes instances in which limited risk plans and fallback prescription drug plans were offered under subsections (f) and (g). The Secretary shall include in such report such recommenda-

tions as may be appropriate to limit the need for the provision of such plans and to maximize the assumption of financial risk under section subsection (f).

(i) NONINTERFERENCE.—In order to promote competition under this part and in carrying out this part, the Secretary—

(1) may not interfere with the negotiations between drug manufacturers and pharmacies and PDP sponsors; and

(2) may not require a particular formulary or institute a price structure for the reimbursement of covered part D drugs.

(j) COORDINATION OF BENEFITS.—A PDP sponsor offering a prescription drug plan shall permit State Pharmaceutical Assistance Programs and Rx plans under sections 1860D-23 and 1860D-24 to coordinate benefits with the plan and, in connection with such coordination with such a Program, not to impose fees that are unrelated to the cost of coordination.

REQUIREMENTS FOR AND CONTRACTS WITH PRESCRIPTION DRUG PLAN (PDP) SPONSORS

SEC. 1860D-12. [42 U.S.C. 1395w-112] (a) GENERAL REQUIREMENTS.—Each PDP sponsor of a prescription drug plan shall meet the following requirements:

(1) LICENSURE.—Subject to subsection (c), the sponsor is organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a prescription drug plan.

(2) ASSUMPTION OF FINANCIAL RISK FOR UNSUBSIDIZED COVERAGE.—

(A) IN GENERAL.—Subject to subparagraph (B), to the extent that the entity is at risk the entity assumes financial risk on a prospective basis for benefits that it offers under a prescription drug plan and that is not covered under section 1860D-15(b).

(B) REINSURANCE PERMITTED.—The plan sponsor may obtain insurance or make other arrangements for the cost of coverage provided to any enrollee to the extent that the sponsor is at risk for providing such coverage.

(3) SOLVENCY FOR UNLICENSED SPONSORS.—In the case of a PDP sponsor that is not described in paragraph (1) and for which a waiver has been approved under subsection (c), such sponsor shall meet solvency standards established by the Secretary under subsection (d).

(b) CONTRACT REQUIREMENTS.—

(1) IN GENERAL.—The Secretary shall not permit the enrollment under section 1860D-1 in a prescription drug plan offered by a PDP sponsor under this part, and the sponsor shall not be eligible for payments under section 1860D-14 or 1860D-15, unless the Secretary has entered into a contract under this subsection with the sponsor with respect to the offering of such plan. Such a contract with a sponsor may cover more than one prescription drug plan. Such contract shall provide that the sponsor agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

(2) LIMITATION ON ENTITIES OFFERING FALLBACK PRESCRIPTION DRUG PLANS.—The Secretary shall not enter into a contract with a PDP sponsor for the offering of a prescription drug

plan (other than a fallback prescription drug plan) in a PDP region for a year if the sponsor—

(A) submitted a bid under section 1860D-11(g) for such year (as the first year of a contract period under such section) to offer a fallback prescription drug plan in any PDP region;

(B) offers a fallback prescription drug plan in any PDP region during the year; or

(C) offered a fallback prescription drug plan in that PDP region during the previous year. For purposes of this paragraph, an entity shall be treated as submitting a bid with respect to a prescription drug plan or offering a fallback prescription drug plan if the entity is acting as a subcontractor of a PDP sponsor that is offering such a plan. The previous sentence shall not apply to entities that are subcontractors of an MA organization except insofar as such organization is acting as a PDP sponsor with respect to a prescription drug plan.

(3) INCORPORATION OF CERTAIN MEDICARE ADVANTAGE CONTRACT REQUIREMENTS.—Except as otherwise provided, the following provisions of section 1857 shall apply to contracts under this section in the same manner as they apply to contracts under section 1857(a):

(A) MINIMUM ENROLLMENT.—Paragraphs (1) and (3) of section 1857(b), except that—

(i) the Secretary may increase the minimum number of enrollees required under such paragraph (1) as the Secretary determines appropriate; and

(ii) the requirement of such paragraph (1) shall be waived during the first contract year with respect to an organization in a region.

(B) CONTRACT PERIOD AND EFFECTIVENESS.—Section 1857(c), except that in applying paragraph (4)(B) of such section any reference to payment amounts under section 1853 shall be deemed payment amounts under section 1860D-15.

(C) Protections against fraud and beneficiary protections.—Section 1857(d).

(D) Additional contract terms.—Section 1857(e); except that section 1857(e)(2) shall apply as specified to PDP sponsors and payments under this part to an MA-PD plan shall be treated as expenditures made under part D.

(E) INTERMEDIATE SANCTIONS.—Section 1857(g) (other than paragraph (1)(F) of such section), except that in applying such section the reference in section 1857(g)(1)(B) to section 1854 is deemed a reference to this part.

(F) PROCEDURES FOR TERMINATION.—Section 1857(h).

(c) WAIVER OF CERTAIN REQUIREMENTS TO EXPAND CHOICE.—

(1) AUTHORIZING WAIVER.—

(A) IN GENERAL.—In the case of an entity that seeks to offer a prescription drug plan in a State, the Secretary shall waive the requirement of subsection (a)(1) that the entity be licensed in that State if the Secretary determines, based on the application and other evidence presented to the Secretary, that any of the grounds for ap-

proval of the application described in paragraph (2) have been met.

(B) APPLICATION OF REGIONAL PLAN WAIVER RULE.—In addition to the waiver available under subparagraph (A), the provisions of section 1858(d) shall apply to PDP sponsors under this part in a manner similar to the manner in which such provisions apply to MA organizations under part C, except that no application shall be required under paragraph (1)(B) of such section in the case of a State that does not provide a licensing process for such a sponsor.

(2) GROUNDS FOR APPROVAL.—

(A) IN GENERAL.—The grounds for approval under this paragraph are—

(i) subject to subparagraph (B), the grounds for approval described in subparagraphs (B), (C), and (D) of section 1855(a)(2); and

(ii) the application by a State of any grounds other than those required under Federal law.

(B) SPECIAL RULES.—In applying subparagraph (A)(i)—

(i) the ground of approval described in section 1855(a)(2)(B) is deemed to have been met if the State does not have a licensing process in effect with respect to the PDP sponsor; and

(ii) for plan years beginning before January 1, 2008, if the State does have such a licensing process in effect, such ground for approval described in such section is deemed to have been met upon submission of an application described in such section.

(3) APPLICATION OF WAIVER PROCEDURES.—With respect to an application for a waiver (or a waiver granted) under paragraph (1)(A) of this subsection, the provisions of subparagraphs (E), (F), and (G) of section 1855(a)(2) shall apply, except that clauses (i) and (ii) of such subparagraph (E) shall not apply in the case of a State that does not have a licensing process described in paragraph (2)(B)(i) in effect.

(4) REFERENCES TO CERTAIN PROVISIONS.—In applying provisions of section 1855(a)(2) under paragraphs (2) and (3) of this subsection to prescription drug plans and PDP sponsors—

(A) any reference to a waiver application under section 1855 shall be treated as a reference to a waiver application under paragraph (1)(A) of this subsection; and

(B) any reference to solvency standards shall be treated as a reference to solvency standards established under subsection (d) of this section.

(d) SOLVENCY STANDARDS FOR NON-LICENSED ENTITIES.—

(1) ESTABLISHMENT AND PUBLICATION.—The Secretary, in consultation with the National Association of Insurance Commissioners, shall establish and publish, by not later than January 1, 2005, financial solvency and capital adequacy standards for entities described in paragraph (2).

(2) COMPLIANCE WITH STANDARDS.—A PDP sponsor that is not licensed by a State under subsection (a)(1) and for which a waiver application has been approved under subsection (c) shall meet solvency and capital adequacy standards established under paragraph (1). The Secretary shall establish cer-

tification procedures for such sponsors with respect to such solvency standards in the manner described in section 1855(c)(2).

(e) LICENSURE DOES NOT SUBSTITUTE FOR OR CONSTITUTE CERTIFICATION.—The fact that a PDP sponsor is licensed in accordance with subsection (a)(1) or has a waiver application approved under subsection (c) does not deem the sponsor to meet other requirements imposed under this part for a sponsor.

(f) PERIODIC REVIEW AND REVISION OF STANDARDS.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary may periodically review the standards established under this section and, based on such review, may revise such standards if the Secretary determines such revision to be appropriate.

(2) PROHIBITION OF MIDYEAR IMPLEMENTATION OF SIGNIFICANT NEW REGULATORY REQUIREMENTS.—The Secretary may not implement, other than at the beginning of a calendar year, regulations under this section that impose new, significant regulatory requirements on a PDP sponsor or a prescription drug plan.

(g) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES; RELATION TO STATE LAWS.—The provisions of sections 1854(g) and 1856(b)(3) shall apply with respect to PDP sponsors and prescription drug plans under this part in the same manner as such sections apply to MA organizations and MA plans under part C.

PREMIUMS; LATE ENROLLMENT PENALTY

SEC. 1860D-13. [42 U.S.C. 1395w-113] (a) MONTHLY BENEFICIARY PREMIUM.—

(1) COMPUTATION.—

(A) IN GENERAL.—The monthly beneficiary premium for a prescription drug plan is the base beneficiary premium computed under paragraph (2) as adjusted under this paragraph.

(B) ADJUSTMENT TO REFLECT DIFFERENCE BETWEEN BID AND NATIONAL AVERAGE BID.—

(i) ABOVE AVERAGE BID.—If for a month the amount of the standardized bid amount (as defined in paragraph (5)) exceeds the amount of the adjusted national average monthly bid amount (as defined in clause (iii)), the base beneficiary premium for the month shall be increased by the amount of such excess.

(ii) BELOW AVERAGE BID.—If for a month the amount of the adjusted national average monthly bid amount for the month exceeds the standardized bid amount, the base beneficiary premium for the month shall be decreased by the amount of such excess.

(iii) ADJUSTED NATIONAL AVERAGE MONTHLY BID AMOUNT DEFINED.—For purposes of this subparagraph, the term 'adjusted national average monthly bid amount' means the national average monthly bid amount computed under paragraph (4), as adjusted under section 1860D-15(c)(2).

(C) INCREASE FOR SUPPLEMENTAL PRESCRIPTION DRUG BENEFITS.—The base beneficiary premium shall be increased by the portion of the PDP approved bid that is attributable to supplemental prescription drug benefits.

(D) INCREASE FOR LATE ENROLLMENT PENALTY.—The base beneficiary premium shall be increased by the amount of any late enrollment penalty under subsection (b).

(E) DECREASE FOR LOW-INCOME ASSISTANCE.—The monthly beneficiary premium is subject to decrease in the case of a subsidy eligible individual under section 1860D-14.

(F) UNIFORM PREMIUM.—Except as provided in subparagraphs (D) and (E), the monthly beneficiary premium for a prescription drug plan in a PDP region is the same for all part D eligible individuals enrolled in the plan.

(2) BASE BENEFICIARY PREMIUM.—The base beneficiary premium under this paragraph for a prescription drug plan for a month is equal to the product—

(A) the beneficiary premium percentage (as specified in paragraph (3)); and

(B) the national average monthly bid amount (computed under paragraph (4)) for the month.

(3) BENEFICIARY PREMIUM PERCENTAGE.—For purposes of this subsection, the beneficiary premium percentage for any year is the percentage equal to a fraction—

(A) the numerator of which is 25.5 percent; and

(B) the denominator of which is 100 percent minus a percentage equal to—

(i) the total reinsurance payments which the Secretary estimates are payable under section 1860D-15(b) with respect to the coverage year; divided by

(ii) the sum of—

(I) the amount estimated under clause (i) for the year; and

(II) the total payments which the Secretary estimates will be paid to prescription drug plans and MA-PD plans that are attributable to the standardized bid amount during the year, taking into account amounts paid by the Secretary and enrollees.

(4) COMPUTATION OF NATIONAL AVERAGE MONTHLY BID AMOUNT.—

(A) IN GENERAL.—For each year (beginning with 2006) the Secretary shall compute a national average monthly bid amount equal to the average of the standardized bid amounts (as defined in paragraph (5)) for each prescription drug plan and for each MA-PD plan described in section 1851(a)(2)(A)(i). Such average does not take into account the bids submitted for MSA plans, MA private fee-for-service plan, and specialized MA plans for special needs individuals, PACE programs under section 1894 (pursuant to section 1860D-21(f)), and under reasonable cost reimbursement contracts under section 1876(h) (pursuant to section 1860D-21(e)).

(B) WEIGHTED AVERAGE.—

(i) IN GENERAL.—The monthly national average monthly bid amount computed under subparagraph (A) for a year shall be a weighted average, with the weight for each plan being equal to the average num-

ber of part D eligible individuals enrolled in such plan in the reference month (as defined in section 1858(f)(4)).

(ii) SPECIAL RULE FOR 2006.—For purposes of applying this paragraph for 2006, the Secretary shall establish procedures for determining the weighted average under clause (i) for 2005.

(5) STANDARDIZED BID AMOUNT DEFINED.—For purposes of this subsection, the term "standardized bid amount" means the following:

(A) PRESCRIPTION DRUG PLANS.—

(i) BASIC COVERAGE.—In the case of a prescription drug plan that provides basic prescription drug coverage, the PDP approved bid (as defined in paragraph (6)).

(ii) SUPPLEMENTAL COVERAGE.—In the case of a prescription drug plan that provides supplemental prescription drug coverage, the portion of the PDP approved bid that is attributable to basic prescription drug coverage.

(B) MA-PD PLANS.—In the case of an MA-PD plan, the portion of the accepted bid amount that is attributable to basic prescription drug coverage.

(6) PDP APPROVED BID DEFINED.—For purposes of this part, the term "PDP approved bid" means, with respect to a prescription drug plan, the bid amount approved for the plan under this part.

(b) LATE ENROLLMENT PENALTY.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, in the case of a part D eligible individual described in paragraph (2) with respect to a continuous period of eligibility, there shall be an increase in the monthly beneficiary premium established under subsection (a) in an amount determined under paragraph (3).

(2) INDIVIDUALS SUBJECT TO PENALTY.—A part D eligible individual described in this paragraph is, with respect to a continuous period of eligibility, an individual for whom there is a continuous period of 63 days or longer (all of which in such continuous period of eligibility) beginning on the day after the last date of the individual's initial enrollment period under section 1860D-1(b)(2) and ending on the date of enrollment under a prescription drug plan or MA-PD plan during all of which the individual was not covered under any creditable prescription drug coverage.

(3) AMOUNT OF PENALTY.—

(A) IN GENERAL.—The amount determined under this paragraph for a part D eligible individual for a continuous period of eligibility is the greater of—

(i) an amount that the Secretary determines is actuarially sound for each uncovered month (as defined in subparagraph (B)) in the same continuous period of eligibility; or

(ii) 1 percent of the base beneficiary premium (computed under subsection (a)(2)) for each such uncovered month in such period.

(B) UNCOVERED MONTH DEFINED.—For purposes of this subsection, the term "uncovered month" means, with respect to a part D eligible individual, any month beginning after the end of the initial enrollment period under section 1860D-1(b)(2) unless the individual can demonstrate that the individual had creditable prescription drug coverage (as defined in paragraph (4)) for any portion of such month.

(4) CREDITABLE PRESCRIPTION DRUG COVERAGE DEFINED.—For purposes of this part, the term "creditable prescription drug coverage" means any of the following coverage, but only if the coverage meets the requirement of paragraph (5):

(A) COVERAGE UNDER PRESCRIPTION DRUG PLAN OR MA-PD PLAN .—Coverage under a prescription drug plan or under an MA-PD plan.

(B) MEDICAID.—Coverage under a medicaid plan under title XIX or under a waiver under section 1115.

(C) GROUP HEALTH PLAN.—Coverage under a group health plan, including a health benefits plan under chapter 89 of title 5, United States Code (commonly known as the Federal employees health benefits program), and a qualified retiree prescription drug plan (as defined in section 1860D-22(a)(2)).

(D) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—Coverage under a State pharmaceutical assistance program described in section 1860D-23(b)(1).

(E) VETERANS' COVERAGE OF PRESCRIPTION DRUGS.—Coverage for veterans, and survivors and dependents of veterans, under chapter 17 of title 38, United States Code.

(F) PRESCRIPTION DRUG COVERAGE UNDER MEDIGAP POLICIES.—Coverage under a medicare supplemental policy under section 1882 that provides benefits for prescription drugs (whether or not such coverage conforms to the standards for packages of benefits under section 1882(p)(1)).

(G) MILITARY COVERAGE (INCLUDING TRICARE).—Coverage under chapter 55 of title 10, United States Code.

(H) OTHER COVERAGE.—Such other coverage as the Secretary determines appropriate.

(5) ACTUARIAL EQUIVALENCE REQUIREMENT.—Coverage meets the requirement of this paragraph only if the coverage is determined (in a manner specified by the Secretary) to provide coverage of the cost of prescription drugs the actuarial value of which (as defined by the Secretary) to the individual equals or exceeds the actuarial value of standard prescription drug coverage (as determined under section 1860D-11(c)).

(6) PROCEDURES TO DOCUMENT CREDITABLE PRESCRIPTION DRUG COVERAGE.—

(A) IN GENERAL.—The Secretary shall establish procedures (including the form, manner, and time) for the documentation of creditable prescription drug coverage, including procedures to assist in determining whether coverage meets the requirement of paragraph (5).

(B) DISCLOSURE BY ENTITIES OFFERING CREDITABLE PRESCRIPTION DRUG COVERAGE.—

(i) IN GENERAL.—Each entity that offers prescription drug coverage of the type described in subparagraphs (B) through (H) of paragraph (4) shall provide for disclosure, in a form, manner, and time consistent with standards established by the Secretary, to the Secretary and part D eligible individuals of whether the coverage meets the requirement of paragraph (5) or whether such coverage is changed so it no longer meets such requirement.

(ii) DISCLOSURE OF NON-CREDITABLE COVERAGE.—In the case of such coverage that does not meet such requirement, the disclosure to part D eligible individuals under this subparagraph shall include information regarding the fact that because such coverage does not meet such requirement there are limitations on the periods in a year in which the individuals may enroll under a prescription drug plan or an MA-PD plan and that any such enrollment is subject to a late enrollment penalty under this subsection.

(C) WAIVER OF REQUIREMENT.—In the case of a part D eligible individual who was enrolled in prescription drug coverage of the type described in subparagraphs (B) through (H) of paragraph (4) which is not creditable prescription drug coverage because it does not meet the requirement of paragraph (5), the individual may apply to the Secretary to have such coverage treated as creditable prescription drug coverage if the individual establishes that the individual was not adequately informed that such coverage did not meet such requirement.

(7) CONTINUOUS PERIOD OF ELIGIBILITY.—

(A) IN GENERAL.—Subject to subparagraph (B), for purposes of this subsection, the term "continuous period of eligibility" means, with respect to a part D eligible individual, the period that begins with the first day on which the individual is eligible to enroll in a prescription drug plan under this part and ends with the individual's death.

(B) SEPARATE PERIOD.—Any period during all of which a part D eligible individual is entitled to hospital insurance benefits under part A and—

(i) which terminated in or before the month preceding the month in which the individual attained age 65; or

(ii) for which the basis for eligibility for such entitlement changed between section 226(b) and section 226(a), between 226(b) and section 226A, or between section 226A and section 226(a), shall be a separate continuous period of eligibility with respect to the individual (and each such period which terminates shall be deemed not to have existed for purposes of subsequently applying this paragraph).

(c) COLLECTION OF MONTHLY BENEFICIARY PREMIUMS.—

(1) IN GENERAL.—Subject to paragraphs (2) and (3), the provisions of section 1854(d) shall apply to PDP sponsors and premiums (and any late enrollment penalty) under this part in the same manner as they apply to MA organizations and beneficiary premiums under part C, except that any reference to a

Trust Fund is deemed for this purpose a reference to the Medicare Prescription Drug Account.

(2) CREDITING OF LATE ENROLLMENT PENALTY.—

(A) PORTION ATTRIBUTABLE TO INCREASED ACTUARIAL COSTS.—With respect to late enrollment penalties imposed under subsection (b), the Secretary shall specify the portion of such a penalty that the Secretary estimates is attributable to increased actuarial costs assumed by the PDP sponsor or MA organization (and not taken into account through risk adjustment provided under section 1860D-15(c)(1) or through reinsurance payments under section 1860D-15(b)) as a result of such late enrollment.

(B) COLLECTION THROUGH WITHHOLDING.—In the case of a late enrollment penalty that is collected from a part D eligible individual in the manner described in section 1854(d)(2)(A), the Secretary shall provide that only the portion of such penalty estimated under subparagraph (A) shall be paid to the PDP sponsor or MA organization offering the part D plan in which the individual is enrolled.

(C) COLLECTION BY PLAN.—In the case of a late enrollment penalty that is collected from a part D eligible individual in a manner other than the manner described in section 1854(d)(2)(A), the Secretary shall establish procedures for reducing payments otherwise made to the PDP sponsor or MA organization by an amount equal to the amount of such penalty less the portion of such penalty estimated under subparagraph (A).

(3) FALLBACK PLANS.—In applying this subsection in the case of a fallback prescription drug plan, paragraph (2) shall not apply and the monthly beneficiary premium shall be collected in the manner specified in section 1854(d)(2)(A) (or such other manner as may be provided under section 1840 in the case of monthly premiums under section 1839).

PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME INDIVIDUALS[386]

SEC. 1860D-14. [42 U.S.C. 1395w-114] (a) INCOME-RELATED SUBSIDIES FOR INDIVIDUALS WITH INCOME UP TO 150 PERCENT OF POVERTY LINE.—

(1) INDIVIDUALS WITH INCOME BELOW 135 PERCENT OF POVERTY LINE.—In the case of a subsidy eligible individual (as defined in paragraph (3)) who is determined to have income that is below 135 percent of the poverty line applicable to a family of the size involved and who meets the resources requirement described in paragraph (3)(D) or who is covered under this paragraph under paragraph (3)(B)(i), the individual is entitled under this section to the following:

(A) FULL PREMIUM SUBSIDY.—An income-related premium subsidy equal to—

(i) 100 percent of the amount described in subsection (b)(1), but not to exceed the premium amount specified in subsection (b)(2)(B); plus

[386] See Vol. II, P.L. 108-173, §107(e), with respect to a GAO study regarding impact of assets test for subsidy eligible individuals.

(ii) 80 percent of any late enrollment penalties imposed under section 1860D-13(b) for the first 60 months in which such penalties are imposed for that individual, and 100 percent of any such penalties for any subsequent month.

(B) ELIMINATION OF DEDUCTIBLE.—A reduction in the annual deductible applicable under section 1860D-2(b)(1) to $0.

(C) CONTINUATION OF COVERAGE ABOVE THE INITIAL COVERAGE LIMIT.—The continuation of coverage from the initial coverage limit (under paragraph (3) of section 1860D-2(b)) for expenditures incurred through the total amount of expenditures at which benefits are available under paragraph (4) of such section, subject to the reduced cost-sharing described in subparagraph (D).

(D) REDUCTION IN COST-SHARING BELOW OUT-OF-POCKET THRESHOLD.—

(i) INSTITUTIONALIZED INDIVIDUALS.—In the case of an individual who is a full-benefit dual eligible individual and who is an institutionalized individual or couple (as defined in section 1902(q)(1)(B)), the elimination of any beneficiary coinsurance described in section 1860D-2(b)(2) (for all amounts through the total amount of expenditures at which benefits are available under section 1860D-2(b)(4)).

(ii) LOWEST INCOME DUAL ELIGIBLE INDIVIDUALS.—In the case of an individual not described in clause (i) who is a full-benefit dual eligible individual and whose income does not exceed 100 percent of the poverty line applicable to a family of the size involved, the substitution for the beneficiary coinsurance described in section 1860D-2(b)(2) (for all amounts through the total amount of expenditures at which benefits are available under section 1860D-2(b)(4)) of a copayment amount that does not exceed $1 for a generic drug or a preferred drug that is a multiple source drug (as defined in section 1927(k)(7)(A)(i)) and $3 for any other drug, or, if less, the copayment amount applicable to an individual under clause (iii).

(iii) OTHER INDIVIDUALS.—In the case of an individual not described in clause (i) or (ii), the substitution for the beneficiary coinsurance described in section 1860D—2(b)(2) (for all amounts through the total amount of expenditures at which benefits are available under section 1860D-2(b)(4)) of a copayment amount that does not exceed the copayment amount specified under section 1860D-2(b)(4)(A)(i)(I) for the drug and year involved.

(E) ELIMINATION OF COST-SHARING ABOVE ANNUAL OUT-OF-POCKET THRESHOLD.—The elimination of any cost-sharing imposed under section 1860D-2(b)(4)(A).

(2) OTHER INDIVIDUALS WITH INCOME BELOW 150 PERCENT OF POVERTY LINE.—In the case of a subsidy eligible individual who is not described in paragraph (1), the individual is entitled under this section to the following:

(A) SLIDING SCALE PREMIUM SUBSIDY.—An income-related premium subsidy determined on a linear sliding scale ranging from 100 percent of the amount described in paragraph (1)(A) for individuals with incomes at or below 135 percent of such level to 0 percent of such amount for individuals with incomes at 150 percent of such level.

(B) REDUCTION OF DEDUCTIBLE.—A reduction in the annual deductible applicable under section 1860D-2(b)(1) to $50.

(C) CONTINUATION OF COVERAGE ABOVE THE INITIAL COVERAGE LIMIT.—The continuation of coverage from the initial coverage limit (under paragraph (3) of section 1860D-2(b)) for expenditures incurred through the total amount of expenditures at which benefits are available under paragraph (4) of such section, subject to the reduced coinsurance described in subparagraph (D).

(D) REDUCTION IN COST-SHARING BELOW OUT-OF-POCKET THRESHOLD.—The substitution for the beneficiary coinsurance described in section 1860D-2(b)(2) (for all amounts above the deductible under subparagraph (B) through the total amount of expenditures at which benefits are available under section 1860D-2(b)(4)) of coinsurance of "15 percent" instead of coinsurance of "25 percent" in section 1860D-2(b)(2).

(E) REDUCTION OF COST-SHARING ABOVE ANNUAL OUT-OF-POCKET THRESHOLD.—Subject to subsection (c), the substitution for the cost-sharing imposed under section 1860D-2(b)(4)(A) of a copayment or coinsurance not to exceed the copayment or coinsurance amount specified under section 1860D-2(b)(4)(A)(i)(I) for the drug and year involved.

(3) DETERMINATION OF ELIGIBILITY.—

(A) SUBSIDY ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this part, subject to subparagraph (F), the term "subsidy eligible individual" means a part D eligible individual who—

(i) is enrolled in a prescription drug plan or MA-PD plan;

(ii) has income below 150 percent of the poverty line applicable to a family of the size involved; and

(iii) meets the resources requirement described in subparagraph (D) or (E).

(B) DETERMINATIONS.—

(i) IN GENERAL.—The determination of whether a part D eligible individual residing in a State is a subsidy eligible individual and whether the individual is described in paragraph (1) shall be determined under the State plan under title XIX for the State under section 1935(a) or by the Commissioner of Social Security. There are authorized to be appropriated to the Social Security Administration such sums as may be necessary for the determination of eligibility under this subparagraph.

(ii) EFFECTIVE PERIOD.—Determinations under this subparagraph shall be effective beginning with the month in which the individual applies for a determination that the individual is a subsidy eligible individual

and shall remain in effect for a period specified by the Secretary, but not to exceed 1 year.

(iii) REDETERMINATIONS AND APPEALS THROUGH MEDICAID.—Redeterminations and appeals, with respect to eligibility determinations under clause (i) made under a State plan under title XIX, shall be made in accordance with the frequency of, and manner in which, redeterminations and appeals of eligibility are made under such plan for purposes of medical assistance under such title.

(iv) REDETERMINATIONS AND APPEALS THROUGH COMMISSIONER.—With respect to eligibility determinations under clause (i) made by the Commissioner of Social Security—

(I) redeterminations shall be made at such time or times as may be provided by the Commissioner; and

(II) the Commissioner shall establish procedures for appeals of such determinations that are similar to the procedures described in the third sentence of section 1631(c)(1)(A).

(v) TREATMENT OF MEDICAID BENEFICIARIES.—Subject to subparagraph (F), the Secretary—

(I) shall provide that part D eligible individuals who are full-benefit dual eligible individuals (as defined in section 1935(c)(6)) or who are recipients of supplemental security income benefits under title XVI shall be treated as subsidy eligible individuals described in paragraph (1); and

(II) may provide that part D eligible individuals not described in subclause (I) who are determined for purposes of the State plan under title XIX to be eligible for medical assistance under clause (i), (iii), or (iv) of section 1902(a)(10)(E) are treated as being determined to be subsidy eligible individuals described in paragraph (1). Insofar as the Secretary determines that the eligibility requirements under the State plan for medical assistance referred to in subclause (II) are substantially the same as the requirements for being treated as a subsidy eligible individual described in paragraph (1), the Secretary shall provide for the treatment described in such subclause.

(C) INCOME DETERMINATIONS.—For purposes of applying this section—

(i) in the case of a part D eligible individual who is not treated as a subsidy eligible individual under subparagraph (B)(v), income shall be determined in the manner described in section 1905(p)(1)(B), without regard to the application of section 1902(r)(2); and

(ii) the term "poverty line" has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section. Nothing in clause (i) shall be construed to affect the application of section

1902(r)(2) for the determination of eligibility for medical assistance under title XIX.

(D) RESOURCE STANDARD APPLIED TO FULL LOW-INCOME SUBSIDY TO BE BASED ON THREE TIMES SSI RESOURCE STANDARD.—The resources requirement of this subparagraph is that an individual's resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed—

(i) for 2006 three times the maximum amount of resources that an individual may have and obtain benefits under that program; and

(ii) for a subsequent year the resource limitation established under this clause for the previous year increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year. Any resource limitation established under clause (ii) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

(E) ALTERNATIVE RESOURCE STANDARD.—

(i) IN GENERAL.—The resources requirement of this subparagraph is that an individual's resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed—

(I) for 2006, $10,000 (or $20,000 in the case of the combined value of the individual's assets or resources and the assets or resources of the individual's spouse); and

(II) for a subsequent year the dollar amounts specified in this subclause (or subclause (I)) for the previous year increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year. Any dollar amount established under subclause (II) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

(ii) USE OF SIMPLIFIED APPLICATION FORM AND PROCESS.—The Secretary, jointly with the Commissioner of Social Security, shall—

(I) develop a model, simplified application form and process consistent with clause (iii) for the determination and verification of a part D eligible individual's assets or resources under this subparagraph; and

(II) provide such form to States.

(iii) DOCUMENTATION AND SAFEGUARDS.—Under such process—

(I) the application form shall consist of an attestation under penalty of perjury regarding the level of assets or resources (or combined assets and resources in the case of a married part D eligible individual) and valuations of general classes of assets or resources;

(II) such form shall be accompanied by copies of recent statements (if any) from financial institutions in support of the application; and

(III) matters attested to in the application shall be subject to appropriate methods of verification.

(iv) METHODOLOGY FLEXIBILITY.—The Secretary may permit a State in making eligibility determinations for premium and cost-sharing subsidies under this section to use the same asset or resource methodologies that are used with respect to eligibility for medical assistance for medicare cost-sharing described in section 1905(p) so long as the Secretary determines that the use of such methodologies will not result in any significant differences in the number of individuals determined to be subsidy eligible individuals.

(F) TREATMENT OF TERRITORIAL RESIDENTS.—In the case of a part D eligible individual who is not a resident of the 50 States or the District of Columbia, the individual is not eligible to be a subsidy eligible individual under this section but may be eligible for financial assistance with prescription drug expenses under section 1935(e).

(4) INDEXING DOLLAR AMOUNTS.—

(A) COPAYMENT FOR LOWEST INCOME DUAL ELIGIBLE INDIVIDUALS.—The dollar amounts applied under paragraph (1)(D)(ii)—

(i) for 2007 shall be the dollar amounts specified in such paragraph increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year; or

(ii) for a subsequent year shall be the dollar amounts specified in this clause (or clause (i)) for the previous year increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year. Any amount established under clause (i) or (ii), that is based on an increase of $1 or $3, that is not a multiple of 5 cents or 10 cents, respectively, shall be rounded to the nearest multiple of 5 cents or 10 cents, respectively.

(B) REDUCED DEDUCTIBLE.—The dollar amount applied under paragraph (2)(B)—

(i) for 2007 shall be the dollar amount specified in such paragraph increased by the annual percentage increase described in section 1860D-2(b)(6) for 2007; or

(ii) for a subsequent year shall be the dollar amount specified in this clause (or clause (i)) for the previous year increased by the annual percentage increase described in section 1860D-2(b)(6) for the year involved. Any amount established under clause (i) or (ii) that is not a multiple of $1 shall be rounded to the nearest multiple of $1.

(b) PREMIUM SUBSIDY AMOUNT.—

(1) IN GENERAL.—The premium subsidy amount described in this subsection for a subsidy eligible individual residing in a PDP region and enrolled in a prescription drug plan or MA-PD plan is the low-income benchmark premium amount (as defined in paragraph (2)) for the PDP region in which the individual resides or, if greater, the amount specified in paragraph (3).

(2) LOW-INCOME BENCHMARK PREMIUM AMOUNT DEFINED.—

(A) IN GENERAL.—For purposes of this subsection, the term "low-income benchmark premium amount" means, with respect to a PDP region in which—

(i) all prescription drug plans are offered by the same PDP sponsor, the weighted average of the amounts described in subparagraph (B)(i) for such plans; or

(ii) there are prescription drug plans offered by more than one PDP sponsor, the weighted average of amounts described in subparagraph (B) for prescription drug plans and MA-PD plans described in section 1851(a)(2)(A)(i) offered in such region.

(B) PREMIUM AMOUNTS DESCRIBED.—The premium amounts described in this subparagraph are, in the case of—

(i) a prescription drug plan that is a basic prescription drug plan, the monthly beneficiary premium for such plan;

(ii) a prescription drug plan that provides alternative prescription drug coverage the actuarial value of which is greater than that of standard prescription drug coverage, the portion of the monthly beneficiary premium that is attributable to basic prescription drug coverage; and

(iii) an MA-PD plan, the portion of the MA monthly prescription drug beneficiary premium that is attributable to basic prescription drug benefits (described in section 1852(a)(6)(B)(ii)). The premium amounts described in this subparagraph do not include any amounts attributable to late enrollment penalties under section 1860D-13(b).

(3) ACCESS TO 0 PREMIUM PLAN.—In no case shall the premium subsidy amount under this subsection for a PDP region be less than the lowest monthly beneficiary premium for a prescription drug plan that offers basic prescription drug coverage in the region.

(c) ADMINISTRATION OF SUBSIDY PROGRAM.—

(1) IN GENERAL.—The Secretary shall provide a process whereby, in the case of a part D eligible individual who is determined to be a subsidy eligible individual and who is enrolled in a prescription drug plan or is enrolled in an MA-PD plan—

(A) the Secretary provides for a notification of the PDP sponsor or the MA organization offering the plan involved that the individual is eligible for a subsidy and the amount of the subsidy under subsection (a);

(B) the sponsor or organization involved reduces the premiums or cost-sharing otherwise imposed by the amount of the applicable subsidy and submits to the Secretary information on the amount of such reduction;

(C) the Secretary periodically and on a timely basis reimburses the sponsor or organization for the amount of such reductions; and

(D) the Secretary ensures the confidentiality of individually identifiable information. In applying subparagraph (C), the Secretary shall compute reductions based upon im-

position under subsections (a)(1)(D) and (a)(2)(E) of unreduced copayment amounts applied under such subsections.

(2) USE OF CAPITATED FORM OF PAYMENT.—The reimbursement under this section with respect to cost-sharing subsidies may be computed on a capitated basis, taking into account the actuarial value of the subsidies and with appropriate adjustments to reflect differences in the risks actually involved.

(d) RELATION TO MEDICAID PROGRAM.—For special provisions under the medicaid program relating to medicare prescription drug benefits, see section 1935.

SUBSIDIES FOR PART D ELIGIBLE INDIVIDUALS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE

SEC. 1860D-15. [42 U.S.C. 1395w-115] (a) SUBSIDY PAYMENT.—In order to reduce premium levels applicable to qualified prescription drug coverage for part D eligible individuals consistent with an overall subsidy level of 74.5 percent for basic prescription drug coverage, to reduce adverse selection among prescription drug plans and MA-PD plans, and to promote the participation of PDP sponsors under this part and MA organizations under part C, the Secretary shall provide for payment to a PDP sponsor that offers a prescription drug plan and an MA organization that offers an MA-PD plan of the following subsidies in accordance with this section:

(1) DIRECT SUBSIDY.—A direct subsidy for each part D eligible individual enrolled in a prescription drug plan or MA-PD plan for a month equal to—

(A) the amount of the plan's standardized bid amount (as defined in section 1860D-13(a)(5)), adjusted under subsection (c)(1), reduced by

(B) the base beneficiary premium (as computed under paragraph (2) of section 1860D-13(a) and as adjusted under paragraph (1)(B) of such section).

(2) SUBSIDY THROUGH REINSURANCE.—The reinsurance payment amount (as defined in subsection (b)). This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this section.

(b) REINSURANCE PAYMENT AMOUNT.—

(1) IN GENERAL.—The reinsurance payment amount under this subsection for a part D eligible individual enrolled in a prescription drug plan or MA-PD plan for a coverage year is an amount equal to 80 percent of the allowable reinsurance costs (as specified in paragraph (2)) attributable to that portion of gross covered prescription drug costs as specified in paragraph (3) incurred in the coverage year after such individual has incurred costs that exceed the annual out-of-pocket threshold specified in section 1860D-2(b)(4)(B).

(2) ALLOWABLE REINSURANCE COSTS.—For purposes of this section, the term "allowable reinsurance costs" means, with respect to gross covered prescription drug costs under a prescription drug plan offered by a PDP sponsor or an MA-PD plan offered by an MA organization, the part of such costs that are actually paid (net of discounts, chargebacks, and average percentage rebates) by the sponsor or organization or by (or on behalf of) an enrollee under the plan, but in no case more than

the part of such costs that would have been paid under the plan if the prescription drug coverage under the plan were basic prescription drug coverage, or, in the case of a plan providing supplemental prescription drug coverage, if such coverage were standard prescription drug coverage.

(3) GROSS COVERED PRESCRIPTION DRUG COSTS.—For purposes of this section, the term "gross covered prescription drug costs" means, with respect to a part D eligible individual enrolled in a prescription drug plan or MA-PD plan during a coverage year, the costs incurred under the plan, not including administrative costs, but including costs directly related to the dispensing of covered part D drugs during the year and costs relating to the deductible. Such costs shall be determined whether they are paid by the individual or under the plan, regardless of whether the coverage under the plan exceeds basic prescription drug coverage.

(4) COVERAGE YEAR DEFINED.—For purposes of this section, the term "coverage year" means a calendar year in which covered part D drugs are dispensed if the claim for such drugs (and payment on such claim) is made not later than such period after the end of such year as the Secretary specifies.

(c) ADJUSTMENTS RELATING TO BIDS.—

(1) HEALTH STATUS RISK ADJUSTMENT.—

(A) ESTABLISHMENT OF RISK ADJUSTORS.—The Secretary shall establish an appropriate methodology for adjusting the standardized bid amount under subsection (a)(1)(A) to take into account variation in costs for basic prescription drug coverage among prescription drug plans and MA-PD plans based on the differences in actuarial risk of different enrollees being served. Any such risk adjustment shall be designed in a manner so as not to result in a change in the aggregate amounts payable to such plans under subsection (a)(1) and through that portion of the monthly beneficiary prescription drug premiums described in subsection (a)(1)(B) and MA monthly prescription drug beneficiary premiums.

(B) CONSIDERATIONS.—In establishing the methodology under subparagraph (A), the Secretary may take into account the similar methodologies used under section 1853(a)(3) to adjust payments to MA organizations for benefits under the original medicare fee-for-service program option.

(C) DATA COLLECTION.—In order to carry out this paragraph, the Secretary shall require—

(i) PDP sponsors to submit data regarding drug claims that can be linked at the individual level to part A and part B data and such other information as the Secretary determines necessary; and

(ii) MA organizations that offer MA-PD plans to submit data regarding drug claims that can be linked at the individual level to other data that such organizations are required to submit to the Secretary and such other information as the Secretary determines necessary.

(D) PUBLICATION.—At the time of publication of risk adjustment factors under section 1853(b)(1)(B)(i)(II), the Sec-

retary shall publish the risk adjusters established under this paragraph for the succeeding year.

(2) GEOGRAPHIC ADJUSTMENT.—

(A) IN GENERAL.—Subject to subparagraph (B), for purposes of section 1860D-13(a)(1)(B)(iii), the Secretary shall establish an appropriate methodology for adjusting the national average monthly bid amount (computed under section 1860D-13(a)(4)) to take into account differences in prices for covered part D drugs among PDP regions.

(B) DE MINIMIS RULE.—If the Secretary determines that the price variations described in subparagraph (A) among PDP regions are de minimis, the Secretary shall not provide for adjustment under this paragraph.

(C) BUDGET NEUTRAL ADJUSTMENT.—Any adjustment under this paragraph shall be applied in a manner so as to not result in a change in the aggregate payments made under this part that would have been made if the Secretary had not applied such adjustment.

(d) PAYMENT METHODS.—

(1) IN GENERAL.—Payments under this section shall be based on such a method as the Secretary determines. The Secretary may establish a payment method by which interim payments of amounts under this section are made during a year based on the Secretary's best estimate of amounts that will be payable after obtaining all of the information.

(2) REQUIREMENT FOR PROVISION OF INFORMATION.—

(A) REQUIREMENT.—Payments under this section to a PDP sponsor or MA organization are conditioned upon the furnishing to the Secretary, in a form and manner specified by the Secretary, of such information as may be required to carry out this section.

(B) RESTRICTION ON USE OF INFORMATION.—Information disclosed or obtained pursuant to subparagraph (A) may be used by officers, employees, and contractors of the Department of Health and Human Services only for the purposes of, and to the extent necessary in, carrying out this section.

(3) SOURCE OF PAYMENTS.—Payments under this section shall be made from the Medicare Prescription Drug Account.

(4) Application of enrollee adjustment.—The provisions of section 1853(a)(2) shall apply to payments to PDP sponsors under this section in the same manner as they apply to payments to MA organizations under section 1853(a).

(e) PORTION OF TOTAL PAYMENTS TO A SPONSOR OR ORGANIZATION SUBJECT TO RISK (APPLICATION OF RISK CORRIDORS).—

(1) COMPUTATION OF ADJUSTED ALLOWABLE RISK CORRIDOR COSTS.—

(A) IN GENERAL.—For purposes of this subsection, the term "adjusted allowable risk corridor costs" means, for a plan for a coverage year (as defined in subsection (b)(4))—

(i) the allowable risk corridor costs (as defined in subparagraph (B)) for the plan for the year, reduced by

(ii) the sum of (I) the total reinsurance payments made under subsection (b) to the sponsor of the plan for the year, and (II) the total subsidy payments made

under section 1860D-14 to the sponsor of the plan for the year.

(B) ALLOWABLE RISK CORRIDOR COSTS.—For purposes of this subsection, the term "allowable risk corridor costs" means, with respect to a prescription drug plan offered by a PDP sponsor or an MA-PD plan offered by an MA organization, the part of costs (not including administrative costs, but including costs directly related to the dispensing of covered part D drugs during the year) incurred by the sponsor or organization under the plan that are actually paid (net of discounts, chargebacks, and average percentage rebates) by the sponsor or organization under the plan, but in no case more than the part of such costs that would have been paid under the plan if the prescription drug coverage under the plan were basic prescription drug coverage, or, in the case of a plan providing supplemental prescription drug coverage, if such coverage were basic prescription drug coverage taking into account the adjustment under section 1860D-11(c)(2). In computing allowable costs under this paragraph, the Secretary shall compute such costs based upon imposition under paragraphs (1)(D) and (2)(E) of section 1860D-14(a) of the maximum amount of copayments permitted under such paragraphs.

(2) ADJUSTMENT OF PAYMENT.—

(A) NO ADJUSTMENT IF ADJUSTED ALLOWABLE RISK CORRIDOR COSTS WITHIN RISK CORRIDOR.—If the adjusted allowable risk corridor costs (as defined in paragraph (1)) for the plan for the year are at least equal to the first threshold lower limit of the risk corridor (specified in paragraph (3)(A)(i)), but not greater than the first threshold upper limit of the risk corridor (specified in paragraph (3)(A)(iii)) for the plan for the year, then no payment adjustment shall be made under this subsection.

(B) INCREASE IN PAYMENT IF ADJUSTED ALLOWABLE RISK CORRIDOR COSTS ABOVE UPPER LIMIT OF RISK CORRIDOR.—

(i) COSTS BETWEEN FIRST AND SECOND THRESHOLD UPPER LIMITS.—If the adjusted allowable risk corridor costs for the plan for the year are greater than the first threshold upper limit, but not greater than the second threshold upper limit, of the risk corridor for the plan for the year, the Secretary shall increase the total of the payments made to the sponsor or organization offering the plan for the year under this section by an amount equal to 50 percent (or, for 2006 and 2007, 75 percent or 90 percent if the conditions described in clause (iii) are met for the year) of the difference between such adjusted allowable risk corridor costs and the first threshold upper limit of the risk corridor.

(ii) COSTS ABOVE SECOND THRESHOLD UPPER LIMITS.—If the adjusted allowable risk corridor costs for the plan for the year are greater than the second threshold upper limit of the risk corridor for the plan for the year, the Secretary shall increase the total of the payments made to the sponsor or organization of-

fering the plan for the year under this section by an amount equal to the sum of—

(I) 50 percent (or, for 2006 and 2007, 75 percent or 90 percent if the conditions described in clause (iii) are met for the year) of the difference between the second threshold upper limit and the first threshold upper limit; and

(II) 80 percent of the difference between such adjusted allowable risk corridor costs and the second threshold upper limit of the risk corridor.

(iii) CONDITIONS FOR APPLICATION OF HIGHER PERCENTAGE FOR 2006 AND 2007.—The conditions described in this clause are met for 2006 or 2007 if the Secretary determines with respect to such year that—

(I) at least 60 percent of prescription drug plans and MA-PD plans to which this subsection applies have adjusted allowable risk corridor costs for the plan for the year that are more than the first threshold upper limit of the risk corridor for the plan for the year; and

(II) such plans represent at least 60 percent of part D eligible individuals enrolled in any prescription drug plan or MA-PD plan.

(C) REDUCTION IN PAYMENT IF ADJUSTED ALLOWABLE RISK CORRIDOR COSTS BELOW LOWER LIMIT OF RISK CORRIDOR.—

(i) COSTS BETWEEN FIRST AND SECOND THRESHOLD LOWER LIMITS.—If the adjusted allowable risk corridor costs for the plan for the year are less than the first threshold lower limit, but not less than the second threshold lower limit, of the risk corridor for the plan for the year, the Secretary shall reduce the total of the payments made to the sponsor or organization offering the plan for the year under this section by an amount (or otherwise recover from the sponsor or organization an amount) equal to 50 percent (or, for 2006 and 2007, 75 percent) of the difference between the first threshold lower limit of the risk corridor and such adjusted allowable risk corridor costs.

(ii) COSTS BELOW SECOND THRESHOLD LOWER LIMIT.—If the adjusted allowable risk corridor costs for the plan for the year are less the second threshold lower limit of the risk corridor for the plan for the year, the Secretary shall reduce the total of the payments made to the sponsor or organization offering the plan for the year under this section by an amount (or otherwise recover from the sponsor or organization an amount) equal to the sum of—

(I) 50 percent (or, for 2006 and 2007, 75 percent) of the difference between the first threshold lower limit and the second threshold lower limit; and

(II) 80 percent of the difference between the second threshold upper limit of the risk corridor and such adjusted allowable risk corridor costs.

(3) ESTABLISHMENT OF RISK CORRIDORS.—

(A) IN GENERAL.—For each plan year the Secretary shall establish a risk corridor for each prescription drug plan and each MA-PD plan. The risk corridor for a plan for a year shall be equal to a range as follows:

(i) FIRST THRESHOLD LOWER LIMIT.—The first threshold lower limit of such corridor shall be equal to—

(I) the target amount described in subparagraph (B) for the plan; minus

(II) an amount equal to the first threshold risk percentage for the plan (as determined under subparagraph (C)(i)) of such target amount.

(ii) SECOND THRESHOLD LOWER LIMIT.—The second threshold lower limit of such corridor shall be equal to—

(I) the target amount described in subparagraph (B) for the plan; minus

(II) an amount equal to the second threshold risk percentage for the plan (as determined under subparagraph (C)(ii)) of such target amount.

(iii) FIRST THRESHOLD UPPER LIMIT.—The first threshold upper limit of such corridor shall be equal to the sum of—

(I) such target amount; and

(II) the amount described in clause (i)(II).

(iv) SECOND THRESHOLD UPPER LIMIT.—The second threshold upper limit of such corridor shall be equal to the sum of—

(I) such target amount; and

(II) the amount described in clause (ii)(II).

(B) TARGET AMOUNT DESCRIBED.—The target amount described in this paragraph is, with respect to a prescription drug plan or an MA-PD plan in a year, the total amount of payments paid to the PDP sponsor or MA-PD organization for the plan for the year, taking into account amounts paid by the Secretary and enrollees, based upon the standardized bid amount (as defined in section 1860D-13(a)(5) and as risk adjusted under subsection (c)(1)), reduced by the total amount of administrative expenses for the year assumed in such standardized bid.

(C) FIRST AND SECOND THRESHOLD RISK PERCENTAGE DEFINED.—

(i) FIRST THRESHOLD RISK PERCENTAGE.—Subject to clause (iii), for purposes of this section, the first threshold risk percentage is—

(I) for 2006 and 2007, and 2.5 percent;

(II) for 2008 through 2011, 5 percent; and

(III) for 2012 and subsequent years, a percentage established by the Secretary, but in no case less than 5 percent.

(ii) SECOND THRESHOLD RISK PERCENTAGE.—Subject to clause (iii), for purposes of this section, the second threshold risk percentage is—

(I) for 2006 and 2007, 5 percent;

(II) for 2008 through 2011, 10 percent; and

(III) for 2012 and subsequent years, a percentage established by the Secretary that is

greater than the percent established for the year under clause (i)(III), but in no case less than 10 percent.

(iii) REDUCTION OF RISK PERCENTAGE TO ENSURE 2 PLANS IN AN AREA.—Pursuant to section 1860D-11(b)(2)(E)(ii), a PDP sponsor may submit a bid that requests a decrease in the applicable first or second threshold risk percentages or an increase in the percents applied under paragraph (2).

(4) PLANS AT RISK FOR ENTIRE AMOUNT OF SUPPLEMENTAL PRESCRIPTION DRUG COVERAGE.—A PDP sponsor and MA organization that offers a plan that provides supplemental prescription drug benefits shall be at full financial risk for the provision of such supplemental benefits.

(5) NO EFFECT ON MONTHLY PREMIUM.—No adjustment in payments made by reason of this subsection shall affect the monthly beneficiary premium or the MA monthly prescription drug beneficiary premium.

(f) DISCLOSURE OF INFORMATION.—

(1) IN GENERAL.—Each contract under this part and under part C shall provide that—

(A) the PDP sponsor offering a prescription drug plan or an MA organization offering an MA-PD plan shall provide the Secretary with such information as the Secretary determines is necessary to carry out this section; and

(B) the Secretary shall have the right in accordance with section 1857(d)(2)(B) (as applied under section 1860D-12(b)(3)(C)) to inspect and audit any books and records of a PDP sponsor or MA organization that pertain to the information regarding costs provided to the Secretary under subparagraph (A).

(2) RESTRICTION ON USE OF INFORMATION.—Information disclosed or obtained pursuant to the provisions of this section may be used by officers, employees, and contractors of the Department of Health and Human Services only for the purposes of, and to the extent necessary in, carrying out this section.

(g) PAYMENT FOR FALLBACK PRESCRIPTION DRUG PLANS.—In lieu of the amounts otherwise payable under this section to a PDP sponsor offering a fallback prescription drug plan (as defined in section 1860D-3(c)(4)), the amount payable shall be the amounts determined under the contract for such plan pursuant to section 1860D-11(g)(5).

MEDICARE PRESCRIPTION DRUG ACCOUNT IN THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

SEC. 1860D-16. [42 U.S.C. 1395w-116] (a) ESTABLISHMENT AND OPERATION OF ACCOUNT.—

(1) ESTABLISHMENT.—There is created within the Federal Supplementary Medical Insurance Trust Fund established by section 1841 an account to be known as the "Medicare Prescription Drug Account" (in this section referred to as the "Account").

(2) FUNDING.—The Account shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), accrued interest on balances in the Account, and such amounts as may

be deposited in, or appropriated to, such Account as provided in this part.

(3) SEPARATE FROM REST OF TRUST FUND.—Funds provided under this part to the Account shall be kept separate from all other funds within the Federal Supplementary Medical Insurance Trust Fund, but shall be invested, and such investments redeemed, in the same manner as all other funds and investments within such Trust Fund.

(b) PAYMENTS FROM ACCOUNT.—

(1) IN GENERAL.—The Managing Trustee shall pay from time to time from the Account such amounts as the Secretary certifies are necessary to make payments to operate the program under this part, including—

(A) payments under section 1860D-14 (relating to low-income subsidy payments);

(B) payments under section 1860D-15 (relating to subsidy payments and payments for fallback plans);

(C) payments to sponsors of qualified retiree prescription drug plans under section 1860D-22(a); and

(D) payments with respect to administrative expenses under this part in accordance with section 201(g).

(2) TRANSFERS TO MEDICAID ACCOUNT FOR INCREASED ADMINISTRATIVE COSTS.—The Managing Trustee shall transfer from time to time from the Account to the Grants to States for Medicaid account amounts the Secretary certifies are attributable to increases in payment resulting from the application of section 1935(b).

(3) PAYMENTS OF PREMIUMS WITHHELD.—The Managing Trustee shall make payment to the PDP sponsor or MA organization involved of the premiums (and the portion of late enrollment penalties) that are collected in the manner described in section 1854(d)(2)(A) and that are payable under a prescription drug plan or MA-PD plan offered by such sponsor or organization.

(4) TREATMENT IN RELATION TO PART B PREMIUM.—Amounts payable from the Account shall not be taken into account in computing actuarial rates or premium amounts under section 1839.

(c) DEPOSITS INTO ACCOUNT.—

(1) LOW-INCOME TRANSFER.—Amounts paid under section 1935(c) (and any amounts collected or offset under paragraph (1)(C) of such section) are deposited into the Account.

(2) AMOUNTS WITHHELD.—Pursuant to sections 1860D-13(c) and 1854(d) (as applied under this part), amounts that are withheld (and allocated) to the Account are deposited into the Account.

(3) APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Account, an amount equivalent to the amount of payments made from the Account under subsection (b) plus such amounts as the Managing Trustee certifies is necessary to maintain an appropriate contingency margin, reduced by the amounts deposited under paragraph (1) or subsection (a)(2).

(4) INITIAL FUNDING AND RESERVE.—In order to assure prompt payment of benefits provided under this part and the

administrative expenses thereunder during the early months of the program established by this part and to provide an initial contingency reserve, there are authorized to be appropriated to the Account, out of any moneys in the Treasury not otherwise appropriated, such amount as the Secretary certifies are required, but not to exceed 10 percent of the estimated total expenditures from such Account in 2006.

(5) TRANSFER OF ANY REMAINING BALANCE FROM TRANSITIONAL ASSISTANCE ACCOUNT.—Any balance in the Transitional Assistance Account that is transferred under section 1860D-31(k)(5) shall be deposited into the Account.

Subpart 3—Application to Medicare Advantage Program and Treatment of Employer-Sponsored Programs and Other Prescription Drug Plans

APPLICATION TO MEDICARE ADVANTAGE PROGRAM AND RELATED MANAGED CARE PROGRAMS

SEC. 1860D-21. [42 U.S.C. 1395w-131] (a) SPECIAL RULES RELATING TO OFFERING OF QUALIFIED PRESCRIPTION DRUG COVERAGE.—

(1) IN GENERAL.—An MA organization on and after January 1, 2006—

(A) may not offer an MA plan described in section 1851(a)(2)(A) in an area unless either that plan (or another MA plan offered by the organization in that same service area) includes required prescription drug coverage (as defined in paragraph (2)); and

(B) may not offer prescription drug coverage (other than that required under parts A and B) to an enrollee—

(i) under an MSA plan; or

(ii) under another MA plan unless such drug coverage under such other plan provides qualified prescription drug coverage and unless the requirements of this section with respect to such coverage are met.

(2) QUALIFYING COVERAGE.—For purposes of paragraph (1)(A), the term "required coverage" means with respect to an MA-PD plan—

(A) basic prescription drug coverage; or

(B) qualified prescription drug coverage that provides supplemental prescription drug coverage, so long as there is no MA monthly supplemental beneficiary premium applied under the plan (due to the application of a credit against such premium of a rebate under section 1854(b)(1)(C)).

(b) APPLICATION OF DEFAULT ENROLLMENT RULES.—

(1) SEAMLESS CONTINUATION.—In applying section 1851(c)(3)(A)(ii), an individual who is enrolled in a health benefits plan shall not be considered to have been deemed to make an election into an MA-PD plan unless such health benefits plan provides any prescription drug coverage.

(2) MA CONTINUATION.—In applying section 1851(c)(3)(B), an individual who is enrolled in an MA plan shall not be considered to have been deemed to make an election into an MA-PD plan unless—

(A) for purposes of the election as of January 1, 2006, the MA plan provided as of December 31, 2005, any prescription drug coverage; or

(B) for periods after January 1, 2006, such MA plan is an MA-PD plan.

(3) DISCONTINUANCE OF MA-PD ELECTION DURING FIRST YEAR OF ELIGIBILITY.—In applying the second sentence of section 1851(e)(4) in the case of an individual who is electing to discontinue enrollment in an MA-PD plan, the individual shall be permitted to enroll in a prescription drug plan under part D at the time of the election of coverage under the original medicare fee-for-service program.

(4) RULES REGARDING ENROLLEES IN MA PLANS NOT PROVIDING QUALIFIED PRESCRIPTION DRUG COVERAGE.—In the case of an individual who is enrolled in an MA plan (other than an MSA plan) that does not provide qualified prescription drug coverage, if the organization offering such coverage discontinues the offering with respect to the individual of all MA plans that do not provide such coverage—

(i) the individual is deemed to have elected the original medicare fee-for-service program option, unless the individual affirmatively elects to enroll in an MA-PD plan; and

(ii) in the case of such a deemed election, the disenrollment shall be treated as an involuntary termination of the MA plan described in subparagraph (B)(ii) of section 1882(s)(3) for purposes of applying such section. The information disclosed under section 1852(c)(1) for individuals who are enrolled in such an MA plan shall include information regarding such rules.

(c) APPLICATION OF PART D RULES FOR PRESCRIPTION DRUG COVERAGE.—With respect to the offering of qualified prescription drug coverage by an MA organization under this part on and after January 1, 2006—

(1) IN GENERAL.—Except as otherwise provided, the provisions of this part shall apply under part C with respect to prescription drug coverage provided under MA-PD plans in lieu of the other provisions of part C that would apply to such coverage under such plans.

(2) WAIVER.—The Secretary shall waive the provisions referred to in paragraph (1) to the extent the Secretary determines that such provisions duplicate, or are in conflict with, provisions otherwise applicable to the organization or plan under part C or as may be necessary in order to improve coordination of this part with the benefits under this part.

(3) TREATMENT OF MA OWNED AND OPERATED PHARMACIES.—The Secretary may waive the requirement of section 1860D-4(b)(1)(C) in the case of an MA-PD plan that provides access (other than mail order) to qualified prescription drug coverage through pharmacies owned and operated by the MA organization, if the Secretary determines that the organization's pharmacy network is sufficient to provide comparable access for enrollees under the plan.

(d) SPECIAL RULES FOR PRIVATE FEE-FOR-SERVICE PLANS THAT OFFER PRESCRIPTION DRUG COVERAGE.—With respect to an MA

plan described in section 1851(a)(2)(C) that offers qualified prescription drug coverage, on and after January 1, 2006, the following rules apply:

(1) REQUIREMENTS REGARDING NEGOTIATED PRICES.—Subsections (a)(1) and (d)(1) of section 1860D-2 and section 1860D-4(b)(2)(A) shall not be construed to require the plan to provide negotiated prices (described in subsection (d)(1)(B) of such section), but shall apply to the extent the plan does so.

(2) MODIFICATION OF PHARMACY ACCESS STANDARD AND DISCLOSURE REQUIREMENT.—If the plan provides coverage for drugs purchased from all pharmacies, without charging additional cost-sharing, and without regard to whether they are participating pharmacies in a network or have entered into contracts or agreements with pharmacies to provide drugs to enrollees covered by the plan, subsections (b)(1)(C) and (k) of section 1860D-4 shall not apply to the plan.

(3) DRUG UTILIZATION MANAGEMENT PROGRAM AND MEDICATION THERAPY MANAGEMENT PROGRAM NOT REQUIRED.—The requirements of subparagraphs (A) and (C) of section 1860D-4(c)(1) shall not apply to the plan.

(4) APPLICATION OF REINSURANCE.—The Secretary shall determine the amount of reinsurance payments under section 1860D-15(b) using a methodology that—

(A) bases such amount on the Secretary's estimate of the amount of such payments that would be payable if the plan were an MA-PD plan described in section 1851(a)(2)(A)(i) and the previous provisions of this subsection did not apply; and

(B) takes into account the average reinsurance payments made under section 1860D-15(b) for populations of similar risk under MA-PD plans described in such section.

(5) EXEMPTION FROM RISK CORRIDOR PROVISIONS.—The provisions of section 1860D-15(e) shall not apply.

(6) EXEMPTION FROM NEGOTIATIONS.—Subsections (d) and (e)(2)(C) of section 1860D-11 shall not apply and the provisions of section 1854(a)(5)(B) prohibiting the review, approval, or disapproval of amounts described in such section shall apply to the proposed bid and terms and conditions described in section 1860D-11(d).

(7) TREATMENT OF INCURRED COSTS WITHOUT REGARD TO FORMULARY.—The exclusion of costs incurred for covered part D drugs which are not included (or treated as being included) in a plan's formulary under section 1860D-2(b)(4)(B)(i) shall not apply insofar as the plan does not utilize a formulary.

(e) APPLICATION TO REASONABLE COST REIMBURSEMENT CONTRACTORS.—

(1) IN GENERAL.—Subject to paragraphs (2) and (3) and rules established by the Secretary, in the case of an organization that is providing benefits under a reasonable cost reimbursement contract under section 1876(h) and that elects to provide qualified prescription drug coverage to a part D eligible individual who is enrolled under such a contract, the provisions of this part (and related provisions of part C) shall apply to the provision of such coverage to such enrollee in the same manner as such provisions apply to the provision of such coverage under an MA-PD local plan described in section 1851(a)(2)(A)(i)

and coverage under such a contract that so provides qualified prescription drug coverage shall be deemed to be an MA- PD local plan.

(2) LIMITATION ON ENROLLMENT.—In applying paragraph (1), the organization may not enroll part D eligible individuals who are not enrolled under the reasonable cost reimbursement contract involved.

(3) BIDS NOT INCLUDED IN DETERMINING NATIONAL AVERAGE MONTHLY BID AMOUNT.—The bid of an organization offering prescription drug coverage under this subsection shall not be taken into account in computing the national average monthly bid amount and low-income benchmark premium amount under this part.

(f) APPLICATION TO PACE.—

(1) IN GENERAL.—Subject to paragraphs (2) and (3) and rules established by the Secretary, in the case of a PACE program under section 1894 that elects to provide qualified prescription drug coverage to a part D eligible individual who is enrolled under such program, the provisions of this part (and related provisions of part C) shall apply to the provision of such coverage to such enrollee in a manner that is similar to the manner in which such provisions apply to the provision of such coverage under an MAPD local plan described in section 1851(a)(2)(A)(ii) and a PACE program that so provides such coverage may be deemed to be an MA-PD local plan.

(2) LIMITATION ON ENROLLMENT.—In applying paragraph (1), the organization may not enroll part D eligible individuals who are not enrolled under the PACE program involved.

(3) BIDS NOT INCLUDED IN DETERMINING STANDARDIZED BID AMOUNT.—The bid of an organization offering prescription drug coverage under this subsection is not be taken into account in computing any average benchmark bid amount and low-income benchmark premium amount under this part.

SPECIAL RULES FOR EMPLOYER-SPONSORED PROGRAMS[387]

SEC. 1860D-22. [42 U.S.C. 1395w-132] (a) SUBSIDY PAYMENT.—

(1) IN GENERAL.—The Secretary shall provide in accordance with this subsection for payment to the sponsor of a qualified retiree prescription drug plan (as defined in paragraph (2)) of a special subsidy payment equal to the amount specified in paragraph (3) for each qualified covered retiree under the plan (as defined in paragraph (4)). This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this section.

(2) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN DEFINED.—For purposes of this subsection, the term "qualified retiree prescription drug plan" means employment-based retiree health coverage (as defined in subsection (c)(1)) if, with respect to a part D eligible individual who is a participant or beneficiary under such coverage, the following requirements are met:

(A) ATTESTATION OF ACTUARIAL EQUIVALENCE TO STANDARD COVERAGE.—The sponsor of the plan provides the Sec-

[387] See Vol. II, P.L. 108-173, §111, with respect to a study on employment-based retireee health coverage.

retary, annually or at such other time as the Secretary may require, with an attestation that the actuarial value of prescription drug coverage under the plan (as determined using the processes and methods described in section 1860D-11(c)) is at least equal to the actuarial value of standard prescription drug coverage.

(B) AUDITS.—The sponsor of the plan, or an administrator of the plan designated by the sponsor, shall maintain (and afford the Secretary access to) such records as the Secretary may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage and the accuracy of payments made under this section. The provisions of section 1860D-2(d)(3) shall apply to such information under this section (including such actuarial value and attestation) in a manner similar to the manner in which they apply to financial records of PDP sponsors and MA organizations.

(C) PROVISION OF DISCLOSURE REGARDING PRESCRIPTION DRUG COVERAGE.—The sponsor of the plan shall provide for disclosure of information regarding prescription drug coverage in accordance with section 1860D-13(b)(6)(B).

(3) EMPLOYER AND UNION SPECIAL SUBSIDY AMOUNTS.—

(A) IN GENERAL.—For purposes of this subsection, the special subsidy payment amount under this paragraph for a qualifying covered retiree for a coverage year enrolled with the sponsor of a qualified retiree prescription drug plan is, for the portion of the retiree's gross covered retiree plan-related prescription drug costs (as defined in subparagraph (C)(ii)) for such year that exceeds the cost threshold amount specified in subparagraph (B) and does not exceed the cost limit under such subparagraph, an amount equal to 28 percent of the allowable retiree costs (as defined in subparagraph (C)(i)) attributable to such gross covered prescription drug costs.

(B) COST THRESHOLD AND COST LIMIT APPLICABLE.—

(i) IN GENERAL.—Subject to clause (ii)—

(I) the cost threshold under this subparagraph is equal to $250 for plan years that end in 2006; and

(II) the cost limit under this subparagraph is equal to $5,000 for plan years that end in 2006.

(ii) INDEXING.—The cost threshold and cost limit amounts specified in subclauses (I) and (II) of clause (i) for a plan year that ends after 2006 shall be adjusted in the same manner as the annual deductible and the annual out-of-pocket threshold, respectively, are annually adjusted under paragraphs (1) and (4)(B) of section 1860D-2(b).

(C) DEFINITIONS.—For purposes of this paragraph:

(i) ALLOWABLE RETIREE COSTS.—The term "allowable retiree costs" means, with respect to gross covered prescription drug costs under a qualified retiree prescription drug plan by a plan sponsor, the part of such costs that are actually paid (net of discounts, chargebacks, and average percentage rebates) by the

sponsor or by or on behalf of a qualifying covered retiree under the plan.

(ii) GROSS COVERED RETIREE PLAN-RELATED PRESCRIPTION DRUG COSTS.—For purposes of this section, the term "gross covered retiree plan-related prescription drug costs" means, with respect to a qualifying covered retiree enrolled in a qualified retiree prescription drug plan during a coverage year, the costs incurred under the plan, not including administrative costs, but including costs directly related to the dispensing of covered part D drugs during the year. Such costs shall be determined whether they are paid by the retiree or under the plan.

(iii) COVERAGE YEAR.—The term "coverage year" has the meaning given such term in section 1860D-15(b)(4).

(4) QUALIFYING COVERED RETIREE DEFINED.—For purposes of this subsection, the term "qualifying covered retiree" means a part D eligible individual who is not enrolled in a prescription drug plan or an MA-PD plan but is covered under a qualified retiree prescription drug plan.

(5) PAYMENT METHODS, INCLUDING PROVISION OF NECESSARY INFORMATION.—The provisions of section 1860D-15(d) (including paragraph (2), relating to requirement for provision of information) shall apply to payments under this subsection in a manner similar to the manner in which they apply to payment under section 1860D-15(b).

(6) CONSTRUCTION.—Nothing in this subsection shall be construed as-

(A) precluding a part D eligible individual who is covered under employment-based retiree health coverage from enrolling in a prescription drug plan or in an MA-PD plan;

(B) precluding such employment-based retiree health coverage or an employer or other person from paying all or any portion of any premium required for coverage under a prescription drug plan or MA-PD plan on behalf of such an individual;

(C) preventing such employment-based retiree health coverage from providing coverage—

(i) that is better than standard prescription drug coverage to retirees who are covered under a qualified retiree prescription drug plan; or

(ii) that is supplemental to the benefits provided under a prescription drug plan or an MA-PD plan, including benefits to retirees who are not covered under a qualified retiree prescription drug plan but who are enrolled in such a prescription drug plan or MA-PD plan; or

(D) preventing employers to provide for flexibility in benefit design and pharmacy access provisions, without regard to the requirements for basic prescription drug coverage, so long as the actuarial equivalence requirement of paragraph (2)(A) is met.

(b) APPLICATION OF MA WAIVER AUTHORITY.—The provisions of section 1857(i) shall apply with respect to prescription drug plans in relation to employment-based retiree health coverage in a man-

ner similar to the manner in which they apply to an MA plan in relation to employers, including authorizing the establishment of separate premium amounts for enrollees in a prescription drug plan by reason of such coverage and limitations on enrollment to part D eligible individuals enrolled under such coverage.

(c) DEFINITIONS.—For purposes of this section:

(1) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term "employment-based retiree health coverage" means health insurance or other coverage of health care costs (whether provided by voluntary insurance coverage or pursuant to statutory or contractual obligation) for part D eligible individuals (or for such individuals and their spouses and dependents) under a group health plan based on their status as retired participants in such plan.

(2) SPONSOR.—The term "sponsor" means a plan sponsor, as defined in section (16)(B) of the Employee Retirement Income Security Act of 1974, in relation to a group health plan, except that, in the case of a plan maintained jointly by one employer and an employee organization and with respect to which the employer is the primary source of financing, such term means such employer.

(3) GROUP HEALTH PLAN.—The term "group health plan" includes such a plan as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 and also includes the following:

(A) FEDERAL AND STATE GOVERNMENTAL PLANS.—Such a plan established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing, including a health benefits plan offered under chapter 89 of title 5, United States Code.

(B) COLLECTIVELY BARGAINED PLANS.—Such a plan established or maintained under or pursuant to one or more collective bargaining agreements.

(C) CHURCH PLANS.—Such a plan established and maintained for its employees (or their beneficiaries) by a church or by a convention or association of churches which is exempt from tax under section 501 of the Internal Revenue Code of 1986.

STATE PHARMACEUTICAL ASSISTANCE PROGRAMS

SEC. 1860D-23. [42 U.S.C. 1395w-133] (a) REQUIREMENTS FOR BENEFIT COORDINATION.—

(1) IN GENERAL.—Before July 1, 2005, the Secretary shall establish consistent with this section requirements for prescription drug plans to ensure the effective coordination between a part D plan (as defined in paragraph (5)) and a State Pharmaceutical Assistance Program (as defined in subsection (b)) with respect to—

(A) payment of premiums and coverage; and

(B) payment for supplemental prescription drug benefits, for part D eligible individuals enrolled under both types of plans.

(2) COORDINATION ELEMENTS.—The requirements under paragraph (1) shall include requirements relating to coordination of each of the following:

(A) Enrollment file sharing.

(B) The processing of claims, including electronic processing.

(C) Claims payment.

(D) Claims reconciliation reports.

(E) Application of the protection against high out-of-pocket expenditures under section 1860D-2(b)(4).

(F) Other administrative processes specified by the Secretary.

Such requirements shall be consistent with applicable law to safeguard the privacy of any individually identifiable beneficiary information.

(3) USE OF LUMP SUM PER CAPITA METHOD.—Such requirements shall include a method for the application by a part D plan of specified funding amounts from a State Pharmaceutical Assistance Program for enrolled individuals for supplemental prescription drug benefits.

(4) CONSULTATION.—In establishing requirements under this subsection, the Secretary shall consult with State Pharmaceutical Assistance Programs, MA organizations, States, pharmaceutical benefit managers, employers, representatives of part D eligible individuals, the data processing experts, pharmacists, pharmaceutical manufacturers, and other experts.

(5) PART D PLAN DEFINED.—For purposes of this section and section 1860D-24, the term "part D plan" means a prescription drug plan and an MA-PD plan.

(b) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—For purposes of this part, the term "State Pharmaceutical Assistance Program" means a State program—

(1) which provides financial assistance for the purchase or provision of supplemental prescription drug coverage or benefits on behalf of part D eligible individuals;

(2) which, in determining eligibility and the amount of assistance to part D eligible individuals under the Program, provides assistance to such individuals in all part D plans and does not discriminate based upon the part D plan in which the individual is enrolled; and

(3) which satisfies the requirements of subsections (a) and (c).

(c) RELATION TO OTHER PROVISIONS.—

(1) MEDICARE AS PRIMARY PAYOR.—The requirements of this section shall not change or affect the primary payor status of a part D plan.

(2) USE OF A SINGLE CARD.—A card that is issued under section 1860D-4(b)(2)(A) for use under a part D plan may also be used in connection with coverage of benefits provided under a State Pharmaceutical Assistance Program and, in such case, may contain an emblem or symbol indicating such connection.

(3) OTHER PROVISIONS.—The provisions of section 1860D-24(c) shall apply to the requirements under this section.

(4) SPECIAL TREATMENT UNDER OUT-OF-POCKET RULE.—In applying section 1860D-2(b)(4)(C)(ii), expenses incurred under a

State Pharmaceutical Assistance Program may be counted toward the annual out-of-pocket threshold.

(5) CONSTRUCTION.—Nothing in this section shall be construed as requiring a State Pharmaceutical Assistance Program to coordinate or provide financial assistance with respect to any part D plan.

(d) FACILITATION OF TRANSITION AND COORDINATION WITH STATE PHARMACEUTICAL ASSISTANCE PROGRAMS.—

(1) TRANSITIONAL GRANT PROGRAM.—The Secretary shall provide payments to State Pharmaceutical Assistance Programs with an application approved under this subsection.

(2) USE OF FUNDS.—Payments under this section may be used by a Program for any of the following:

(A) Educating part D eligible individuals enrolled in the Program about the prescription drug coverage available through part D plans under this part.

(B) Providing technical assistance, phone support, and counseling for such enrollees to facilitate selection and enrollment in such plans.

(C) Other activities designed to promote the effective coordination of enrollment, coverage, and payment between such Program and such plans.

(3) ALLOCATION OF FUNDS.—Of the amount appropriated to carry out this subsection for a fiscal year, the Secretary shall allocate payments among Programs that have applications approved under paragraph (4) for such fiscal year in proportion to the number of enrollees enrolled in each such Program as of October 1, 2003.

(4) APPLICATION.—No payments may be made under this subsection except pursuant to an application that is submitted and approved in a time, manner, and form specified by the Secretary.

(5) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated for each of fiscal years 2005 and 2006, $62,500,000 to carry out this subsection.

COORDINATION REQUIREMENTS FOR PLANS PROVIDING PRESCRIPTION DRUG COVERAGE

SEC. 1860D-24. [42 U.S.C. 1395w-134] (a) APPLICATION OF BENEFIT COORDINATION REQUIREMENTS TO ADDITIONAL PLANS.—

(1) IN GENERAL.—The Secretary shall apply the coordination requirements established under section 1860D-23(a) to Rx plans described in subsection (b) in the same manner as such requirements apply to a State Pharmaceutical Assistance Program.

(2) APPLICATION TO TREATMENT OF CERTAIN OUT-OF-POCKET EXPENDITURES.—To the extent specified by the Secretary, the requirements referred to in paragraph (1) shall apply to procedures established under section 1860D-2(b)(4)(D).

(3) USER FEES.—

(A) IN GENERAL.—The Secretary may impose user fees for the transmittal of information necessary for benefit coordination under section 1860D-2(b)(4)(D) in a manner similar to the manner in which user fees are imposed under section 1842(h)(3)(B), except that the Secretary may

retain a portion of such fees to defray the Secretary's costs in carrying out procedures under section 1860D-2(b)(4)(D).

(B) APPLICATION.—A user fee may not be imposed under subparagraph (A) with respect to a State Pharmaceutical Assistance Program.

(b) RX PLAN.—An Rx plan described in this subsection is any of the following:

(1) MEDICAID PROGRAMS.—A State plan under title XIX, including such a plan operating under a waiver under section 1115, if it meets the requirements of section 1860D-23(b)(2).

(2) GROUP HEALTH PLANS.—An employer group health plan.

(3) FEHBP.—The Federal employees health benefits plan under chapter 89 of title 5, United States Code.

(4) MILITARY COVERAGE (INCLUDING TRICARE).—Coverage under chapter 55 of title 10, United States Code.

(5) OTHER PRESCRIPTION DRUG COVERAGE.—Such other health benefit plans or programs that provide coverage or financial assistance for the purchase or provision of prescription drug coverage on behalf of part D eligible individuals as the Secretary may specify.

(c) RELATION TO OTHER PROVISIONS.—

(1) USE OF COST MANAGEMENT TOOLS.—The requirements of this section shall not impair or prevent a PDP sponsor or MA organization from applying cost management tools (including differential payments) under all methods of operation.

(2) NO AFFECT ON TREATMENT OF CERTAIN OUT-OF-POCKET EXPENDITURES.—The requirements of this section shall not affect the application of the procedures established under section 1860D-2(b)(4)(D).

Subpart 4—Medicare Prescription Drug Discount Card and Transitional Assistance Program [388]

MEDICARE PRESCRIPTION DRUG DISCOUNT CARD AND TRANSITIONAL ASSISTANCE PROGRAM

SEC. 1860D-31. [42 U.S.C. 1395w-141] (a) ESTABLISHMENT OF PROGRAM.—

(1) IN GENERAL.—The Secretary shall establish a program under this section—

(A) to endorse prescription drug discount card programs that meet the requirements of this section in order to provide access to prescription drug discounts through prescription drug card sponsors for discount card eligible individuals throughout the United States; and (B) to provide for transitional assistance for transitional assistance eligible individuals enrolled in such endorsed programs.

(2) PERIOD OF OPERATION.—

(A) IMPLEMENTATION DEADLINE.—The Secretary shall implement the program under this section so that discount cards and transitional assistance are first available by not later than 6 months after the date of the enactment of this section.

[388] See Vol. II, P.L. 108-173, §105(c), with respect to rules for implementation.

(B) EXPEDITING IMPLEMENTATION.—The Secretary shall promulgate regulations to carry out the program under this section which may be effective and final immediately on an interim basis as of the date of publication of the interim final regulation. If the Secretary provides for an interim final regulation, the Secretary shall provide for a period of public comments on such regulation after the date of publication. The Secretary may change or revise such regulation after completion of the period of public comment.

(C) TERMINATION AND TRANSITION.—

(i) IN GENERAL.—Subject to clause (ii)—

(I) the program under this section shall not apply to covered discount card drugs dispensed after December 31, 2005; and

(II) transitional assistance shall be available after such date to the extent the assistance relates to drugs dispensed on or before such date.

(ii) TRANSITION.—In the case of an individual who is enrolled in an endorsed discount card program as of December 31, 2005, during the individual's transition period (if any) under clause (iii), in accordance with transition rules specified by the Secretary—

(I) such endorsed program may continue to apply to covered discount card drugs dispensed to the individual under the program during such transition period;

(II) no annual enrollment fee shall be applicable during the transition period;

(III) during such period the individual may not change the endorsed program plan in which the individual is enrolled; and

(IV) the balance of any transitional assistance remaining on January 1, 2006, shall remain available for drugs dispensed during the individual's transition period.

(iii) TRANSITION PERIOD.—The transition period under this clause for an individual is the period beginning on January 1, 2006, and ending in the case of an individual who—

(I) is enrolled in a prescription drug plan or an MA-PD plan before the last date of the initial enrollment period under section 1860D-1(b)(2)(A), on the effective date of the individual's coverage under such part; or

(II) is not so enrolled, on the last day of such initial period.

(3) VOLUNTARY NATURE OF PROGRAM.—Nothing in this section shall be construed as requiring a discount card eligible individual to enroll in an endorsed discount card program under this section.

(4) GLOSSARY AND DEFINITIONS OF TERMS.—For purposes of this section:

(A) COVERED DISCOUNT CARD DRUG.—The term "covered discount card drug" has the meaning given the term "covered part D drug" in section 1860D-2(e).

(B) DISCOUNT CARD ELIGIBLE INDIVIDUAL.—The term "discount card eligible individual" is defined in subsection (b)(1)(A).

(C) ENDORSED DISCOUNT CARD PROGRAM; ENDORSED PROGRAM.—The terms "endorsed discount card program" and "endorsed program" mean a prescription drug discount card program that is endorsed (and for which the sponsor has a contract with the Secretary) under this section.

(D) NEGOTIATED PRICE.—Negotiated prices are described in subsection (e)(1)(A)(ii).

(E) PRESCRIPTION DRUG CARD SPONSOR; SPONSOR.—The terms "prescription drug card sponsor" and "sponsor" are defined in subsection (h)(1)(A).

(F) STATE.—The term "State" has the meaning given such term for purposes of title XIX.

(G) TRANSITIONAL ASSISTANCE ELIGIBLE INDIVIDUAL.—The term "transitional assistance eligible individual" is defined in subsection (b)(2).

(b) ELIGIBILITY FOR DISCOUNT CARD AND FOR TRANSITIONAL ASSISTANCE.—For purposes of this section:

(1) DISCOUNT CARD ELIGIBLE INDIVIDUAL.—

(A) IN GENERAL.—The term "discount card eligible individual" means an individual who—

(i) is entitled to benefits, or enrolled, under part A or enrolled under part B; and (ii) subject to paragraph (4), is not an individual described in subparagraph (B).

(B) INDIVIDUAL DESCRIBED.—An individual described in this subparagraph is an individual described in subparagraph (A)(i) who is enrolled under title XIX (or under a waiver under section 1115 of the requirements of such title) and is entitled to any medical assistance for outpatient prescribed drugs described in section 1905(a)(12).

(2) TRANSITIONAL ASSISTANCE ELIGIBLE INDIVIDUAL.—

(A) IN GENERAL.—Subject to subparagraph (B), the term "transitional assistance eligible individual" means a discount card eligible individual who resides in one of the 50 States or the District of Columbia and whose income (as determined under subsection (f)(1)(B)) is not more than 135 percent of the poverty line (as defined in section 673(2) of the Community Services Block Grant Act, 42 U.S.C. 9902(2), including any revision required by such section) applicable to the family size involved (as determined under subsection (f)(1)(B)).

(B) EXCLUSION OF INDIVIDUALS WITH CERTAIN PRESCRIPTION DRUG COVERAGE.—Such term does not include an individual who has coverage of, or assistance for, covered discount card drugs under any of the following:

(i) A group health plan or health insurance coverage (as such terms are defined in section 2791 of the Public Health Service Act), other than coverage under a plan under part C and other than coverage consisting only of excepted benefits (as defined in such section).

(ii) Chapter 55 of title 10, United States Code (relating to medical and dental care for members of the uniformed services).

(iii) A plan under chapter 89 of title 5, United States Code (relating to the Federal employees' health benefits program).

(3) SPECIAL TRANSITIONAL ASSISTANCE ELIGIBLE INDIVIDUAL.—The term "special transitional assistance eligible individual" means a transitional assistance eligible individual whose income (as determined under subsection (f)(1)(B)) is not more than 100 percent of the poverty line (as defined in section 673(2) of the Community Services Block Grant Act, 42 U.S.C. 9902(2), including any revision required by such section) applicable to the family size involved (as determined under subsection (f)(1)(B)).

(4) TREATMENT OF MEDICAID MEDICALLY NEEDY.—For purposes of this section, the Secretary shall provide for appropriate rules for the treatment of medically needy individuals described in section 1902(a)(10)(C) as discount card eligible individuals and as transitional assistance eligible individuals.

(c) ENROLLMENT AND ENROLLMENT FEES.—

(1) ENROLLMENT PROCESS.—The Secretary shall establish a process through which a discount card eligible individual is enrolled and disenrolled in an endorsed discount card program under this section consistent with the following:

(A) CONTINUOUS OPEN ENROLLMENT.—Subject to the succeeding provisions of this paragraph and subsection (h)(9), a discount card eligible individual who is not enrolled in an endorsed discount card program and is residing in a State may enroll in any such endorsed program—

(i) that serves residents of the State; and

(ii) at any time beginning on the initial enrollment date, specified by the Secretary, and before January 1, 2006.

(B) USE OF STANDARD ENROLLMENT FORM.—An enrollment in an endorsed program shall only be effected through completion of a standard enrollment form specified by the Secretary. Each sponsor of an endorsed program shall transmit to the Secretary (in a form and manner specified by the Secretary) information on individuals who complete such enrollment forms and, to the extent provided under subsection (f), information regarding certification as a transitional assistance eligible individual.

(C) ENROLLMENT ONLY IN ONE PROGRAM.—

(i) IN GENERAL.—Subject to clauses (ii) and (iii), a discount card eligible individual may be enrolled in only one endorsed discount card program under this section.

(ii) CHANGE IN ENDORSED PROGRAM PERMITTED FOR 2005.—The Secretary shall establish a process, similar to (and coordinated with) the process for annual, coordinated elections under section 1851(e)(3) during 2004, under which an individual enrolled in an endorsed discount card program may change the endorsed program in which the individual is enrolled for 2005.

(iii) ADDITIONAL EXCEPTIONS.—The Secretary shall permit an individual to change the endorsed discount card program in which the individual is enrolled in the

case of an individual who changes residence to be outside the service area of such program and in such other exceptional cases as the Secretary may provide (taking into account the circumstances for special election periods under section 1851(e)(4)). Under the previous sentence, the Secretary may consider a change in residential setting (such as placement in a nursing facility) or enrollment in or disenrollment from a plan under part C through which the individual was enrolled in an endorsed program to be an exceptional circumstance.

(D) DISENROLLMENT.—

(i) VOLUNTARY.—An individual may voluntarily disenroll from an endorsed discount card program at any time. In the case of such a voluntary disenrollment, the individual may not enroll in another endorsed program, except under such exceptional circumstances as the Secretary may recognize under subparagraph (C)(iii) or during the annual coordinated enrollment period provided under subparagraph (C)(ii).

(ii) INVOLUNTARY.—An individual who is enrolled in an endorsed discount card program and not a transitional assistance eligible individual may be disenrolled by the sponsor of the program if the individual fails to pay any annual enrollment fee required under the program.

(E) APPLICATION TO CERTAIN ENROLLEES.—In the case of a discount card eligible individual who is enrolled in a plan described in section 1851(a)(2)(A) or under a reasonable cost reimbursement contract under section 1876(h) that is offered by an organization that also is a prescription discount card sponsor that offers an endorsed discount card program under which the individual may be enrolled and that has made an election to apply the special rules under subsection (h)(9)(B) for such an endorsed program, the individual may only enroll in such an endorsed discount card program offered by that sponsor.

(2) ENROLLMENT FEES.—

(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, a prescription drug card sponsor may charge an annual enrollment fee for each discount card eligible individual enrolled in an endorsed discount card program offered by such sponsor. The annual enrollment fee for either 2004 or 2005 shall not be prorated for portions of a year. There shall be no annual enrollment fee for a year after 2005.

(B) AMOUNT.—No annual enrollment fee charged under subparagraph (A) may exceed $30.

(C) UNIFORM ENROLLMENT FEE.—A prescription drug card sponsor shall ensure that the annual enrollment fee (if any) for an endorsed discount card program is the same for all discount card eligible individuals enrolled in the program and residing in the State.

(D) COLLECTION.—The annual enrollment fee (if any) charged for enrollment in an endorsed program shall be collected by the sponsor of the program.

(E) PAYMENT OF FEE FOR TRANSITIONAL ASSISTANCE ELIGIBLE INDIVIDUALS.—Under subsection (g)(1)(A), the annual enrollment fee (if any) otherwise charged under this paragraph with respect to a transitional assistance eligible individual shall be paid by the Secretary on behalf of such individual.

(F) OPTIONAL PAYMENT OF FEE BY STATE.—

(i) IN GENERAL.—The Secretary shall establish an arrangement under which a State may provide for payment of some or all of the enrollment fee for some or all enrollees who are not transitional assistance eligible individuals in the State, as specified by the State under the arrangement. Insofar as such a payment arrangement is made with respect to an enrollee, the amount of the enrollment fee shall be paid directly by the State to the sponsor.

(ii) NO FEDERAL MATCHING AVAILABLE UNDER MEDICAID OR SCHIP.—Expenditures made by a State for enrollment fees described in clause (i) shall not be treated as State expenditures for purposes of Federal matching payments under title XIX or XXI.

(G) RULES IN CASE OF CHANGES IN PROGRAM ENROLLMENT DURING A YEAR.—The Secretary shall provide special rules in the case of payment of an annual enrollment fee for a discount card eligible individual who changes the endorsed program in which the individual is enrolled during a year.

(3) ISSUANCE OF DISCOUNT CARD.—Each prescription drug card sponsor of an endorsed discount card program shall issue, in a standard format specified by the Secretary, to each discount card eligible individual enrolled in such program a card that establishes proof of enrollment and that can be used in a coordinated manner to identify the sponsor, program, and individual for purposes of the program under this section.

(4) PERIOD OF ACCESS.—In the case of a discount card eligible individual who enrolls in an endorsed program, access to negotiated prices and transitional assistance, if any, under such endorsed program shall take effect on such date as the Secretary shall specify.

(d) PROVISION OF INFORMATION ON ENROLLMENT AND PROGRAM FEATURES.—

(1) SECRETARIAL RESPONSIBILITIES.—

(A) IN GENERAL.—The Secretary shall provide for activities under this subsection to broadly disseminate information to discount card eligible individuals (and prospective eligible individuals) regarding—

(i) enrollment in endorsed discount card programs; and

(ii) the features of the program under this section, including the availability of transitional assistance.

(B) PROMOTION OF INFORMED CHOICE.—In order to promote informed choice among endorsed prescription drug

discount card programs, the Secretary shall provide for the dissemination of information which—

(i) compares the annual enrollment fee and other features of such programs, which may include comparative prices for covered discount card drugs; and

(ii) includes educational materials on the variability of discounts on prices of covered discount card drugs under an endorsed program. The dissemination of information under clause (i) shall, to the extent practicable, be coordinated with the dissemination of educational information on other medicare options.

(C) SPECIAL RULE FOR INITIAL ENROLLMENT DATE UNDER THE PROGRAM.—To the extent practicable, the Secretary shall ensure, through the activities described in subparagraphs (A) and (B), that discount card eligible individuals are provided with such information at least 30 days prior to the initial enrollment date specified under subsection (c)(1)(A)(ii).

(D) USE OF MEDICARE TOLL-FREE NUMBER.—The Secretary shall provide through the toll-free telephone number 1-800-MEDICARE for the receipt and response to inquiries and complaints concerning the program under this section and endorsed programs.

(2) PRESCRIPTION DRUG CARD SPONSOR RESPONSIBILITIES.—

(A) IN GENERAL.—Each prescription drug card sponsor that offers an endorsed discount card program shall make available to discount card eligible individuals (through the Internet and otherwise) information that the Secretary identifies as being necessary to promote informed choice among endorsed discount card programs by such individuals, including information on enrollment fees and negotiated prices for covered discount card drugs charged to such individuals.

(B) RESPONSE TO ENROLLEE QUESTIONS.—Each sponsor offering an endorsed discount card program shall have a mechanism (including a toll-free telephone number) for providing upon request specific information (such as negotiated prices and the amount of transitional assistance remaining available through the program) to discount card eligible individuals enrolled in the program. The sponsor shall inform transitional assistance eligible individuals enrolled in the program of the availability of such toll-free telephone number to provide information on the amount of available transitional assistance.

(C) INFORMATION ON BALANCE OF TRANSITIONAL ASSISTANCE AVAILABLE AT POINT-OF-SALE.—Each sponsor offering an endorsed discount card program shall have a mechanism so that information on the amount of transitional assistance remaining under subsection (g)(1)(B) is available (electronically or by telephone) at the point-of-sale of covered discount card drugs.

(3) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—

(A) IN GENERAL.—A prescription drug card sponsor offering an endorsed discount card program shall provide that each pharmacy that dispenses a covered discount card

drug shall inform a discount card eligible individual enrolled in the program of any differential between the price of the drug to the enrollee and the price of the lowest priced generic covered discount card drug under the program that is therapeutically equivalent and bioequivalent and available at such pharmacy.

(B) TIMING OF NOTICE.—

(i) IN GENERAL.—Subject to clause (ii), the information under subparagraph (A) shall be provided at the time of purchase of the drug involved, or, in the case of dispensing by mail order, at the time of delivery of such drug.

(ii) WAIVER.—The Secretary may waive clause (i) in such circumstances as the Secretary may specify.

(e) DISCOUNT CARD FEATURES.—

(1) SAVINGS TO ENROLLEES THROUGH NEGOTIATED PRICES.—

(A) ACCESS TO NEGOTIATED PRICES.—

(i) IN GENERAL.—Each prescription drug card sponsor that offers an endorsed discount card program shall provide each discount card eligible individual enrolled in the program with access to negotiated prices.

(ii) NEGOTIATED PRICES.—For purposes of this section, negotiated prices shall take into account negotiated price concessions, such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations, for covered discount card drugs, and include any dispensing fees for such drugs.

(B) ENSURING PHARMACY ACCESS.—Each prescription drug card sponsor offering an endorsed discount card program shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than solely by mail order) drugs directly to enrollees to ensure convenient access to covered discount card drugs at negotiated prices (consistent with rules established by the Secretary). The Secretary shall establish convenient access rules under this clause that are no less favorable to enrollees than the standards for convenient access to pharmacies included in the statement of work of solicitation (#MDA906-03-R-0002) of the Department of Defense under the TRICARE Retail Pharmacy (TRRx) as of March 13, 2003.

(C) PROHIBITION ON CHARGES FOR REQUIRED SERVICES.—

(i) IN GENERAL.—Subject to clause (ii), a prescription drug card sponsor (and any pharmacy contracting with such sponsor for the provision of covered discount card drugs to individuals enrolled in such sponsor's endorsed discount card program) may not charge an enrollee any amount for any items and services required to be provided by the sponsor under this section.

(ii) CONSTRUCTION.—Nothing in clause (i) shall be construed to prevent—

(I) the sponsor from charging the annual enrollment fee (except in the case of a transitional assistance eligible individual); and

(II) the pharmacy dispensing the covered discount card drug, from imposing a charge

(consistent with the negotiated price) for the covered discount card drug dispensed, reduced by the amount of any transitional assistance made available.

(D) INAPPLICABILITY OF MEDICAID BEST PRICE RULES.—The prices negotiated from drug manufacturers for covered discount card drugs under an endorsed discount card program under this section shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1927(c)(1)(C).

(2) REDUCTION OF MEDICATION ERRORS AND ADVERSE DRUG INTERACTIONS.—Each endorsed discount card program shall implement a system to reduce the likelihood of medication errors and adverse drug interactions and to improve medication use.

(f) ELIGIBILITY PROCEDURES FOR ENDORSED PROGRAMS AND TRANSITIONAL ASSISTANCE.—

(1) DETERMINATIONS.—

(A) PROCEDURES.—The determination of whether an individual is a discount card eligible individual or a transitional assistance eligible individual or a special transitional assistance eligible individual (as defined in subsection (b)) shall be determined under procedures specified by the Secretary consistent with this subsection.

(B) INCOME AND FAMILY SIZE DETERMINATIONS.—For purposes of this section, the Secretary shall define the terms "income" and "family size" and shall specify the methods and period for which they are determined. If under such methods income or family size is determined based on the income or family size for prior periods of time, the Secretary shall permit (whether through a process of reconsideration or otherwise) an individual whose income or family size has changed to elect to have eligibility for transitional assistance determined based on income or family size for a more recent period.

(2) USE OF SELF-CERTIFICATION FOR TRANSITIONAL ASSISTANCE.—

(A) IN GENERAL.—Under the procedures specified under paragraph (1)(A) an individual who wishes to be treated as a transitional assistance eligible individual or a special transitional assistance eligible individual under this section (or another qualified person on such individual's behalf) shall certify on the enrollment form under subsection (c)(1)(B) (or similar form specified by the Secretary), through a simplified means specified by the Secretary and under penalty of perjury or similar sanction for false statements, as to the amount of the individual's income, family size, and individual's prescription drug coverage (if any) insofar as they relate to eligibility to be a transitional assistance eligible individual or a special transitional assistance eligible individual. Such certification shall be deemed as consent to verification of respective eligibility under paragraph (3). A certification under this paragraph may be provided before, on, or after the time of enrollment under an endorsed program.

(B) TREATMENT OF SELF-CERTIFICATION.—The Secretary shall treat a certification under subparagraph (A) that is verified under paragraph (3) as a determination that the individual involved is a transitional assistance eligible individual or special transitional assistance eligible individual (as the case may be) for the entire period of the enrollment of the individual in any endorsed program.

(3) VERIFICATION.—

(A) IN GENERAL.—The Secretary shall establish methods (which may include the use of sampling and the use of information described in subparagraph (B)) to verify eligibility for individuals who seek to enroll in an endorsed program and for individuals who provide a certification under paragraph (2).

(B) INFORMATION DESCRIBED.—The information described in this subparagraph is as follows:

(i) MEDICAID-RELATED INFORMATION.—Information on eligibility under title XIX and provided to the Secretary under arrangements between the Secretary and States in order to verify the eligibility of individuals who seek to enroll in an endorsed program and of individuals who provide certification under paragraph (2).

(ii) SOCIAL SECURITY INFORMATION.—Financial information made available to the Secretary under arrangements between the Secretary and the Commissioner of Social Security in order to verify the eligibility of individuals who provide such certification.

(iii) INFORMATION FROM SECRETARY OF THE TREASURY.—Financial information made available to the Secretary under section 6103(l)(19) of the Internal Revenue Code of 1986 in order to verify the eligibility of individuals who provide such certification.

(C) VERIFICATION IN CASES OF MEDICAID ENROLLEES.—

(i) IN GENERAL.—Nothing in this section shall be construed as preventing the Secretary from finding that a discount card eligible individual meets the income requirements under subsection (b)(2)(A) if the individual is within a category of discount card eligible individuals who are enrolled under title XIX (such as qualified medicare beneficiaries (QMBs), specified low-income medicare beneficiaries (SLMBs), and certain qualified individuals (QI-1s)).

(ii) AVAILABILITY OF INFORMATION FOR VERIFICATION PURPOSES.—As a condition of provision of Federal financial participation to a State that is one of the 50 States or the District of Columbia under title XIX, for purposes of carrying out this section, the State shall provide the information it submits to the Secretary relating to such title in a manner specified by the Secretary that permits the Secretary to identify individuals who are described in subsection (b)(1)(B) or are transitional assistance eligible individuals or special transitional assistance eligible individuals.

(4) RECONSIDERATION.—

(A) IN GENERAL.—The Secretary shall establish a process under which a discount card eligible individual, who is de-

termined through the certification and verification methods under paragraphs (2) and (3) not to be a transitional assistance eligible individual or a special transitional assistance eligible individual, may request a reconsideration of the determination.

(B) CONTRACT AUTHORITY.—The Secretary may enter into a contract to perform the reconsiderations requested under subparagraph (A).

(C) COMMUNICATION OF RESULTS.—Under the process under subparagraph (A) the results of such reconsideration shall be communicated to the individual and the prescription drug card sponsor involved.

(g) TRANSITIONAL ASSISTANCE.—

(1) PROVISION OF TRANSITIONAL ASSISTANCE.—An individual who is a transitional assistance eligible individual (as determined under this section) and who is enrolled with an endorsed program is entitled—

(A) to have payment made of any annual enrollment fee charged under subsection (c)(2) for enrollment under the program; and

(B) to have payment made, up to the amount specified in paragraph (2), under such endorsed program of 90 percent (or 95 percent in the case of a special transitional assistance eligible individual) of the costs incurred for covered discount card drugs obtained through the program taking into account the negotiated price (if any) for the drug under the program.

(2) LIMITATION ON DOLLAR AMOUNT.—

(A) IN GENERAL.—Subject to subparagraph (B), the amount specified in this paragraph for a transitional assistance eligible individual—

(i) for costs incurred during 2004, is $600; or

(ii) for costs incurred during 2005, is—

(I) $600, plus 32

(II) except as provided in subparagraph (E), the amount by which the amount available under this paragraph for 2004 for that individual exceeds the amount of payment made under paragraph (1)(B) for that individual for costs incurred during 2004.

(B) PRORATION.—

(i) IN GENERAL.—In the case of an individual not described in clause (ii) with respect to a year, the Secretary may prorate the amount specified in subparagraph (A) for the balance of the year involved in a manner specified by the Secretary.

(ii) INDIVIDUAL DESCRIBED.—An individual described in this clause is a transitional assistance eligible individual who—

(I) with respect to 2004, enrolls in an endorsed program, and provides a certification under subsection (f)(2), before the initial implementation date of the program under this section; and

(II) with respect to 2005, is enrolled in an endorsed program, and has provided such a certification, before February 1, 2005.

(C) ACCOUNTING FOR AVAILABLE BALANCES IN CASES OF CHANGES IN PROGRAM ENROLLMENT.—In the case of a transitional assistance eligible individual who changes the endorsed discount card program in which the individual is enrolled under this section, the Secretary shall provide a process under which the Secretary provides to the sponsor of the endorsed program in which the individual enrolls information concerning the balance of amounts available on behalf of the individual under this paragraph.

(D) LIMITATION ON USE OF FUNDS.—Pursuant to subsection (a)(2)(C), no assistance shall be provided under paragraph (1)(B) with respect to covered discount card drugs dispensed after December 31, 2005.

(E) NO ROLLOVER PERMITTED IN CASE OF VOLUNTARY DISENROLLMENT.—Except in such exceptional cases as the Secretary may provide, in the case of a transitional assistance eligible individual who voluntarily disenrolls from an endorsed plan, the provisions of subclause (II) of subparagraph (A)(ii) shall not apply.

(3) PAYMENT.—The Secretary shall provide a method for the reimbursement of prescription drug card sponsors for assistance provided under this subsection.

(4) COVERAGE OF COINSURANCE.—

(A) WAIVER PERMITTED BY PHARMACY.—Nothing in this section shall be construed as precluding a pharmacy from reducing or waiving the application of coinsurance imposed under paragraph (1)(B) in accordance with section 1128B(b)(3)(G).

(B) OPTIONAL PAYMENT OF COINSURANCE BY STATE.—

(i) IN GENERAL.—The Secretary shall establish an arrangement under which a State may provide for payment of some or all of the coinsurance under paragraph (1)(B) for some or all enrollees in the State, as specified by the State under the arrangement. Insofar as such a payment arrangement is made with respect to an enrollee, the amount of the coinsurance shall be paid directly by the State to the pharmacy involved.

(ii) NO FEDERAL MATCHING AVAILABLE UNDER MEDICAID OR SCHIP.—Expenditures made by a State for coinsurance described in clause (i) shall not be treated as State expenditures for purposes of Federal matching payments under title XIX or XXI.

(iii) NOT TREATED AS MEDICARE COST-SHARING.—Coinsurance described in paragraph (1)(B) shall not be treated as coinsurance under this title for purposes of section 1905(p)(3)(B).

(C) TREATMENT OF COINSURANCE.—The amount of any coinsurance imposed under paragraph (1)(B), whether paid or waived under this paragraph, shall not be taken into account in applying the limitation in dollar amount under paragraph (2).

(5) ENSURING ACCESS TO TRANSITIONAL ASSISTANCE FOR QUALIFIED RESIDENTS OF LONG-TERM CARE FACILITIES AND AMERICAN INDIANS.—

(A) RESIDENTS OF LONG-TERM CARE FACILITIES.—The Secretary shall establish procedures and may waive re-

quirements of this section as necessary to negotiate arrangements with sponsors to provide arrangements with pharmacies that support long-term care facilities in order to ensure access to transitional assistance for transitional assistance eligible individuals who reside in long-term care facilities.

(B) AMERICAN INDIANS.—The Secretary shall establish procedures and may waive requirements of this section to ensure that, for purposes of providing transitional assistance, pharmacies operated by the Indian Health Service, Indian tribes and tribal organizations, and urban Indian organizations (as defined in section 4 of the Indian Health Care Improvement Act) have the opportunity to participate in the pharmacy networks of at least two endorsed programs in each of the 50 States and the District of Columbia where such a pharmacy operates.

(6) NO IMPACT ON BENEFITS UNDER OTHER PROGRAMS.—The availability of negotiated prices or transitional assistance under this section shall not be treated as benefits or otherwise taken into account in determining an individual's eligibility for, or the amount of benefits under, any other Federal program.

(7) DISREGARD FOR PURPOSES OF PART C.—Nonuniformity of benefits resulting from the implementation of this section (including the provision or nonprovision of transitional assistance and the payment or waiver of any enrollment fee under this section) shall not be taken into account in applying section 1854(f).

(h) QUALIFICATION OF PRESCRIPTION DRUG CARD SPONSORS AND ENDORSEMENT OF DISCOUNT CARD PROGRAMS; BENEFICIARY PROTECTIONS.—

(1) PRESCRIPTION DRUG CARD SPONSOR AND QUALIFICATIONS.—

(A) PRESCRIPTION DRUG CARD SPONSOR AND SPONSOR DEFINED.—For purposes of this section, the terms "prescription drug card sponsor"and "sponsor" mean any nongovernmental entity that the Secretary determines to be appropriate to offer an endorsed discount card program under this section, which may include—

(i) a pharmaceutical benefit management company;

(ii) a wholesale or retail pharmacy delivery system;

(iii) an insurer (including an insurer that offers medicare supplemental policies under section 1882);

(iv) an organization offering a plan under part C; or

(v) any combination of the entities described in clauses (i) through (iv).

(B) ADMINISTRATIVE QUALIFICATIONS.—Each endorsed discount card program shall be operated directly, or through arrangements with an affiliated organization (or organizations), by one or more entities that have demonstrated experience and expertise in operating such a program or a similar program and that meets such business stability and integrity requirements as the Secretary may specify.

(C) ACCOUNTING FOR TRANSITIONAL ASSISTANCE.—The sponsor of an endorsed discount card program shall have arrangements satisfactory to the Secretary to account for

the assistance provided under subsection (g) on behalf of transitional assistance eligible individuals.

(2) Applications for program endorsement.—

(A) SUBMISSION.—Each prescription drug card sponsor that seeks endorsement of a prescription drug discount card program under this section shall submit to the Secretary, at such time and in such manner as the Secretary may specify, an application containing such information as the Secretary may require.

(B) APPROVAL; COMPLIANCE WITH APPLICABLE REQUIREMENTS.—The Secretary shall review the application submitted under subparagraph (A) and shall determine whether to endorse the prescription drug discount card program. The Secretary may not endorse such a program unless—

(i) the program and prescription drug card sponsor offering the program comply with the applicable requirements under this section; and

(ii) the sponsor has entered into a contract with the Secretary to carry out such requirements.

(C) TERMINATION OF ENDORSEMENT AND CONTRACTS.—An endorsement of an endorsed program and a contract under subparagraph (B) shall be for the duration of the program under this section (including any transition applicable under subsection (a)(2)(C)(ii)), except that the Secretary may, with notice and for cause (as defined by the Secretary), terminate such endorsement and contract.

(D) ENSURING CHOICE OF PROGRAMS.—

(i) IN GENERAL.—The Secretary shall ensure that there is available to each discount card eligible individual a choice of at least 2 endorsed programs (each offered by a different sponsor).

(ii) LIMITATION ON NUMBER.—The Secretary may limit (but not below 2) the number of sponsors in a State that are awarded contracts under this paragraph.

(3) SERVICE AREA ENCOMPASSING ENTIRE STATES.—Except as provided in paragraph (9), if a prescription drug card sponsor that offers an endorsed program enrolls in the program individuals residing in any part of a State, the sponsor must permit any discount card eligible individual residing in any portion of the State to enroll in the program.

(4) SAVINGS TO MEDICARE BENEFICIARIES.—Each prescription drug card sponsor that offers an endorsed discount card program shall pass on to discount card eligible individuals enrolled in the program negotiated prices on covered discount card drugs, including discounts negotiated with pharmacies and manufacturers, to the extent disclosed under subsection (i)(1).

(5) GRIEVANCE MECHANISM.—Each prescription drug card sponsor shall provide meaningful procedures for hearing and resolving grievances between the sponsor (including any entity or individual through which the sponsor carries out the endorsed discount card program) and enrollees in endorsed discount card programs of the sponsor under this section in a manner similar to that required under section 1852(f).

(6) CONFIDENTIALITY OF ENROLLEE RECORDS.—

(A) IN GENERAL.—For purposes of the program under this section, the operations of an endorsed program are covered functions and a prescription drug card sponsor is a covered entity for purposes of applying part C of title XI and all regulatory provisions promulgated there under, including regulations (relating to privacy) adopted pursuant to the authority of the Secretary under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-2 note).

(B) WAIVER AUTHORITY.—In order to promote participation of sponsors in the program under this section, the Secretary may waive such relevant portions of regulations relating to privacy referred to in subparagraph (A), for such appropriate, limited period of time, as the Secretary specifies.

(7) LIMITATION ON PROVISION AND MARKETING OF PRODUCTS AND SERVICES.—The sponsor of an endorsed discount card program—

(A) may provide under the program—

(i) a product or service only if the product or service is directly related to a covered discount card drug; or

(ii) a discount price for nonprescription drugs; and

(B) may, to the extent otherwise permitted under paragraph (6) (relating to application of HIPAA requirements), market a product or service under the program only if the product or service is directly related to—

(i) a covered discount card drug; or

(ii) a drug described in subparagraph (A)(ii) and the marketing consists of information on the discounted price made available for the drug involved.

(8) ADDITIONAL PROTECTIONS.—Each endorsed discount card program shall meet such additional requirements as the Secretary identifies to protect and promote the interest of discount card eligible individuals, including requirements that ensure that discount card eligible individuals enrolled in endorsed discount card programs are not charged more than the lower of the price based on negotiated prices or the usual and customary price.

(9) SPECIAL RULES FOR CERTAIN ORGANIZATIONS.—

(A) IN GENERAL.—In the case of an organization that is offering a plan under part C or enrollment under a reasonable cost reimbursement contract under section 1876(h) that is seeking to be a prescription drug card sponsor under this section, the organization may elect to apply the special rules under subparagraph (B) with respect to enrollees in any plan described in section 1851(a)(2)(A) that it offers or under such contract and an endorsed discount card program it offers, but only if it limits enrollment under such program to individuals enrolled in such plan or under such contract.

(B) SPECIAL RULES.—The special rules under this subparagraph are as follows:

(i) LIMITATION ON ENROLLMENT.—The sponsor limits enrollment under this section under the endorsed discount card program to discount card eligible individ-

uals who are enrolled in the part C plan involved or under the reasonable cost reimbursement contract involved and is not required nor permitted to enroll other individuals under such program.

(ii) PHARMACY ACCESS.—Pharmacy access requirements under subsection (e)(1)(B) are deemed to be met if the access is made available through a pharmacy network (and not only through mail order) and the network used by the sponsor is approved by the Secretary.

(iii) SPONSOR REQUIREMENTS.—The Secretary may waive the application of such requirements for a sponsor as the Secretary determines to be duplicative or to conflict with a requirement of the organization under part C or section 1876 (as the case may be) or to be necessary in order to improve coordination of this section with the benefits under such part or section.

(i) DISCLOSURE AND OVERSIGHT.—

(1) DISCLOSURE.—Each prescription drug card sponsor offering an endorsed discount card program shall disclose to the Secretary (in a manner specified by the Secretary) information relating to program performance, use of prescription drugs by discount card eligible individuals enrolled in the program, the extent to which negotiated price concessions described in subsection (e)(1)(A)(ii) made available to the entity by a manufacturer are passed through to enrollees through pharmacies or otherwise, and such other information as the Secretary may specify. The provisions of section 1927(b)(3)(D) shall apply to drug pricing data reported under the previous sentence (other than data in aggregate form).

(2) OVERSIGHT; AUDIT AND INSPECTION AUTHORITY.—The Secretary shall provide appropriate oversight to ensure compliance of endorsed discount card programs and their sponsors with the requirements of this section. The Secretary shall have the right to audit and inspect any books and records of a prescription discount card sponsor (and of any affiliated organization referred to in subsection (h)(1)(B)) that pertain to the endorsed discount card program under this section, including amounts payable to the sponsor under this section.

(3) SANCTIONS FOR ABUSIVE PRACTICES.—The Secretary may implement intermediate sanctions or may revoke the endorsement of a program offered by a sponsor under this section if the Secretary determines that the sponsor or the program no longer meets the applicable requirements of this section or that the sponsor has engaged in false or misleading marketing practices. The Secretary may impose a civil money penalty in an amount not to exceed $10,000 for conduct that a party knows or should know is a violation of this section. The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(j) TREATMENT OF TERRITORIES.—

(1) IN GENERAL.—The Secretary may waive any provision of this section (including subsection (h)(2)(D)) in the case of a

resident of a State (other than the 50 States and the District of Columbia) insofar as the Secretary determines it is necessary to secure access to negotiated prices for discount card eligible individuals (or, at the option of the Secretary, individuals described in subsection (b)(1)(A)(i)).

(2) TRANSITIONAL ASSISTANCE.—

(A) IN GENERAL.—In the case of a State, other than the 50 States and the District of Columbia, if the State establishes a plan described in subparagraph (B) (for providing transitional assistance with respect to the provision of prescription drugs to some or all individuals residing in the State who are described in subparagraph (B)(i)), the Secretary shall pay to the State for the entire period of the operation of this section an amount equal to the amount allotted to the State under subparagraph (C).

(B) PLAN.—The plan described in this subparagraph is a plan that—

(i) provides transitional assistance with respect to the provision of covered discount card drugs to some or all individuals who are entitled to benefits under part A or enrolled under part B, who reside in the State, and who have income below 135 percent of the poverty line; and

(ii) assures that amounts received by the State under this paragraph are used only for such assistance.

(C) ALLOTMENT LIMIT.—The amount described in this subparagraph for a State is equal to $35,000,000 multiplied by the ratio (as estimated by the Secretary) of—

(i) the number of individuals who are entitled to benefits under part A or enrolled under part B and who reside in the State (as determined by the Secretary as of July 1, 2003), to

(ii) the sum of such numbers for all States to which this paragraph applies.

(D) CONTINUED AVAILABILITY OF FUNDS.—Amounts made available to a State under this paragraph which are not used under this paragraph shall be added to the amount available to that State for purposes of carrying out section 1935(e).

(k) FUNDING.—

(1) ESTABLISHMENT OF TRANSITIONAL ASSISTANCE ACCOUNT.—

(A) IN GENERAL.—There is created within the Federal Supplementary Medical Insurance Trust Fund established by section 1841 an account to be known as the "Transitional Assistance Account" (in this subsection referred to as the "Account").

(B) FUNDS.—The Account shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), accrued interest on balances in the Account, and such amounts as may be deposited in, or appropriated to, the Account as provided in this subsection.

(C) SEPARATE FROM REST OF TRUST FUND.—Funds provided under this subsection to the Account shall be kept separate from all other funds within the Federal Supplementary Medical Insurance Trust Fund, but shall be in-

vested, and such investments redeemed, in the same manner as all other funds and investments within such Trust Fund.

(2) PAYMENTS FROM ACCOUNT.—

(A) IN GENERAL.—The Managing Trustee shall pay from time to time from the Account such amounts as the Secretary certifies are necessary to make payments for transitional assistance provided under subsections (g) and (j)(2).

(B) TREATMENT IN RELATION TO PART B PREMIUM.—Amounts payable from the Account shall not be taken into account in computing actuarial rates or premium amounts under section 1839.

(3) APPROPRIATIONS TO COVER BENEFITS.—There are appropriated to the Account in a fiscal year, out of any moneys in the Treasury not otherwise appropriated, an amount equal to the payments made from the Account in the year.

(4) FOR ADMINISTRATIVE EXPENSES.—There are authorized to be appropriated to the Secretary such sums as may be necessary to carry out the Secretary's responsibilities under this section.

(5) TRANSFER OF ANY REMAINING BALANCE TO MEDICARE PRESCRIPTION DRUG ACCOUNT.—Any balance remaining in the Account after the Secretary determines that funds in the Account are no longer necessary to carry out the program under this section shall be transferred and deposited into the Medicare Prescription Drug Account under section 1860D-16.

(6) CONSTRUCTION.—Nothing in this section shall be construed as authorizing the Secretary to provide for payment (other than payment of an enrollment fee on behalf of a transitional assistance eligible individual under subsection (g)(1)(A)) to a sponsor for administrative expenses incurred by the sponsor in carrying out this section (including in administering the transitional assistance provisions of subsections (f) and (g)).

Subpart 5—Definitions and Miscellaneous Provisions

DEFINITIONS; TREATMENT OF REFERENCES TO PROVISIONS IN PART C

SEC. 1860D-41. [42 U.S.C. 1395w-151] (a) DEFINITIONS.—FOR PURPOSES OF THIS PART:

(1) BASIC PRESCRIPTION DRUG COVERAGE.—The term "basic prescription drug coverage" is defined in section 1860D-2(a)(3).

(2) COVERED PART D DRUG.—The term "covered part D drug" is defined in section 1860D-2(e).

(3) CREDITABLE PRESCRIPTION DRUG COVERAGE.—The term "creditable prescription drug coverage" has the meaning given such term in section 1860D-13(b)(4).

(4) PART D ELIGIBLE INDIVIDUAL.—The term "part D eligible individual" has the meaning given such term in section 1860D-1(a)(4)(A).

(5) FALLBACK PRESCRIPTION DRUG PLAN.—The term "fallback prescription drug plan" has the meaning given such term in section 1860D-11(g)(4).

(6) INITIAL COVERAGE LIMIT.—The term "initial coverage limit" means such limit as established under section 1860D-2(b)(3), or, in the case of coverage that is not standard pre-

scription drug coverage, the comparable limit (if any) established under the coverage.

(7) INSURANCE RISK.—The term "insurance risk" means, with respect to a participating pharmacy, risk of the type commonly assumed only by insurers licensed by a State and does not include payment variations designed to reflect performance-based measures of activities within the control of the pharmacy, such as formulary compliance and generic drug substitution.

(8) MA PLAN.—The term "MA plan" has the meaning given such term in section 1860D-1(a)(4)(B).

(9) MA-PD PLAN.—The term "MA-PD plan" has the meaning given such term in section 1860D-1(a)(4)(C).

(10) MEDICARE PRESCRIPTION DRUG ACCOUNT.—The term "Medicare Prescription Drug Account" means the Account created under section 1860D-16(a).

(11) PDP APPROVED BID.—The term "PDP approved bid" has the meaning given such term in section 1860D-13(a)(6).

(12) PDP REGION.—The term "PDP region" means such a region as provided under section 1860D-11(a)(2).

(13) PDP SPONSOR.—The term "PDP sponsor" means a nongovernmental entity that is certified under this part as meeting the requirements and standards of this part for such a sponsor.

(14) PRESCRIPTION DRUG PLAN.—The term "prescription drug plan" means prescription drug coverage that is offered—

(A) under a policy, contract, or plan that has been approved under section 1860D-11(e); and

(B) by a PDP sponsor pursuant to, and in accordance with, a contract between the Secretary and the sponsor under section 1860D-12(b).

(15) QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term "qualified prescription drug coverage" is defined in section 1860D-2(a)(1).

(16) STANDARD PRESCRIPTION DRUG COVERAGE.— The term "standard prescription drug coverage" is defined in section 1860D-2(b).

(17) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—The term "State Pharmaceutical Assistance Program" has the meaning given such term in section 1860D-23(b).

(18) SUBSIDY ELIGIBLE INDIVIDUAL.—The term "subsidy eligible individual" has the meaning given such term in section 1860D-14(a)(3)(A).

(b) APPLICATION OF PART C PROVISIONS UNDER THIS PART.—For purposes of applying provisions of part C under this part with respect to a prescription drug plan and a PDP sponsor, unless otherwise provided in this part such provisions shall be applied as if—

(1) any reference to an MA plan included a reference to a prescription drug plan;

(2) any reference to an MA organization or a provider-sponsored organization included a reference to a PDP sponsor;

(3) any reference to a contract under section 1857 included a reference to a contract under section 1860D-12(b);

(4) any reference to part C included a reference to this part; and

(5) any reference to an election period under section 1851 were a reference to an enrollment period under section 1860D-1.

MISCELLANEOUS PROVISIONS

SEC. 1860D-42. [42 U.S.C. 1395w-152] (a) ACCESS TO COVERAGE IN TERRITORIES.—The Secretary may waive such requirements of this part, including section 1860D-3(a)(1), insofar as the Secretary determines it is necessary to secure access to qualified prescription drug coverage for part D eligible individuals residing in a State (other than the 50 States and the District of Columbia).

(b) APPLICATION OF DEMONSTRATION AUTHORITY.—The provisions of section 402 of the Social Security Amendments of 1967 (Public Law 90-248) shall apply with respect to this part and part C in the same manner it applies with respect to parts A and B, except that any reference with respect to a Trust Fund in relation to an experiment or demonstration project relating to prescription drug coverage under this part shall be deemed a reference to the Medicare Prescription Drug Account within the Federal Supplementary Medical Insurance Trust Fund.

Part E [389]—Miscellaneous Provisions

DEFINITIONS OF SERVICES, INSTITUTIONS, ETC. [390]

SEC. 1861. [42 U.S.C. 1395x] For purposes of this title—

Spell of Illness

(a) The term "spell of illness" with respect to any individual means a period of consecutive days—

(1) beginning with the first day (not included in a previous spell of illness) (A) on which such individual is furnished inpatient hospital services, inpatient critical access hospital services or extended care services, and (B) which occurs in a month for which he is entitled to benefits under part A, and

(2) ending with the close of the first period of 60 consecutive days thereafter on each of which he is neither an inpatient of a hospital or critical access hospital nor an inpatient of a facility described in section 1819(a)(1) or subsection (y)(1).

Inpatient Hospital Services

(b) The term "inpatient hospital services" means the following items and services furnished to an inpatient of a hospital and (except as provided in paragraph (3)) by the hospital—

(1) bed and board;

[389] P.L. 108-173, §101(a)(1), redesignated the former Part D as Part E, effective December 8, 2003.

[390] See Vol. II, P.L. 94–437, §403, with respect to an accounting of funds which must be included in the Secretary's annual report.

See Vol. II, P.L. 108-173, §434, with respect to a frontier extended stay clinic demonstration project; §643, with respect to a MEDPAC study of coverage of surgical first assisting services of certified registered nurse first assistants; §645, with respect to studies relating to vision impairments; §651, with respect to demonstration project on coverage of chiropractic services under Medicare; §702, with respect to a demonstration project to clarify the definition of homebound; and §926(a), with respect to availability of information relating to Medicare skilled nursing facilities.

(2) such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by such hospital for the care and treatment of inpatients; and

(3) such other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangements with them made by the hospital, as are ordinarily furnished to inpatients either by such hospital or by others under such arrangements;

excluding, however—

(4) medical or surgical services provided by a physician, resident, or intern, services described by subsection (s)(2)(K), certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist; and

(5) the services of a private-duty nurse or other private-duty attendant.

Paragraph (4) shall not apply to services provided in a hospital by—

(6) an intern or a resident-in-training under a teaching program approved by the Council on Medical Education of the American Medical Association or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, or, in the case of services in a hospital or osteopathic hospital by an intern or resident-in-training in the field of dentistry, approved by the Council on Dental Education of the American Dental Association, or in the case of services in a hospital or osteopathic hospital by an intern or resident-in-training in the field of podiatry, approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association; or

(7) a physician where the hospital has a teaching program approved as specified in paragraph (6), if (A) the hospital elects to receive any payment due under this title for reasonable costs of such services, and (B) all physicians in such hospital agree not to bill charges for professional services rendered in such hospital to individuals covered under the insurance program established by this title.

Inpatient Psychiatric Hospital Services

(c) The term "inpatient psychiatric hospital services" means inpatient hospital services furnished to an inpatient of a psychiatric hospital.

Supplier

(d)[391] The term "supplier" means, unless the context otherwise requires, a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under this title.

[391] P.L. 108–173, §901(b), added subsection (d), effective December 8, 2003.

Hospital

(e) The term "hospital" (except for purposes of sections 1814(d), 1814(f), and 1835(b), subsection (a)(2) of this section, paragraph (7) of this subsection, and subsection (i) of this section) means an institution which—

(1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(2) maintains clinical records on all patients;

(3) has bylaws in effect with respect to its staff of physicians;

(4) has a requirement that every patient with respect to whom payment may be made under this title must be under the care of a physician except that a patient receiving qualified psychologist services (as defined in subsection (ii)) may be under the care of a clinical psychologist with respect to such services to the extent permitted under State law;

(5) provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times; except that until January 1, 1979, the Secretary is authorized to waive the requirement of this paragraph for any one-year period with respect to any institution, insofar as such requirement relates to the provision of twenty-four-hour nursing service rendered or supervised by a registered professional nurse (except that in any event a registered professional nurse must be present on the premises to render or supervise the nursing service provided, during at least the regular daytime shift), where immediately preceding such one-year period he finds that—

(A) such institution is located in a rural area and the supply of hospital services in such area is not sufficient to meet the needs of individuals residing therein,

(B) the failure of such institution to qualify as a hospital would seriously reduce the availability of such services to such individuals, and

(C) such institution has made and continues to make a good faith effort to comply with this paragraph, but such compliance is impeded by the lack of qualified nursing personnel in such area;

(6)(A) has in effect a hospital utilization review plan which meets the requirements of subsection (k) and

(B) has in place a discharge planning process that meets the requirements of subsection (ee);

(7) in the case of an institution in any State in which State or applicable local law provides for the licensing of hospitals, (A) is licensed pursuant to such law or (B) is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing;

(8) has in effect an overall plan and budget that meets the requirements of subsection (z); and

(9) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution.

For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. For purposes of sections 1814(d) and 1835(b) (including determination of whether an individual received inpatient hospital services or diagnostic services for purposes of such sections), section 1814(f)(2), and subsection (i) of this section, such term includes any institution which (i) meets the requirements of paragraphs (5) and (7) of this subsection, (ii) is not primarily engaged in providing the services described in section 1861(j)(1)(A) and (iii) is primarily engaged in providing, by or under the supervision of individuals referred to in paragraph (1) of section 1861(r), to inpatients diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. For purposes of section 1814(f)(1), such term includes an institution which (i) is a hospital for purposes of sections 1814(d), 1814(f)(2), and 1835(b) and (ii) is accredited by the Joint Commission on Accreditation of Hospitals, or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be essentially equivalent to those of the Joint Commission on Accreditation of Hospitals. Notwithstanding the preceding provisions of this subsection, such term shall not, except for purposes of subsection (a)(2), include any institution which is primarily for the care and treatment of mental diseases unless it is a psychiatric hospital (as defined in subsection (f)). The term "hospital" also includes a religious nonmedical health care institution (as defined in subsection (ss)(1)), with respect to items and services ordinarily furnished by such institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations consistent with section 1821. For provisions deeming certain requirements of this subsection to be met in the case of accredited institutions, see section 1865. The term "hospital" also includes a facility of fifty beds or less which is located in an area determined by the Secretary to meet the definition relating to a rural area described in subparagraph (A) of paragraph (5) of this subsection and which meets the other requirements of this subsection, except that—

(A) with respect to the requirements for nursing services applicable after December 31, 1978, such requirements shall provide for temporary waiver of the requirements, for such period as the Secretary deems appropriate, where (i) the facility's failure to fully comply with the requirements is attributable to a temporary shortage of qualified nursing personnel in the area in which the facility is located, (ii) a registered professional nurse is present on the premises to render or supervise the nursing service provided during at least the regular daytime shift, and (iii) the Secretary determines that the employment of such nursing personnel as are available to the facility during such temporary period will not adversely affect the health and safety of patients;

(B) with respect to the health and safety requirements promulgated under paragraph (9), such requirements shall be applied by the Secretary to a facility herein defined in such manner as to assure that personnel requirements take into account the availability of technical personnel and the educational opportunities for technical personnel in the area in which such facility is located, and the scope of services rendered by such facility; and the Secretary, by regulations, shall provide for the continued participation of such a facility where such personnel requirements are not fully met, for such period as the Secretary determines that (i) the facility is making good faith efforts to fully comply with the personnel requirements, (ii) the employment by the facility of such personnel as are available to the facility will not adversely affect the health and safety of patients, and (iii) if the Secretary has determined that because of the facility's waiver under this subparagraph the facility should limit its scope of services in order not to adversely affect the health and safety of the facility's patients, the facility is so limiting the scope of services it provides; and

(C) with respect to the fire and safety requirements promulgated under paragraph (9), the Secretary (i) may waive, for such period as he deems appropriate, specific provisions of such requirements which if rigidly applied would result in unreasonable hardship for such a facility and which, if not applied, would not jeopardize the health and safety of patients, and (ii) may accept a facility's compliance with all applicable State codes relating to fire and safety in lieu of compliance with the fire and safety requirements promulgated under paragraph (9), if he determines that such State has in effect fire and safety codes, imposed by State law, which adequately protect patients.

The term "hospital" does not include, unless the context otherwise requires, a critical access hospital (as defined in section 1861(mm)(1)).

Psychiatric Hospital

(f) The term "psychiatric hospital" means an institution which—

(1) is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons;

(2) satisfies the requirements of paragraphs (3) through (9) of subsection (e);

(3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals entitled to hospital insurance benefits under part A; and

(4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution.

In the case of an institution which satisfies paragraphs (1) and (2) of the preceding sentence and which contains a distinct part which

also satisfies paragraphs (3) and (4) of such sentence, such distinct part shall be considered to be a "psychiatric hospital".

Outpatient Occupational Therapy Services

(g) The term "outpatient occupational therapy services" has the meaning given the term "outpatient physical therapy services" in subsection (p), except that "occupational" shall be substituted for "physical" each place it appears therein.

Extended Care Services

(h) The term "extended care services" means the following items and services furnished to an inpatient of a skilled nursing facility and (except as provided in paragraphs (3), (6), and (7)) by such skilled nursing facility—

(1) nursing care provided by or under the supervision of a registered professional nurse;

(2) bed and board in connection with the furnishing of such nursing care;

(3) physical or occupational therapy or speech-language pathology services furnished by the skilled nursing facility or by others under arrangements with them made by the facility;

(4) medical social services;

(5) such drugs, biologicals, supplies, appliances, and equipment, furnished for use in the skilled nursing facility, as are ordinarily furnished by such facility for the care and treatment of inpatients;

(6) medical services provided by an intern or resident-in-training of a hospital with which the facility has in effect a transfer agreement (meeting the requirements of subsection (l)), under a teaching program of such hospital approved as provided in the last sentence of subsection (b), and other diagnostic or therapeutic services provided by a hospital with which the facility has such an agreement in effect; and

(7) such other services necessary to the health of the patients as are generally provided by skilled nursing facilities, or by others under arrangements with them made by the facility; able).

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital.

Post–Hospital Extended Care Services

(i) The term "post-hospital extended care services" means extended care services furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer. For purposes of the preceding sentence, items and services shall be deemed to have been furnished to an individual after transfer from a hospital, and he shall be deemed to have been an inpatient in the hospital immediately before transfer therefrom, if he is admitted to the skilled nursing facility (A) within 30 days after discharge from such hospital, or (B) within such time as it would be medically appropriate to begin an active course of treatment, in the case of an individual whose condition is such that skilled nursing facility care would not be medically appropriate

within 30 days after discharge from a hospital; and an individual shall be deemed not to have been discharged from a skilled nursing facility if, within 30 days after discharge therefrom, he is admitted to such facility or any other skilled nursing facility.

Skilled Nursing Facility

(j) The term "skilled nursing facility" has the meaning given such term in section 1819(a).

Utilization Review

(k) A utilization review plan of a hospital or skilled nursing facility shall be considered sufficient if it is applicable to services furnished by the institution to individuals entitled to insurance benefits under this title and if it provides—

(1) for the review, on a sample or other basis, of admissions to the institution, the duration of stays therein, and the professional services (including drugs and biologicals) furnished, (A) with respect to the medical necessity of the services, and (B) for the purpose of promoting the most efficient use of available health facilities and services;

(2) for such review to be made by either (A) a staff committee of the institution composed of two or more physicians (of which at least two must be physicians described in subsection (r)(1) of this section), with or without participation of other professional personnel, or (B) a group outside the institution which is similarly composed and (i) which is established by the local medical society and some or all of the hospitals and skilled nursing facilities in the locality, or (ii) if (and for as long as) there has not been established such a group which serves such institution, which is established in such other manner as may be approved by the Secretary;

(3) for such review, in each case of inpatient hospital services or extended care services furnished to such an individual during a continuous period of extended duration, as of such days of such period (which may differ for different classes of cases) as may be specified in regulations, with such review to be made as promptly as possible, after each day so specified, and in no event later than one week following such day; and

(4) for prompt notification to the institution, the individual, and his attending physician of any finding (made after opportunity for consultation to such attending physician) by the physician members of such committee or group that any further stay in the institution is not medically necessary.

The review committee must be composed as provided in clause (B) of paragraph (2) rather than as provided in clause (A) of such paragraph in the case of any hospital or skilled nursing facility where, because of the small size of the institution, or (in the case of a skilled nursing facility) because of lack of an organized medical staff, or for such other reason or reasons as may be included in regulations, it is impracticable for the institution to have a properly functioning staff committee for the purposes of this subsection. If the Secretary determines that the utilization review procedures established pursuant to title XIX are superior in their effectiveness to the procedures required under this section, he may, to the extent that he deems it appropriate, require for purposes of this title that

the procedures established pursuant to title XIX be utilized instead of the procedures required by this section.

Agreements for Transfer Between Skilled Nursing Facilities and Hospitals

(l) A hospital and a skilled nursing facility shall be considered to have a transfer agreement in effect if, by reason of a written agreement between them or (in case the two institutions are under common control) by reason of a written undertaking by the person or body which controls them, there is reasonable assurance that—

(1) transfer of patients will be effected between the hospital and the skilled nursing facility whenever such transfer is medically appropriate as determined by the attending physician; and

(2) there will be interchange of medical and other information necessary or useful in the care and treatment of individuals transferred between the institutions, or in determining whether such individuals can be adequately cared for otherwise than in either of such institutions.

Any skilled nursing facility which does not have such an agreement in effect, but which is found by a State agency (of the State in which such facility is situated) with which an agreement under section 1864 is in effect (or, in the case of a State in which no such agency has an agreement under section 1864, by the Secretary) to have attempted in good faith to enter into such an agreement with a hospital sufficiently close to the facility to make feasible the transfer between them of patients and the information referred to in paragraph (2), shall be considered to have such an agreement in effect if and for so long as such agency (or the Secretary, as the case may be) finds that to do so is in the public interest and essential to assuring extended care services for persons in the community who are eligible for payments with respect to such services under this title.

Home Health Services

(m) The term "home health services" means the following items and services furnished to an individual, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician, which items and services are, except as provided in paragraph (7), provided on a visiting basis in a place of residence used as such individual's home—

(1) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

(2) physical or occupational therapy or speech-language pathology services;

(3) medical social services under the direction of a physician;

(4) to the extent permitted in regulations, part-time or intermittent services of a home health aide who has successfully completed a training program approved by the Secretary;

(5) medical supplies (including catheters, catheter supplies, ostomy bags, and supplies related to ostomy care, and a covered osteoporosis drug (as defined in subsection (kk)), but ex-

cluding other drugs and biologicals) and durable medical equipment while under such a plan;

(6) in the case of a home health agency which is affiliated or under common control with a hospital, medical services provided by an intern or resident-in-training of such hospital, under a teaching program of such hospital approved as provided in the last sentence of subsection (b); and

(7) any of the foregoing items and services which are provided on an outpatient basis, under arrangements made by the home health agency, at a hospital or skilled nursing facility, or at a rehabilitation center which meets such standards as may be prescribed in regulations, and—

(A) the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual in such place of residence, or

(B) which are furnished at such facility while he is there to receive any such item or service described in clause (A),

but not including transportation of the individual in connection with any such item or service;

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital. For purposes of paragraphs (1) and (4), the term "part–time or intermittent services" means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case–by–case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week). For purposes of sections 1814(a)(2)(C) and 1835(a)(2)(A), "intermittent" means skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).

Durable Medical Equipment

(n) The term "durable medical equipment" includes iron lungs, oxygen tents, hospital beds, and wheelchairs (which may include a power-operated vehicle that may be appropriately used as a wheelchair, but only where the use of such a vehicle is determined to be necessary on the basis of the individual's medical and physical condition and the vehicle meets such safety requirements as the Secretary may prescribe) used in the patient's home (including an institution used as his home other than an institution that meets the requirements of subsection (e)(1) of this section or section 1819(a)(1)), whether furnished on a rental basis or purchased, and includes blood–testing strips and blood glucose monitors for individuals with diabetes without regard to whether the individual has Type I or Type II diabetes or to the individual's use of insulin (as determined under standards established by the Secretary in consultation with the appropriate organizations); except that such term does not include such equipment furnished by a supplier who has used, for the demonstration and use of specific equipment, an individual who has not met such minimum training standards as the Secretary may establish with respect to the demonstration and

use of such specific equipment. With respect to a seat-lift chair, such term includes only the seat-lift mechanism and does not include the chair.

Home Health Agency

(o) The term "home health agency" means a public agency or private organization, or a subdivision of such an agency or organization, which—

(1) is primarily engaged in providing skilled nursing services and other therapeutic services;

(2) has policies, established by a group of professional personnel (associated with the agency or organization), including one or more physicians and one or more registered professional nurses, to govern the services (referred to in paragraph (1)) which it provides, and provides for supervision of such services by a physician or registered professional nurse;

(3) maintains clinical records on all patients;

(4) in the case of an agency or organization in any State in which State or applicable local law provides for the licensing of agencies or organizations of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing;

(5) has in effect an overall plan and budget that meets the requirements of subsection (z);

(6) meets the conditions of participation specified in section 1891(a) and such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such agency or organization;

(7) provides the Secretary with a surety bond—

(A) effective for a period of 4 years (as specified by the Secretary) or in the case of a change in the ownership or control of the agency (as determined by the Secretary) during or after such 4–year period, an additional period of time that the Secretary determines appropriate, such additional period not to exceed 4 years from the date of such change in ownership or control;

(B) in a form specified by the Secretary; and

(C) for a year in the period described in subparagraph (A) in an amount that is equal to the lesser of $50,000 or 10 percent of the aggregate amount of payments to the agency under this title and title XIX for that year, as estimated by the Secretary; and

(8) meets such additional requirements (including conditions relating to bonding or establishing of escrow accounts as the Secretary finds necessary for the financial security of the program) as the Secretary finds necessary for the effective and efficient operation of the program;

except that for purposes of part A such term shall not include any agency or organization which is primarily for the care and treatment of mental diseases. The Secretary may waive the requirement of a surety bond under paragraph (7) in the case of an agency or

organization that provides a comparable surety bond under State law.

Outpatient Physical Therapy Services

(p) The term "outpatient physical therapy services" means physical therapy services furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient—

(1) who is under the care of a physician (as defined in paragraph (1), (3), or (4) of section 1861(r)), and

(2) with respect to whom a plan prescribing the type, amount, and duration of physical therapy services that are to be furnished such individual has been established by a physician (as so defined) or by a qualified physical therapist and is periodically reviewed by a physician (as so defined);

excluding, however—

(3) any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital; and

(4) any such service—

(A) if furnished by a clinic or rehabilitation agency, or by others under arrangements with such clinic or agency, unless such clinic or rehabilitation agency—

(i) provides an adequate program of physical therapy services for outpatients and has the facilities and personnel required for such program or required for the supervision of such a program, in accordance with such requirements as the Secretary may specify,

(ii) has policies, established by a group of professional personnel, including one or more physicians (associated with the clinic or rehabilitation agency) and one or more qualified physical therapists, to govern the services (referred to in clause (i)) it provides,

(iii) maintains clinical records on all patients,

(iv) if such clinic or agency is situated in a State in which State or applicable local law provides for the licensing of institutions of this nature, (I) is licensed pursuant to such law, or (II) is approved by the agency of such State or locality responsible for licensing institutions of this nature, as meeting the standards established for such licensing; and

(v) meets such other conditions relating to the health and safety of individuals who are furnished services by such clinic or agency on an outpatient basis, as the Secretary may find necessary, and provides the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000, or

(B) if furnished by a public health agency, unless such agency meets such other conditions relating to health and safety of individuals who are furnished services by such agency on an outpatient basis, as the Secretary may find necessary.

The term "outpatient physical therapy services" also includes physical therapy services furnished an individual by a physical therapist (in his office or in such individual's home) who meets licensing and other standards prescribed by the Secretary in regulations, otherwise than under an arrangement with and under the supervision of a provider of services, clinic, rehabilitation agency, or public health agency, if the furnishing of such services meets such conditions relating to health and safety as the Secretary may find necessary. In addition, such term includes physical therapy services which meet the requirements of the first sentence of this subsection except that they are furnished to an individual as an inpatient of a hospital or extended care facility. The term "outpatient physical therapy services" also includes speech-language pathology services furnished by a provider of services, a clinic, rehabilitation agency, or by a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient, subject to the conditions prescribed in this subsection. Nothing in this subsection shall be construed as requiring, with respect to outpatients who are not entitled to benefits under this title, a physical therapist to provide outpatient physical therapy services only to outpatients who are under the care of a physician or pursuant to a plan of care established by a physician. The Secretary may waive the requirement of a surety bond under paragraph (4)(A)(v) in the case of a clinic or agency that provides a comparable surety bond under State law.

Physicians' Services

(q) The term "physicians' services" means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls (but not including services described in subsection (b)(6)).

Physician

(r) The term "physician", when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)), (2) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions, (3) a doctor of podiatric medicine for the purposes of subsections (k), (m), (p)(1), and (s) of this section and sections 1814(a), 1832(a)(2)(F)(ii), and 1835 but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them, (4) a doctor of optometry, but only for purposes of subsection (p)(1) with respect to the provision of items or services described in subsection (s) which he is legally authorized to perform as a doctor of optometry by the State in which he performs them, or (5) a chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Sec-

retary, but only for the purpose of sections 1861(s)(1) and 1861(s)(2)(A) and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided. For the purposes of section 1862(a)(4) and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previous sentence, legally authorized to practice such art in the country in which the inpatient hospital services (referred to in such section 1862(a)(4)) are furnished.

Medical and Other Health Services

(s) The term "medical and other health services" means any of the following items or services:

(1) physicians' services;

(2)(A) services and supplies (including drugs and biologicals which are not usually self–administered by the patient) furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills (or would have been so included but for the application of section 1847B)[392];

(B) hospital services (including drugs and biologicals which are not usually self–administered by the patient) incident to physicians' services rendered to outpatients and partial hospitalization services incident to such services;

(C) diagnostic services which are—

(i) furnished to an individual as an outpatient by a hospital or by others under arrangements with them made by a hospital, and

(ii) ordinarily furnished by such hospital (or by others under such arrangements) to its outpatients for the purpose of diagnostic study;

(D) outpatient physical therapy services and outpatient occupational therapy services;

(E) rural health clinic services and Federally qualified health center services;

(F) home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies;

(G) antigens (subject to quantity limitations prescribed in regulations by the Secretary) prepared by a physician, as defined in section 1861(r)(1), for a particular patient, including antigens so prepared which are forwarded to another qualified person (including a rural health clinic) for administration to such patient, from time to time, by or under the supervision of another such physician;

(H)(i) services furnished pursuant to a contract under section 1876 to a member of an eligible organization by a physician assistant or by a nurse practitioner (as defined in subsection (aa)(5)) and such services and supplies furnished as an incident to his service to such a member as

[392] P.L. 108–173, §303(i)(2), inserted "(or would have been so included but for the application of section 1847B)", effective December 8, 2003.

would otherwise be covered under this part if furnished by a physician or as an incident to a physician's service; and

(ii) services furnished pursuant to a risk-sharing contract under section 1876(g) to a member of an eligible organization by a clinical psychologist (as defined by the Secretary) or by a clinical social worker (as defined in subsection (hh)(2)), and such services and supplies furnished as an incident to such clinical psychologist's services or clinical social worker's services to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician's service;

(I) blood clotting factors, for hemophilia patients competent to use such factors to control bleeding without medical or other supervision, and items related to the administration of such factors, subject to utilization controls deemed necessary by the Secretary for the efficient use of such factors;

(J) prescription drugs used in immunosuppressive therapy furnished, to an individual who receives an organ transplant for which payment is made under this title;

(K)(i) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a physician assistant (as defined in subsection (aa)(5)) under the supervision of a physician (as so defined) and which the physician assistant is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service, but[393] only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services,

(ii) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner or clinical nurse specialist (as defined in subsection (aa)(5)) working in collaboration (as defined in subsection (aa)(6)) with a physician (as defined in subsection (r)(1)) which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services;

(L) certified nurse-midwife services;

(M) qualified psychologist services;

(N) clinical social worker services (as defined in subsection (hh)(2));

(O) erythropoietin for dialysis patients competent to use such drug without medical or other supervision with re-

[393] P.L. 108–173, §736(b)(11), struck out "; and but" and substituted ", but".

spect to the administration of such drug, subject to methods and standards established by the Secretary by regulation for the safe and effective use of such drug, and items related to the administration of such drug;

(P) prostate cancer screening tests (as defined in subsection (oo));

(Q) an oral drug (which is approved by the Federal Food and Drug Administration) prescribed for use as an anticancer chemotherapeutic agent for a given indication, and containing an active ingredient (or ingredients), which is the same indication and active ingredient (or ingredients) as a drug which the carrier determines would be covered pursuant to subparagraph (A) or (B) if the drug could not be self-administered;

(R) colorectal cancer screening tests (as defined in subsection (pp));

(S) diabetes outpatient self–management training services (as defined in subsection (qq));

(T) an oral drug (which is approved by the Federal Food and Drug Administration) prescribed for use as an acute anti–emetic used as part of an anticancer chemotherapeutic regimen if the drug is administered by a physician (or as prescribed by a physician)—

(i) for use immediately before, at, or within 48 hours after the time of the administration of the anticancer chemotherapeutic agent; and

(ii) as a full replacement for the anti–emetic therapy which would otherwise be administered intravenously;

(U) screening for glaucoma (as defined in subsection (uu)) for individuals determined to be at high risk for glaucoma, individuals with a family history of glaucoma and individuals with diabetes;[394]

(V) medical nutrition therapy services (as defined in subsection (vv)(1)) in the case of a beneficiary with diabetes or a renal disease who—

(i) has not received diabetes outpatient self–management training services within a time period determined by the Secretary;

(ii) is not receiving maintenance dialysis for which payment is made under section 1881; and

(iii) meets such other criteria determined by the Secretary after consideration of protocols established by dietitian or nutrition professional organizations;[395]

(W)[396] an initial preventive physical examination (as defined in subsection (ww));[397]

(X)[398] cardiovascular screening blood tests (as defined in subsection (xx)(1));[399]

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[394] P.L. 108-173, §611(a)(1), struck out "and".

[395] P.L. 108-173, §611(a)(2), inserted "and"; 612(a)(1), struck out "and".

[396] P.L. 108-173, §611(a)(3), added subparagraph (W), applicable to services furnished on or after January 1, 2005, but only for individuals whose coverage period under part B begins on or after such date.

[397] P.L. 108-173, §612(a)(2), inserted "and"; §613(a)(1), struck out "and".

[398] P.L. 108-173, §612(a)(3), added subparagraph (X), applicable to tests furnished on or after January 1, 2005.

[399] P.L. 108-173, §613(a)(2), added "and"; §642(a)(1)(A), struck out "and".

(Y)[400] diabetes screening tests (as defined in subsection (yy)); and[401]

(Z)[402] intravenous immune globulin for the treatment of primary immune deficiency diseases in the home (as defined in subsection (zz));

(3) diagnostic X-ray tests (including tests under the supervision of a physician, furnished in a place of residence used as the patient's home, if the performance of such tests meets such conditions relating to health and safety as the Secretary may find necessary and including diagnostic mammography if conducted by a facility that has a certificate (or provisional certificate) issued under section 354 of the Public Health Service Act[403]), diagnostic laboratory tests, and other diagnostic tests;

(4) X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;

(5) surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations;

(6) durable medical equipment;

(7)[404] ambulance service where the use of other methods of transportation is contraindicated by the individual's condition, but[405] only to the extent provided in regulations;

(8) prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of such devices, and including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens;

(9) leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the patient's physical condition;

(10)(A) pneumococcal vaccine and its administration and, subject to section 4071(b) of the Omnibus Budget Reconciliation Act of 1987,[406] influenza vaccine and its administration; and

(B) hepatitis B vaccine and its administration, furnished to an individual who is at high or intermediate risk of contracting hepatitis B (as determined by the Secretary under regulations);

(11) services of a certified registered nurse anesthetist (as defined in subsection (bb));

(12) subject to section 4072(e) of the Omnibus Budget Reconciliation Act of 1987[407], extra-depth shoes with inserts or custom molded shoes with inserts for an individual with diabetes, if—

(A) the physician who is managing the individual's diabetic condition (i) documents that the individual has peripheral neuropathy with evidence of callus formation, a

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[400] P.L. 108-173, §613(a)(3), added subparagraph (Y), applicable to tests furnished after January 1, 2005.

[401] P.L. 108-173, §642(a)(1)(B), added "and".

[402] P.L. 108-173, §642(a)(1)(c), added subparagraph (Z), applicable to items furnished administered on or after January 1, 2004.

[403] See Vol. II, P.L. 78–410.

[404] See Vol. II, P.L. 105–33, §4531(c), with respect to authorizing payment for paramedic intercept service providers in rural communities.

[405] P.L. 108-173, §415(b), inserted ", subject to section 1834(l)(14),".

[406] See Vol. II, P.L. 100–203.

[407] See Vol. II, P.L. 100–203.

history of pre-ulcerative calluses, a history of previous ulceration, foot deformity, or previous amputation, or poor circulation, and (ii) certifies that the individual needs such shoes under a comprehensive plan of care related to the individual's diabetic condition;

(B) the particular type of shoes are prescribed by a podiatrist or other qualified physician (as established by the Secretary); and

(C) the shoes are fitted and furnished by a podiatrist or other qualified individual (such as a pedorthist or orthotist, as established by the Secretary) who is not the physician described in subparagraph (A) (unless the Secretary finds that the physician is the only such qualified individual in the area);

(13) screening mammography (as defined in subsection (jj));

(14) screening pap smear and screening pelvic exam; and

(15) bone mass measurement (as defined in subsection (rr)).

No diagnostic tests performed in any laboratory, including a laboratory that is part of a rural health clinic, or a hospital (which, for purposes of this sentence, means an institution considered a hospital for purposes of section 1814(d)) shall be included within paragraph (3) unless such laboratory—

(16) if situated in any State in which State or applicable local law provides for licensing of establishments of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing establishments of this nature, as meeting the standards established for such licensing; and

(17)(A) meets the certification requirements under section 353 of the Public Health Service Act;[408] and

(B) meets such other conditions relating to the health and safety of individuals with respect to whom such tests are performed as the Secretary may find necessary.

There shall be excluded from the diagnostic services specified in paragraph (2)(C) any item or service (except services referred to in paragraph (1)) which would not be included under subsection (b) if it were furnished to an inpatient of a hospital. None of the items and services referred to in the preceding paragraphs (other than paragraphs (1) and (2)(A)) of this subsection which are furnished to a patient of an institution which meets the definition of a hospital for purposes of section 1814(d) shall be included unless such other conditions are met as the Secretary may find necessary relating to health and safety of individuals with respect to whom such items and services are furnished.

Drugs and Biologicals

(t)(1) The term "drugs" and the term "biologicals", except for purposes of subsection (m)(5) and paragraph (2), include only such drugs (including contrast agents) and biologicals, respectively, as are included (or approved for inclusion) in the United States Pharmacopoeia, the National Formulary, or the United States Homeopathic Pharmacopoeia, or in New Drugs or Accepted Dental Remedies (except for any drugs and biologicals unfavorably evaluated therein), or as are approved by the pharmacy and drug thera-

[408] See Vol. II, P.L. 78–410.

peutics committee (or equivalent committee) of the medical staff of the hospital furnishing such drugs and biologicals for use in such hospital.

(2)(A) For purposes of paragraph (1), the term "drugs" also includes any drugs or biologicals used in an anticancer chemotherapeutic regimen for a medically accepted indication (as described in subparagraph (B)).

(B) In subparagraph (A), the term "medically accepted indication", with respect to the use of a drug, includes any use which has been approved by the Food and Drug Administration for the drug, and includes another use of the drug if—

(i) the drug has been approved by the Food and Drug Administration; and

(ii)(I) such use is supported by one or more citations which are included (or approved for inclusion) in one or more of the following compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations, the United States Pharmacopoeia-Drug Information, and other authoritative compendia as identified by the Secretary, unless the Secretary has determined that the use is not medically appropriate or the use is identified as not indicated in one or more such compendia, or

(II) the carrier involved determines, based upon guidance provided by the Secretary to carriers for determining accepted uses of drugs, that such use is medically accepted based on supportive clinical evidence in peer reviewed medical literature appearing in publications which have been identified for purposes of this subclause by the Secretary.

The Secretary may revise the list of compendia in clause (ii)(I) as is appropriate for identifying medically accepted indications for drugs.

Provider of Services

(u) The term "provider of services" means a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, or, for purposes of section 1814(g) and section 1835(e), a fund.

Reasonable Cost

(v)(1)(A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence,

the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this title, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this title) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

(B) In the case of extended care services, the regulations under subparagraph (A) shall not include provision for specific recognition of a return on equity capital.

(C) Where a hospital has an arrangement with a medical school under which the faculty of such school provides services at such hospital, an amount not in excess of the reasonable cost of such services to the medical school shall be included in determining the reasonable cost to the hospital of furnishing services—

(i) for which payment may be made under part A, but only if—

(I) payment for such services as furnished under such arrangement would be made under part A to the hospital had such services been furnished by the hospital, and

(II) such hospital pays to the medical school at least the reasonable cost of such services to the medical school, or

(ii) for which payment may be made under part B, but only if such hospital pays to the medical school at least the reasonable cost of such services to the medical school.

(D) Where (i) physicians furnish services which are either inpatient hospital services (including services in con-

junction with the teaching programs of such hospital) by reason of paragraph (7) of subsection (b) or for which entitlement exists by reason of clause (II) of section 1832(a)(2)(B)(i), and (ii) such hospital (or medical school under arrangement with such hospital) incurs no actual cost in the furnishing of such services, the reasonable cost of such services shall (under regulations of the Secretary) be deemed to be the cost such hospital or medical school would have incurred had it paid a salary to such physicians rendering such services approximately equivalent to the average salary paid to all physicians employed by such hospital (or if such employment does not exist, or is minimal in such hospital, by similar hospitals in a geographic area of sufficient size to assure reasonable inclusion of sufficient physicians in development of such average salary).

(E) Such regulations may, in the case of skilled nursing facilities in any State, provide for the use of rates, developed by the State in which such facilities are located, for the payment of the cost of skilled nursing facility services furnished under the State's plan approved under title XIX (and such rates may be increased by the Secretary on a class or size of institution or on a geographical basis by a percentage factor not in excess of 10 percent to take into account determinable items or services or other requirements under this title not otherwise included in the computation of such State rates), if the Secretary finds that such rates are reasonably related to (but not necessarily limited to) analyses undertaken by such State of costs of care in comparable facilities in such State. Notwithstanding the previous sentence, such regulations with respect to skilled nursing facilities shall take into account (in a manner consistent with subparagraph (A) and based on patient-days of services furnished) the costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this title) of such facilities complying with the requirements of subsections (b), (c), and (d) of section 1819 (including the costs of conducting nurse aide training and competency evaluation programs and competency evaluation programs).

(F) Such regulations shall require each provider of services (other than a fund) to make reports to the Secretary of information described in section 1121(a) in accordance with the uniform reporting system (established under such section) for that type of provider.

(G)(i) In any case in which a hospital provides inpatient services to an individual that would constitute post-hospital extended care services if provided by a skilled nursing facility and a quality control and peer review organization (or, in the absence of such a qualified organization, the Secretary or such agent as the Secretary may designate) determines that inpatient hospital services for the individual are not medically necessary but post-hospital extended care services for the individual are medically necessary and such extended care services are not otherwise available to the individual (as determined in accordance

with criteria established by the Secretary) at the time of such determination, payment for such services provided to the individual shall continue to be made under this title at the payment rate described in clause (ii) during the period in which—

(I) such post-hospital extended care services for the individual are medically necessary and not otherwise available to the individual (as so determined),

(II) inpatient hospital services for the individual are not medically necessary, and

(III) the individual is entitled to have payment made for post-hospital extended care services under this title,

except that if the Secretary determines that there is not an excess of hospital beds in such hospital and (subject to clause (iv)) there is not an excess of hospital beds in the area of such hospital, such payment shall be made (during such period) on the basis of the amount otherwise payable under part A with respect to inpatient hospital services.

(ii)(I) Except as provided in subclause (II), the payment rate referred to in clause (i) is a rate equal to the estimated adjusted State-wide average rate per patient-day paid for services provided in skilled nursing facilities under the State plan approved under title XIX for the State in which such hospital is located, or, if the State in which the hospital is located does not have a State plan approved under title XIX, the estimated adjusted State-wide average allowable costs per patient-day for extended care services under this title in that State.

(II) If a hospital has a unit which is a skilled nursing facility, the payment rate referred to in clause (i) for the hospital is a rate equal to the lesser of the rate described in subclause (I) or the allowable costs in effect under this title for extended care services provided to patients of such unit.

(iii) Any day on which an individual receives inpatient services for which payment is made under this subparagraph shall, for purposes of this Act (other than this subparagraph), be deemed to be a day on which the individual received inpatient hospital services.

(iv) In determining under clause (i), in the case of a public hospital, whether or not there is an excess of hospital beds in the area of such hospital, such determination shall be made on the basis of only the public hospitals (including the hospital) which are in the area of the hospital and which are under common ownership with that hospital.

(H) In determining such reasonable cost with respect to home health agencies, the Secretary may not include—

(i) any costs incurred in connection with bonding or establishing an escrow account by any such agency as a result of the surety bond requirement described in

subsection (o)(7) and the financial security requirement described in subsection (o)(8);

(ii) in the case of home health agencies to which the surety bond requirement described in subsection (o)(7) and the financial security requirement described in subsection (o)(8) apply, any costs attributed to interest charged such an agency in connection with amounts borrowed by the agency to repay overpayments made under this title to the agency, except that such costs may be included in reasonable cost if the Secretary determines that the agency was acting in good faith in borrowing the amounts;

(iii) in the case of contracts entered into by a home health agency after the date of the enactment of this subparagraph[409] for the purpose of having services furnished for or on behalf of such agency, any cost incurred by such agency pursuant to any such contract which is entered into for a period exceeding five years; and

(iv) in the case of contracts entered into by a home health agency before the date of the enactment of this subparagraph[410] for the purpose of having services furnished for or on behalf of such agency, any cost incurred by such agency pursuant to any such contract, which determines the amount payable by the home health agency on the basis of a percentage of the agency's reimbursement or claim for reimbursement for services furnished by the agency, to the extent that such cost exceeds the reasonable value of the services furnished on behalf of such agency.

(I) In determining such reasonable cost, the Secretary may not include any costs incurred by a provider with respect to any services furnished in connection with matters for which payment may be made under this title and furnished pursuant to a contract between the provider and any of its subcontractors which is entered into after the date of the enactment of this subparagraph[411] and the value or cost of which is $10,000 or more over a twelve-month period unless the contract contains a clause to the effect that—

(i) until the expiration of four years after the furnishing of such services pursuant to such contract, the subcontractor shall make available, upon written request by the Secretary, or upon request by the Comptroller General, or any of their duly authorized representatives, the contract, and books, documents and records of such subcontractor that are necessary to certify the nature and extent of such costs, and

(ii) if the subcontractor carries out any of the duties of the contract through a subcontract, with a value or cost of $10,000 or more over a twelve-month period, with a related organization, such subcontract shall contain a clause to the effect that until the expiration

[409] December 5, 1980 [P.L. 96–499; 94 Stat. 2599].
[410] December 5, 1980 [P.L. 96–499; 94 Stat. 2599].
[411] December 5, 1980 [P.L. 96–499; 94 Stat. 2599].

of four years after the furnishing of such services pursuant to such subcontract, the related organization shall make available, upon written request by the Secretary, or upon request by the Comptroller General, or any of their duly authorized representatives, the subcontract, and books, documents and records of such organization that are necessary to verify the nature and extent of such costs.

The Secretary shall prescribe in regulation criteria and procedures which the Secretary shall use in obtaining access to books, documents, and records under clauses required in contracts and subcontracts under this subparagraph.

(J) Such regulations may not provide for any inpatient routine salary cost differential as a reimbursable cost for hospitals and skilled nursing facilities.

(K)(i) The Secretary shall issue regulations that provide, to the extent feasible, for the establishment of limitations on the amount of any costs or charges that shall be considered reasonable with respect to services provided on an outpatient basis by hospitals (other than bona fide emergency services as defined in clause (ii)) or clinics (other than rural health clinics), which are reimbursed on a cost basis or on the basis of cost related charges, and by physicians utilizing such outpatient facilities. Such limitations shall be reasonably related to the charges in the same area for similar services provided in physicians' offices. Such regulations shall provide for exceptions to such limitations in cases where similar services are not generally available in physicians' offices in the area to individuals entitled to benefits under this title.

(ii) For purposes of clause (i), the term "bona fide emergency services" means services provided in a hospital emergency room after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(I) placing the patient's health in serious jeopardy;

(II) serious impairment to bodily functions; or

(III) serious dysfunction of any bodily organ or part.

(L)(i) The Secretary, in determining the amount of the payments that may be made under this title with respect to services furnished by home health agencies, may not recognize as reasonable (in the efficient delivery of such services) costs for the provision of such services by an agency to the extent these costs exceed (on the aggregate for the agency) for cost reporting periods beginning on or after—

(I) July 1, 1985, and before July 1, 1986, 120 percent of the mean of the labor–related and nonlabor per visit costs for freestanding home health agencies,

(II) July 1, 1986, and before July 1, 1987, 115 percent of such mean,

(III) July 1, 1987, and before October 1, 1997, 112 percent of such mean,

(IV) October 1, 1997, and before October 1, 1998, 105 percent of the median of the labor–related and nonlabor per visit costs for freestanding home health agencies; or

(V) October 1, 1998, 106 percent of such median.

(ii) Effective for cost reporting periods beginning on or after July 1, 1986, such limitations shall be applied on an aggregate basis for the agency, rather than on a discipline specific basis. The Secretary may provide for such exemptions and exceptions to such limitation as he deems appropriate.[412]

(iii) Not later than July 1, 1991, and annually thereafter (but not for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996, or on or after July 1, 1997, and before October 1, 1997), the Secretary shall establish limits under this subparagraph for cost reporting periods beginning on or after such date by utilizing the area wage index applicable under section 1886(d)(3)(E) and determined using the survey of the most recent available wages and wage-related costs of hospitals located in the geographic area in which the home health service is furnished (determined without regard to whether such hospitals have been reclassified to a new geographic area pursuant to section 1886(d)(8)(B), a decision of the Medicare Geographic Classification Review Board under section 1886(d)(10), or a decision of the Secretary).

(iv) In establishing limits under this subparagraph for cost reporting periods beginning after September 30, 1997, the Secretary shall not take into account any changes in the home health market basket, as determined by the Secretary, with respect to cost reporting periods which began on or after July 1, 1994, and before July 1, 1996.[413]

(v) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, subject to clause (viii)(I), the Secretary shall provide for an interim system of limits. Payment shall not exceed the costs determined under the preceding provisions of this subparagraph or, if lower, the product of—

(I) an agency–specific per beneficiary annual limitation calculated based 75 percent on 98 percent of the reasonable costs (including nonroutine medical supplies) for the agency's 12–month cost reporting period ending during fiscal year 1994, and based 25 percent on 98 percent of the standardized regional average of such costs for the agency's census division, as applied to such agency, for cost reporting periods ending during

[412] See Vol. II, P.L. 99–509, §9315(b) with respect to considerations in establishing limits and (c) with respect to the GAO report.

[413] See Vol. II, P.L. 105–33, §4601(b), with respect to exceptions not permitted based on this amendment.

fiscal year 1994, such costs updated by the home health market basket index; and

(II) the agency's unduplicated census count of patients (entitled to benefits under this title) for the cost reporting period subject to the limitation.

(vi) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, the following rules apply:

(I) For new providers and those providers without a 12–month cost reporting period ending in fiscal year 1994 subject to clauses (viii)(II) and (viii)(III), the per beneficiary limitation shall be equal to the median of these limits (or the Secretary's best estimates thereof) applied to other home health agencies as determined by the Secretary. A home health agency that has altered its corporate structure or name shall not be considered a new provider for this purpose.

(II) For beneficiaries who use services furnished by more than one home health agency, the per beneficiary limitations shall be prorated among the agencies.

(vii)(I) Not later than January 1, 1998, the Secretary shall establish per visit limits applicable for fiscal year 1998, and not later than April 1, 1998, the Secretary shall establish per beneficiary limits under clause (v)(I) for fiscal year 1998.

(II) Not later than August 1 of each year (beginning in 1998) the Secretary shall establish the limits applicable under this subparagraph for services furnished during the fiscal year beginning October 1 of the year.

(viii)(I) In the case of a provider with a 12–month cost reporting period ending in fiscal year 1994, if the limit imposed under clause (v) (determined without regard to this subclause) for a cost reporting period beginning during or after fiscal year 1999 is less than the median described in clause (vi)(I) (but determined as if any reference in clause (v) to "98 percent" were a reference to "100 percent"), the limit otherwise imposed under clause (v) for such provider and period shall be increased by ⅓ of such difference.

(II) Subject to subclause (IV), for new providers and those providers without a 12–month cost reporting period ending in fiscal year 1994, but for which the first cost reporting period begins before fiscal year 1999, for cost reporting periods beginning during or after fiscal year 1999, the per beneficiary limitation described in clause (vi)(I) shall be equal to the median described in such clause (determined as if any reference in clause (v) to "98 percent" were a reference to "100 percent").

(III) Subject to subclause (IV), in the case of a new provider for which the first cost reporting period begins during or after fiscal year 1999, the

limitation applied under clause (vi)(I) (but only with respect to such provider) shall be equal to 75 percent of the median described in clause (vi)(I).

(IV) In the case of a new provider or a provider without a 12–month cost reporting period ending in fiscal year 1994, subclause (II) shall apply, instead of subclause (III), to a home health agency which filed an application for home health agency provider status under this title before September 15, 1998, or which was approved as a branch of its parent agency before such date and becomes a subunit of the parent agency or a separate agency on or after such date.

(V) Each of the amounts specified in subclauses (I) through (III) are such amounts as adjusted under clause (iii) to reflect variations in wages among different areas.

(ix) Notwithstanding the per beneficiary limit under clause (viii), if the limit imposed under clause (v) (determined without regard to this clause) for a cost reporting period beginning during or after fiscal year 2000 is less than the median described in clause (vi)(I) (but determined as if any reference in clause (v) to "98 percent" were a reference to "100 percent"), the limit otherwise imposed under clause (v) for such provider and period shall be increased by 2 percent. amended paragraph

(x) Notwithstanding any other provision of this subparagraph, in updating any limit under this subparagraph by a home health market basket index for cost reporting periods beginning during each of fiscal years 2000, 2002, and 2003, the update otherwise provided shall be reduced by 1.1 percentage points. With respect to cost reporting periods beginning during fiscal year 2001, the update to any limit under this subparagraph shall be the home health market basket index.

(M) Such regulations shall provide that costs respecting care provided by a provider of services, pursuant to an assurance under title VI or XVI of the Public Health Service Act[414] that the provider will make available a reasonable volume of services to persons unable to pay therefor, shall not be allowable as reasonable costs.

(N) In determining such reasonable costs, costs incurred for activities directly related to influencing employees respecting unionization may not be included.

(O)(i) In establishing an appropriate allowance for depreciation and for interest on capital indebtedness with respect to an asset of a provider of services which has undergone a change of ownership, such regulations shall provide, except as provided in clause (iii), that the valuation of the asset after such change of ownership shall be the historical cost of the asset, as recognized under this title, less depreciation allowed, to the owner of record as of the

[414] P.L. 78–410.

date of enactment of the Balanced Budget Act of 1997[415] (or, in the case of an asset not in existence as of that date, the first owner of record of the asset after that date).

(ii) Such regulations shall not recognize, as reasonable in the provision of health care services, costs (including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has previously been made under this title.

(iii) In the case of the transfer of a hospital from ownership by a State to ownership by a nonprofit corporation without monetary consideration, the basis for capital allowances to the new owner shall be the book value of the hospital to the State at the time of the transfer.

(P) If such regulations provide for the payment for a return on equity capital (other than with respect to costs of inpatient hospital services), the rate of return to be recognized, for determining the reasonable cost of services furnished in a cost reporting period, shall be equal to the average of the rates of interest, for each of the months any part of which is included in the period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

(Q) Except as otherwise explicitly authorized, the Secretary is not authorized to limit the rate of increase on allowable costs of approved medical educational activities.

(R) In determining such reasonable cost, costs incurred by a provider of services representing a beneficiary in an unsuccessful appeal of a determination described in section 1869(b) shall not be allowable as reasonable costs.

(S)(i) Such regulations shall not include provision for specific recognition of any return on equity capital with respect to hospital outpatient departments.

(ii)(I) Such regulations shall provide that, in determining the amount of the payments that may be made under this title with respect to all the capital-related costs of outpatient hospital services, the Secretary shall reduce the amounts of such payments otherwise established under this title by 15 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1990, by 15 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1991, and by 10 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1992 through 1999 and until the first date that the prospective payment system under section 1833(t) is implemented.

(II) The Secretary shall reduce the reasonable cost of outpatient hospital services (other than the capital-related costs of such services) otherwise determined pursuant to section 1833(a)(2)(B)(i)(I)

[415] P.L. 105-33 was enacted August 5, 1997.

by 5.8 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1991 through 1999 and until the first date that the prospective payment system under section 1833(t) is implemented during fiscal year 2000 before January 1, 2000.

(III) Subclauses (I) and (II) shall not apply to payments with respect to the costs of hospital outpatient services provided by any hospital that is a sole community hospital (as defined in section 1886(d)(5)(D)(iii))[416] or a critical access hospital (as defined in section 1861(mm)(1)).

(IV) In applying subclauses (I) and (II) to services for which payment is made on the basis of a blend amount under section 1833(i)(3)(A)(ii) or 1833(n)(1)(A)(ii), the costs reflected in the amounts described in sections 1833(i)(3)(B)(i)(I) and 1833(n)(1)(B)(i)(I), respectively, shall be reduced in accordance with such subclause.

(T) In determining such reasonable costs for hospitals, no reduction in copayments under section 1833(t)(5)(B) shall be treated as a bad debt and the amount of bad debts otherwise treated as allowable costs which are attributable to the deductibles and coinsurance amounts under this title shall be reduced—

(i) for cost reporting periods beginning during fiscal year 1998, by 25 percent of such amount otherwise allowable,

(ii) for cost reporting periods beginning during fiscal year 1999, by 40 percent of such amount otherwise allowable,

(iii) for cost reporting periods beginning during fiscal year 2000, by 45 percent of such amount otherwise allowable, and

(iv) for cost reporting periods beginning during a subsequent fiscal year, by 30 percent of such amount otherwise allowable.

(U)[417] In determining the reasonable cost of ambulance services (as described in subsection (s)(7)) provided during fiscal year 1998, during fiscal year 1999, and during so much of fiscal year 2000 as precedes January 1, 2000, the Secretary shall not recognize the costs per trip in excess of costs recognized as reasonable for ambulance services provided on a per trip basis during the previous fiscal year (after application of this subparagraph), increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12–month period ending with the midpoint of the fiscal year involved reduced by 1.0 percentage point. For ambulance services provided after June 30, 1998, the Secretary may provide that claims for such services must include a code (or codes) under a uniform coding

[416] P.L. 108–173, §736(b)(3), struck out "(as defined in section 1886(d)(5)(D)(iii)" and substituted "(as defined in section 1886(d)(5)(D)(iii))".

[417] P.L. 108-173, §414(g)(2), moved subparagraph (U)

system specified by the Secretary that identifies the services furnished.

(2)(A) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services is in accommodations more expensive than semi-private accommodations, the amount taken into account for purposes of payment under this title with respect to such services may not exceed the amount that would be taken into account with respect to such services if furnished in such semi-private accommodations unless the more expensive accommodations were required for medical reasons.

(B) Where a provider of services which has an agreement in effect under this title furnishes to an individual items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under part A or part B, as the case may be, the Secretary shall take into account for purposes of payment to such provider of services only the items or services with respect to which such payment may be made.[418]

(3) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services is in accommodations other than, but not more expensive than, semi-private accommodations and the use of such other accommodations rather than semi-private accommodations was neither at the request of the patient nor for a reason which the Secretary determines is consistent with the purposes of this title, the amount of the payment with respect to such bed and board under part A shall be the amount otherwise payable under this title for such bed and board furnished in semi-private accommodations minus the difference between the charge customarily made by the hospital or skilled nursing facility for bed and board in semi-private accommodations and the charge customarily made by it for bed and board in the accommodations furnished.

(4) If a provider of services furnishes items or services to an individual which are in excess of or more expensive than the items or services determined to be necessary in the efficient delivery of needed health services and charges are imposed for such more expensive items or services under the authority granted in section 1866(a)(2)(B)(ii), the amount of payment with respect to such items or services otherwise due such provider in any fiscal period shall be reduced to the extent that such payment plus such charges exceed the cost actually incurred for such items or services in the fiscal period in which such charges are imposed.

(5)(A) Where physical therapy services, occupational therapy services, speech therapy services, or other therapy services or services of other health-related personnel (other than physicians) are furnished under an arrangement with a provider of services or other organization, specified in the first sentence of subsection (p) (including through the operation of subsection (g)) the amount included in any payment to such provider or

[418] See Vol. II, P.L. 97–248, §111, with respect to elimination of private room subsidy.

other organization under this title as the reasonable cost of such services (as furnished under such arrangements) shall not exceed an amount equal to the salary which would reasonably have been paid for such services (together with any additional costs that would have been incurred by the provider or other organization) to the person performing them if they had been performed in an employment relationship with such provider or other organization (rather than under such arrangement) plus the cost of such other expenses (including a reasonable allowance for traveltime and other reasonable types of expense related to any differences in acceptable methods of organization for the provision of such therapy) incurred by such person, as the Secretary may in regulations determine to be appropriate.

(B) Notwithstanding the provisions of subparagraph (A), if a provider of services or other organization specified in the first sentence of section 1861(p) requires the services of a therapist on a limited part-time basis, or only to perform intermittent services, the Secretary may make payment on the basis of a reasonable rate per unit of service, even though such rate is greater per unit of time than salary related amounts, where he finds that such greater payment is, in the aggregate, less than the amount that would have been paid if such organization had employed a therapist on a full-or part-time salary basis.

(6) For purposes of this subsection, the term "semi-private accommodations" means two-bed, three-bed, or four-bed accommodations.

(7)(A) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122.

(B) For further limitations on reasonable cost and determination of payment amounts for operating costs of inpatient hospital services and waivers for certain States, see section 1886.

(C) For provisions restricting payment for provider-based physicians' services and for payments under certain percentage arrangements, see section 1887.

(D) For further limitations on reasonable cost and determination of payment amounts for routine service costs of skilled nursing facilities, see subsections (a) through (c) of section 1888.

(8)[419] Items unrelated to patient care—Reasonable costs do not include costs for the following—

(i) entertainment, including tickets to sporting and other entertainment events;

(ii) gifts or donations;

(iii) personal use of motor vehicles;

(iv) costs for fines and penalties resulting from violations of Federal, State, or local laws; and

(v) education expenses for spouses or other dependents of providers of services, their employees or contractors.

[419] P.L. 108–173, §736(c)(4), moved paragraph (8) and clauses (i)-(v) 2 ems to the left.

Arrangements for Certain Services

(w)(1) The term "arrangements" is limited to arrangements under which receipt of payment by the hospital, critical access hospital, skilled nursing facility, home health agency, or hospice program (whether in its own right or as agent), with respect to services for which an individual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.

(2) Utilization review activities conducted, in accordance with the requirements of the program established under part B of title XI of the Social Security Act with respect to services furnished by a hospital or critical access hospital to patients insured under part A of this title or entitled to have payment made for such services under part B of this title or under a State plan approved under title XIX, by a quality control and peer review organization designated for the area in which such hospital or critical access hospital is located shall be deemed to have been conducted pursuant to arrangements between such hospital or critical access hospital and such organization under which such hospital or critical access hospital is obligated to pay to such organization, as a condition of receiving payment for hospital or critical access hospital services so furnished under this part or under such a State plan, such amount as is reasonably incurred and requested (as determined under regulations of the Secretary) by such organization in conducting such review activities with respect to services furnished by such hospital or critical access hospital to such patients.

State and United States

(x) The terms "State" and "United States" have the meaning given to them by subsections (h) and (i), respectively, of section 210.

Extended Care in Religious Nonmedical Health Care Institutions

(y)(1) The term "skilled nursing facility" also includes a religious nonmedical health care institution (as defined in subsection (ss)(1)), (except for purposes of subsection (a)(2)) with respect to items and services ordinarily furnished by such an institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations.

(2) Notwithstanding any other provision of this title, payment under part A may not be made for services furnished an individual in a skilled nursing facility to which paragraph (1) applies unless such individual elects, in accordance with regulations, for a spell of illness to have such services treated as post-hospital extended care services for purposes of such part; and payment under part A may not be made for post-hospital extended care services—

(A) furnished an individual during such spell of illness in a skilled nursing facility to which paragraph (1) applies after—

(i) such services have been furnished to him in such a facility for 30 days during such spell, or

(ii) such services have been furnished to him during such spell in a skilled nursing facility to which such paragraph does not apply; or

(B) furnished an individual during such spell of illness in a skilled nursing facility to which paragraph (1) does not apply after such services have been furnished to him during such spell in a skilled nursing facility to which such paragraph applies.

(3) The amount payable under part A for post-hospital extended care services furnished an individual during any spell of illness in a skilled nursing facility to which paragraph (1) applies shall be reduced by a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day before the 31st day on which he is furnished such services in such a facility during such spell (and the reduction under this paragraph shall be in lieu of any reduction under section 1813(a)(3)).

(4) For purposes of subsection (i), the determination of whether services furnished by or in an institution described in paragraph (1) constitute post-hospital extended care services shall be made in accordance with and subject to such conditions, limitations, and requirements as may be provided in regulations.

Institutional Planning

(z) An overall plan and budget of a hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, or home health agency shall be considered sufficient if it—

(1) provides for an annual operating budget which includes all anticipated income and expenses related to items which would, under generally accepted accounting principles, be considered income and expense items (except that nothing in this paragraph shall require that there be prepared, in connection with any budget, an item-by-item identification of the components of each type of anticipated expenditure or income);

(2)(A) provides for a capital expenditures plan for at least a 3-year period (including the year to which the operating budget described in paragraph (1) is applicable) which includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure in excess of $600,000 (or such lesser amount as may be established by the State under section 1122(g)(1) in which the hospital is located) related to the acquisition of land, the improvement of land, buildings, and equipment, and the replacement, modernization, and expansion of the buildings and equipment which would, under generally accepted accounting principles, be considered capital items;

(B) provides that such plan is submitted to the agency designated under section 1122(b), or if no such agency is designated, to the appropriate health planning agency in

the State (but this subparagraph shall not apply in the case of a facility exempt from review under section 1122 by reason of section 1122(j));

(3) provides for review and updating at least annually; and

(4) is prepared, under the direction of the governing body of the institution or agency, by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff (if any) of the institution or agency.

Rural Health Clinic Services and Federally Qualified Health Center Services

(aa)(1) The term "rural health clinic services" means—

(A) physicians' services and such services and supplies as are covered under section 1861(s)(2)(A) if furnished as an incident to a physician's professional service and items and services described in section 1861(s)(10),

(B) such services furnished by a physician assistant or a nurse practitioner (as defined in paragraph (5)), by a clinical psychologist (as defined by the Secretary) or by a clinical social worker (as defined in subsection (hh)(1)),[420] and such services and supplies furnished as an incident to his service as would otherwise be covered if furnished by a physician or as an incident to a physician's service, and

(C) in the case of a rural health clinic located in an area in which there exists a shortage of home health agencies, part-time or intermittent nursing care and related medical supplies (other than drugs and biologicals) furnished by a registered professional nurse or licensed practical nurse to a homebound individual under a written plan of treatment (i) established and periodically reviewed by a physician described in paragraph (2)(B), or (ii) established by a nurse practitioner or physician assistant and periodically reviewed and approved by a physician described in paragraph (2)(B),

when furnished to an individual as an outpatient of a rural health clinic.

(2) The term "rural health clinic" means a facility which—

(A) is primarily engaged in furnishing to outpatients services described in subparagraphs (A) and (B) of paragraph (1);

(B) in the case of a facility which is not a physician-directed clinic, has an arrangement (consistent with the provisions of State and local law relative to the practice, performance, and delivery of health services) with one or more physicians (as defined in subsection (r)(1)) under which provision is made for the periodic review by such physicians of covered services furnished by physician assistants and nurse practitioners, the supervision and guidance by such physicians of physician assistants and nurse practitioners, the preparation by such physicians of such medical orders for care and treatment of clinic patients as may be necessary, and the availability of such physicians for such referral of and consultation for patients as is necessary and for advice and assistance in the management of medi-

[420] P.L. 108–173, §736(b)(12), struck out ",," and substituted a comma.

cal emergencies; and, in the case of a physician-directed clinic, has one or more of its staff physicians perform the activities accomplished through such an arrangement;

(C) maintains clinical records on all patients;

(D) has arrangements with one or more hospitals, having agreements in effect under section 1866, for the referral and admission of patients requiring inpatient services or such diagnostic or other specialized services as are not available at the clinic;

(E) has written policies, which are developed with the advice of (and with provision for review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more physician assistants or nurse practitioners, to govern those services described in paragraph (1) which it furnishes;

(F) has a physician, physician assistant, or nurse practitioner responsible for the execution of policies described in subparagraph (E) and relating to the provision of the clinic's services;

(G) directly provides routine diagnostic services, including clinical laboratory services, as prescribed in regulations by the Secretary, and has prompt access to additional diagnostic services from facilities meeting requirements under this title;

(H) in compliance with State and Federal law, has available for administering to patients of the clinic at least such drugs and biologicals as are determined by the Secretary to be necessary for the treatment of emergency cases (as defined in regulations) and has appropriate procedures or arrangements for storing, administering, and dispensing any drugs and biologicals;

(I) has a quality assessment and performance improvement program, and appropriate procedures for review of utilization of clinic services, as the Secretary may specify;

(J) has a nurse practitioner, a physician assistant, or a certified nurse-midwife (as defined in subsection (gg)) available to furnish patient care services not less than 50 percent of the time the clinic operates; and

(K) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are furnished services by the clinic.

For the purposes of this title, such term includes only a facility which (i) is located in an area that is not an urbanized area (as defined by the Bureau of the Census) and in which there are insufficient numbers of needed health care practitioners (as determined by the Secretary), and that, within the previous 3–year period, has been designated by the chief executive officer of the State and certified by the Secretary as an area with a shortage of personal health services or designated by the Secretary either (I) as an area with a shortage of personal health services under section 330(b)(3) or 1302(7) of the Public Health Service Act,[421] (II) as a health professional shortage area described in section 332(a)(1)(A) of that Act because of its shortage of primary medical care manpower, (III) as a high impact area described in section 329(a)(5) of that Act, of (IV)

[421] See Vol. II, P.L. 78–410.

as an area which includes a population group which the Secretary determines has a health manpower shortage under section 332(a)(1)(B) of that Act, (ii) has filed an agreement with the Secretary by which it agrees not to charge any individual or other person for items or services for which such individual is entitled to have payment made under this title, except for the amount of any deductible or coinsurance amount imposed with respect to such items or services (not in excess of the amount customarily charged for such items and services by such clinic), pursuant to subsections (a) and (b) of section 1833, (iii) employs a physician assistant or nurse practitioner, and (iv) is not a rehabilitation agency or a facility which is primarily for the care and treatment of mental diseases. A facility that is in operation and qualifies as a rural health clinic under this title or title XIX and that subsequently fails to satisfy the requirement of clause (i) shall be considered, for purposes of this title and title XIX, as still satisfying the requirement of such clause if it is determined, in accordance with criteria established by the Secretary in regulations, to be essential to the delivery of primary care services that would otherwise be unavailable in the geographic area served by the clinic. If a State agency has determined under section 1864(a) that a facility is a rural health clinic and the facilityhas applied to the Secretary for approval as such a clinic, the Secretary shall notify the facility of the Secretary's approval or disapproval later than 60 days after the date of the State agency determination or the application (whichever is later).

(3) The term "Federally qualified health center services" means—

(A) services of the type described in subparagraphs (A) through (C) of paragraph (1), and

(B) preventive primary health services that a center is required to provide under sections 329, 330, and 340 of the Public Health Service Act, [422]

when furnished to an individual as an outpatient of a Federally qualified health center and, for this purpose, any reference to a rural health clinic or a physician described in paragraph (2)(B) is deemed a reference to a Federally qualified health center or a physician at the center, respectively.

(4) The term "Federally qualified health center" means an entity which—

(A)(i) is receiving a grant under section 330 (other than subsection (h)) of the Public Health Service Act, or

(ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and (II) meets the requirements to receive a grant under section 330 (other than subsection (h)) of such Act;

(B) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant;

(C) was treated by the Secretary, for purposes of part B, as a comprehensive Federally funded health center as of January 1, 1990; or

[422] See Vol. II, P.L. 78–410.

(D) is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act[423].

(5)(A) The term "physician assistant" and the term "nurse practitioner" mean, for purposes of this title, a physician assistant or nurse practitioner who performs such services as such individual is legally authorized to perform (in the State in which the individual performs such services) in accordance with State law (or the State regulatory mechanism provided by State law), and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.

(B) The term "clinical nurse specialist" means, for purposes of this title, an individual who—

(i) is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed; and

(ii) holds a master's degree in a defined clinical area of nursing from an accredited educational institution.

(6) The term "collaboration" means a process in which a nurse practitioner works with a physician to deliver health care services within the scope of the practitioner's professional expertise, with medical direction and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as defined by the law of the State in which the services are performed.

(7)(A) The Secretary shall waive for a 1-year period the requirements of paragraph (2) that a rural health clinic employ a physician assistant, nurse practitioner or certified nurse midwife or that such clinic require such providers to furnish services at least 50 percent of the time that the clinic operates for any facility that requests such waiver if the facility demonstrates that the facility has been unable, despite reasonable efforts, to hire a physician assistant, nurse practitioner, or certified nurse-midwife in the previous 90-day period.

(B) The Secretary may not grant such a waiver under subparagraph (A) to a facility if the request for the waiver is made less than 6 months after the date of the expiration of any previous such waiver for the facility, or if the facility has not yet been determined to meet the requirements (including subparagraph (J) of the first sentence of paragraph (2)) of a rural health clinic.

(C) A waiver which is requested under this paragraph shall be deemed granted unless such request is denied by the Secretary within 60 days after the date such request is received.

Services of a Certified Registered Nurse Anesthetist

(bb)(1) The term "services of a certified registered nurse anesthetist" means anesthesia services and related care furnished by a certified registered nurse anesthetist (as defined in paragraph (2))

[423] See Vol. II, P.L. 94–437, title V.

which the nurse anesthetist is legally authorized to perform as such by the State in which the services are furnished.

(2) The term "certified registered nurse anesthetist" means a certified registered nurse anesthetist licensed by the State who meets such education, training, and other requirements relating to anesthesia services and related care as the Secretary may prescribe. In prescribing such requirements the Secretary may use the same requirements as those established by a national organization for the certification of nurse anesthetists. Such term also includes, as prescribed by the Secretary, an anesthesiologist assistant.

Comprehensive Outpatient Rehabilitation Facility Services

(cc)(1) The term "comprehensive outpatient rehabilitation facility services" means the following items and services furnished by a physician or other qualified professional personnel (as defined in regulations by the Secretary) to an individual who is an outpatient of a comprehensive outpatient rehabilitation facility under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician—

(A) physicians' services;

(B) physical therapy, occupational therapy, speech-language pathology services, and respiratory therapy;

(C) prosthetic and orthotic devices, including testing, fitting, or training in the use of prosthetic and orthotic devices;

(D) social and psychological services;

(E) nursing care provided by or under the supervision of a registered professional nurse;

(F) drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered;

(G) supplies and durable medical equipment; and

(H) such other items and services as are medically necessary for the rehabilitation of the patient and are ordinarily furnished by comprehensive outpatient rehabilitation facilities,

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital. In the case of physical therapy, occupational therapy, and speech pathology services, there shall be no requirement that the item or service be furnished at any single fixed location if the item or service is furnished pursuant to such plan and payments are not otherwise made for the item or service under this title.

(2) The term "comprehensive outpatient rehabilitation facility" means a facility which—

(A) is primarily engaged in providing (by or under the supervision of physicians) diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons;

(B) provides at least the following comprehensive outpatient rehabilitation services: (i) physicians' services (rendered by physicians, as defined in section 1861(r)(1), who are available at the facility on a full-or part-time basis); (ii) physical therapy; and (iii) social or psychological services;

(C) maintains clinical records on all patients;

(D) has policies established by a group of professional personnel (associated with the facility), including one or more physicians defined in subsection (r)(1) to govern the comprehensive outpatient rehabilitation services it furnishes, and provides for the carrying out of such policies by a full-or part-time physician referred to in subparagraph (B)(i);

(E) has a requirement that every patient must be under the care of a physician;

(F) in the case of a facility in any State in which State or applicable local law provides for the licensing of facilities of this nature (i) is licensed pursuant to such law, or (ii) is approved by the agency of such State or locality, responsible for licensing facilities of this nature, as meeting the standards established for such licensing;

(G) has in effect a utilization review plan in accordance with regulations prescribed by the Secretary;

(H) has in effect an overall plan and budget that meets the requirements of subsection (z);

(I) provides the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000; and

(J) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such facility, including conditions concerning qualifications of personnel in these facilities.

Hospice Care; Hospice Program

(dd)(1) The term "hospice care" means the following items and services provided to a terminally ill individual by, or by others under arrangements made by, a hospice program under a written plan (for providing such care to such individual) established and periodically reviewed by the individual's attending physician and by the medical director (and by the interdisciplinary group described in paragraph (2)(B)) of the program—

(A) nursing care provided by or under the supervision of a registered professional nurse,

(B) physical or occupational therapy, or speech-language pathology services,

(C) medical social services under the direction of a physician,

(D)(i) services of a home health aide who has successfully completed a training program approved by the Secretary and

(ii) homemaker services,

(E) medical supplies (including drugs and biologicals) and the use of medical appliances, while under such a plan,

(F) physicians' services,

(G) short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management) in an inpatient facility meeting such conditions as the Secretary determines to be

appropriate to provide such care, but such respite care may be provided only on an intermittent, nonroutine, and occasional basis and may not be provided consecutively over longer than five days,

(H) counseling (including dietary counseling) with respect to care of the terminally ill individual and adjustment to his death, and

(I) any other item or service which is specified in the plan and for which payment may otherwise be made under this title.

The care and services described in subparagraphs (A) and (D) may be provided on a 24-hour, continuous basis only during periods of crisis (meeting criteria established by the Secretary) and only as necessary to maintain the terminally ill individual at home.

(2) The term "hospice program" means a public agency or private organization (or a subdivision thereof) which—

(A)(i) is primarily engaged in providing the care and services described in paragraph (1) and makes such services available (as needed) on a 24-hour basis and which also provides bereavement counseling for the immediate family of terminally ill individuals and services described in section 1812(a)(5)[424],

(ii) provides for such care and services in individuals' homes, on an outpatient basis, and on a short-term inpatient basis, directly or under arrangements made by the agency or organization, except that—

(I) the agency or organization must routinely provide directly substantially all of each of the services described in subparagraphs (A), (C), and (H) of paragraph (1), except as otherwise provided in paragraph (5), and

(II) in the case of other services described in paragraph (1) which are not provided directly by the agency or organization, the agency or organization must maintain professional management responsibility for all such services furnished to an individual, regardless of the location or facility in which such services are furnished; and

(iii) provides assurances satisfactory to the Secretary that the aggregate number of days of inpatient care described in paragraph (1)(G) provided in any 12-month period to individuals who have an election in effect under section 1812(d) with respect to that agency or organization does not exceed 20 percent of the aggregate number of days during that period on which such elections for such individuals are in effect;

(B) has an interdisciplinary group of personnel which—

(i) includes at least—

(I) one physician (as defined in subsection (r)(1)),

(II) one registered professional nurse, and

(III) one social worker,

[424] P.L. 108-173, §512(c), inserted "and services described in section 1821(a)(5)", applicable to services provided by a hospice program on or after January 1, 2005.

employed by or, in the case of a physician described in subclause (I), under contract with the agency or organization, and also includes at least one pastoral or other counselor,

(ii) provides (or supervises the provision of) the care and services described in paragraph (1), and

(iii) establishes the policies governing the provision of such care and services;

(C) maintains central clinical records on all patients;

(D) does not discontinue the hospice care it provides with respect to a patient because of the inability of the patient to pay for such care;

(E)(i) utilizes volunteers in its provision of care and services in accordance with standards set by the Secretary, which standards shall ensure a continuing level of effort to utilize such volunteers, and

(ii) maintains records on the use of these volunteers and the cost savings and expansion of care and services achieved through the use of these volunteers;

(F) in the case of an agency or organization in any State in which State or applicable local law provides for the licensing of agencies or organizations of this nature, is licensed pursuant to such law; and

(G) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are provided care and services by such agency or organization.

(3)(A) An individual is considered to be "terminally ill" if the individual has a medical prognosis that the individual's life expectancy is 6 months or less.

(B) The term "attending physician" means, with respect to an individual, the physician (as defined in subsection (r)(1)) or nurse practitioner (as defined in subsection (aa)(5))[425], who may be employed by a hospice program, whom the individual identifies as having the most significant role in the determination and delivery of medical care to the individual at the time the individual makes an election to receive hospice care.

(4)(A) An entity which is certified as a provider of services other than a hospice program shall be considered, for purposes of certification as a hospice program, to have met any requirements under paragraph (2) which are also the same requirements for certification as such other type of provider. The Secretary shall coordinate surveys for determining certification under this title so as to provide, to the extent feasible, for simultaneous surveys of an entity which seeks to be certified as a hospice program and as a provider of services of another type.

(B) Any entity which is certified as a hospice program and as a provider of another type shall have separate provider agreements under section 1866 and shall file separate cost reports with respect to costs incurred in providing hospice care and in providing other services and items under this title.

[425] P.L. 108–173, §408(a), inserted "or nurse practitioner (as defined in subsection (aa)(5))", effective December 8, 2003.

(5)(A) The Secretary may waive the requirements of paragraph (2)(A)(ii)(I) for an agency or organization with respect to all or part of the nursing care described in paragraph (1)(A) if such agency or organization—

(i) is located in an area which is not an urbanized area (as defined by the Bureau of the Census);

(ii) was in operation on or before January 1, 1983; and

(iii) has demonstrated a good faith effort (as determined by the Secretary) to hire a sufficient number of nurses to provide such nursing care directly.

(B) Any waiver, which is in such form and containing such information as the Secretary may require and which is requested by an agency or organization under subparagraph (A) or (C), shall be deemed to be granted unless such request is denied by the Secretary within 60 days after the date such request is received by the Secretary. The granting of a waiver under subparagraph (A) or (C) shall not preclude the granting of any subsequent waiver request should such a waiver again become necessary.

(C) The Secretary may waive the requirements of paragraph (2)(A)(i) and (2)(A)(ii) for an agency or organization with respect to the services described in paragraph (1)(B) and, with respect to dietary counseling, paragraph (1)(H), if such agency or organization—

(i) is located in an area which is not an urbanized area (as defined by the Bureau of Census), and

(ii) demonstrates to the satisfaction of the Secretary that the agency or organization has been unable, despite diligent efforts, to recruit appropriate personnel.

(D)[426] In extraordinary, exigent, or other non-routine circumstances, such as unanticipated periods of high patient loads, staffing shortages due to illness or other events, or temporary travel of a patient outside a hospice program's service area, a hospice program may enter into arrangements with another hospice program for the provision by that other program of services described in paragraph (2)(A)(ii)(I). The provisions of paragraph (2)(A)(ii)(II) shall apply with respect to the services provided under such arrangements.

(E)[427] A hospice program may provide services described in paragraph (1)(A) other than directly by the program if the services are highly specialized services of a registered professional nurse and are provided non-routinely and so infrequently so that the provision of such services directly would be impracticable and prohibitively expensive.

Discharge Planning Process

(ee)(1) A discharge planning process of a hospital shall be considered sufficient if it is applicable to services furnished by the hospital to individuals entitled to benefits under this title and if it

[426] P.L. 108–173, §946(a), added subparagraph (D), applicable to hospice care provided on or after December 8, 2003.

[427] P.L. 108–173, §946(a), added subparagraph (E), applicable to hospice care provided on or after December 8, 2003.

meets the guidelines and standards established by the Secretary under paragraph (2).

(2) The Secretary shall develop guidelines and standards for the discharge planning process in order to ensure a timely and smooth transition to the most appropriate type of and setting for post-hospital or rehabilitative care. The guidelines and standards shall include the following:

(A) The hospital must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning.

(B) Hospitals must provide a discharge planning evaluation for patients identified under subparagraph (A) and for other patients upon the request of the patient, patient's representative, or patient's physician.

(C) Any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-hospital care will be made before discharge and to avoid unnecessary delays in discharge.

(D) A discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-hospital services, including hospice care and post-hospital extended care services[428] and the availability of those services, including the availability of home health services through individuals and entities that participate in the program under this title and that serve the area in which the patient resides and that request to be listed by the hospital as available and, in the case of individuals who are likely to need post-hospital extended care services, the availability of such services through facilities that participate in the program under this title and that serve the area in which the patient resides[429].

(E) The discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative).

(F) Upon the request of a patient's physician, the hospital must arrange for the development and initial implementation of a discharge plan for the patient.

(G) Any discharge planning evaluation or discharge plan required under this paragraph must be developed by, or under the supervision of, a registered professional nurse, social worker, or other appropriately qualified personnel.

(H) Consistent with section 1802, the discharge plan shall—

[428] P.L. 108–173, §926(b)(1)(A), struck out "hospice services" and substituted "hospice care and post-hospital extended care services", applicable to discharge plans made on or after such date as the Secretary shall specify, but not later than 6 months after the date the Secretary provides for availability of information that enables hospital discharge planners, medicare beneficiaries, and the public to identify skilled nursing facilities that are participating in the medicare program.

[429] P.L. 108–173, §926(b)(1)(B), inserted "and, in the case of individuals who are likely to need post-hospital extended care services, the availability of such services through facilities that participate in the program under this title and that serve the area in which the patient resides", applicable to discharge plans made on or after such date as the Secretary shall specify, but not later than 6 months after the date the Secretary provides for availability of information that enables hospital discharge planners, medicare beneficiaries, and the public to identify skilled nursing facilities that are participating in the medicare program.

(i) not specify or otherwise limit the qualified provider which may provide post–hospital home health services, and

(ii) identify (in a form and manner specified by the Secretary) any entity to whom the individual is referred in which the hospital has a disclosable financial interest (as specified by the Secretary consistent with section 1866(a)(1)(S)) or which has such an interest in the hospital.

(3) With respect to a discharge plan for an individual who is enrolled with a Medicare+Choice organization under a Medicare+Choice plan and is furnished inpatient hospital services by a hospital under a contract with the organization—

(A) the discharge planning evaluation under paragraph (2)(D) is not required to include information on the availability of home health services through individuals and entities which do not have a contract with the organization; and

(B) notwithstanding subparagraph (H)(i), the plan may specify or limit the provider (or providers) of post–hospital home health services or other post–hospital services under the plan.

Partial Hospitalization Services

(ff)(1) The term "partial hospitalization services" means the items and services described in paragraph (2) prescribed by a physician and provided under a program described in paragraph (3) under the supervision of a physician pursuant to an individualized, written plan of treatment established and periodically reviewed by a physician (in consultation with appropriate staff participating in such program), which plan sets forth the physician's diagnosis, the type, amount, frequency, and duration of the items and services provided under the plan, and the goals for treatment under the plan.

(2) The items and services described in this paragraph are—

(A) individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),

(B) occupational therapy requiring the skills of a qualified occupational therapist,

(C) services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients,

(D) drugs and biologicals furnished for therapeutic purposes (which cannot, as determined in accordance with regulations, be self-administered),

(E) individualized activity therapies that are not primarily recreational or diversionary,

(F) family counseling (the primary purpose of which is treatment of the individual's condition),

(G) patient training and education (to the extent that training and educational activities are closely and clearly related to individual's care and treatment),

(H) diagnostic services, and

(I) such other items and services as the Secretary may provide (but in no event to include meals and transportation);

that are reasonable and necessary for the diagnosis or active treatment of the individual's condition, reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization, and furnished pursuant to such guidelines relating to frequency and duration of services as the Secretary shall by regulation establish (taking into account accepted norms of medical practice and the reasonable expectation of patient improvement).

(3)(A) A program described in this paragraph is a program which is furnished by a hospital to its outpatients or by a community mental health center (as defined in subparagraph (B)), and which is a distinct and organized intensive ambulatory treatment service offering less than 24-hour-daily care.

(B) For purposes of subparagraph (A), the term "community mental health center" means an entity that—

(i)(I) provides the mental health services described in section 1913(c)(1) of the Public Health Service Act; or

(II) in the case of an entity operating in a State that by law precludes the entity from providing itself the service described in subparagraph (E) of such section, provides for such service by contract with an approved organization or entity (as determined by the Secretary);

(ii) meets applicable licensing or certification requirements for community mental health centers in the State in which it is located; and

(iii) meets such additional conditions as the Secretary shall specify to ensure (I) the health and safety of individuals being furnished such services, (II) the effective and efficient furnishing of such services, and (III) the compliance of such entity with the criteria described in section 1931(c)(1) of the Public Health Service Act.

Certified Nurse-Midwife Services

(gg)(1) The term "certified nurse-midwife services" means such services furnished by a certified nurse-midwife (as defined in paragraph (2)) and such services and supplies furnished as an incident to the nurse-midwife's service which the certified nurse-midwife is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) as would otherwise be covered if furnished by a physician or as an incident to a physicians' service.

(2) The term "certified nurse-midwife" means a registered nurse who has successfully completed a program of study and clinical experience meeting guidelines prescribed by the Secretary, or has been certified by an organization recognized by the Secretary.

Clinical Social Worker; Clinical Social Worker Services

(hh)(1) The term "clinical social worker" means an individual who—

(A) possesses a master's or doctor's degree in social work;

(B) after obtaining such degree has performed at least 2 years of supervised clinical social work; and

(C)(i) is licensed or certified as a clinical social worker by the State in which the services are performed, or

(ii) in the case of an individual in a State which does not provide for licensure or certification—

(I) has completed at least 2 years or 3,000 hours of post-master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate setting (as determined by the Secretary), and

(II) meets such other criteria as the Secretary establishes.

(2) The term "clinical social worker services" means services performed by a clinical social worker (as defined in paragraph (1)) for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital and other than services furnished to an inpatient of a skilled nursing facility which the facility is required to provide as a requirement for participation) which the clinical social worker is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.

Qualified Psychologist Services

(ii) The term "qualified psychologist services" means such services and such services and supplies furnished as an incident to his service furnished by a clinical psychologist (as defined by the Secretary) which the psychologist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) as would otherwise be covered if furnished by a physician or as an incident to a physician's service.

Screening Mammography

(jj) The term "screening mammography" means a radiologic procedure provided to a woman for the purpose of early detection of breast cancer and includes a physician's interpretation of the results of the procedure.

Covered Osteoporosis Drug

(kk) The term "covered osteoporosis drug" means an injectable drug approved for the treatment of post-menopausal osteoporosis provided to an individual by a home health agency if, in accordance with regulations promulgated by the Secretary—

(1) the individual's attending physician certifies that the individual has suffered a bone fracture related to post-menopausel osteoporosis and that the individual is unable to

learn the skills needed to self-administer such drug or is otherwise physically or mentally incapable of self-administering such drug; and

(2) the individual is confined to the individual's home (except when receiving items and services referred to in subsection (m)(7)).

Speech-Language Pathology Services; Audiology Services

(ll)(1) The term "speech-language pathology services" means such speech, language, and related function assessment and rehabilitation services furnished by a qualified speech-language pathologist as the speech-language pathologist is legally authorized to perform under State law (or the State regulatory mechanism provided by the State law) as would otherwise be covered if furnished by a physician.

(2) The term "audiology services" means such hearing and balance assessment services furnished by a qualified audiologist as the audiologist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), as would otherwise be covered if furnished by a physician.

(3) In this subsection:

(A) The term "qualified speech-language pathologist" means an individual with a masters's or doctoral degree in speech-language pathology who—

(i) is licensed as a speech-language pathologist by the State in which the individual furnishes such services, or

(ii) in the case of an individual who furnishes services in a State which does not license speech-language pathologists, has successfully completed 350 clock hours of supervised clinical practicum (or is in the process of accumulating such supervised clinical experience), performed not less than 9 months of supervised full-time speech-language pathology services after obtaining a master's or doctoral degree in speech-language pathology or a related field, and successfully completed a national examination in speech-language pathology approved by the Secretary.

(B) The term "qualified audiologist" means an individual with a master's or doctoral degree in audiology who—

(i) is licensed as an audiologist by the State in which the individual furnishes such services, or

(ii) in the case of an individual who furnishes services in a State which does not license audiologists, has successfully completed 350 clock hours of supervised clinical practicum (or is in the process of accumulating such supervised clinical experience), performed not less than 9 months of supervised full-time audiology services after obtaining a master's or doctoral degree in audiology or a related field, and successfully completed a national examination in audiology approved by the Secretary.

Critical Access Hospital; Critical Access Hospital Services[430]

(mm)(1) The term "critical access hospital" means a facility certified by the Secretary as a critical access hospital under section 1820(e).

(2) The term "inpatient critical access hospital services" means items and services, furnished to an inpatient of a critical access hospital by such facility, that would be inpatient hospital services if furnished to an inpatient of a hospital by a hospital.

(3) The term "outpatient critical access hospital services" means medical and other health services furnished by a critical access hospital on an outpatient basis.

Screening Pap Smear; Screening Pelvic Exam

(nn)(1) The term "screening pap smear" means a diagnostic laboratory test consisting of a routine exfoliative cytology test (Papanicolaou test) provided to a woman for the purpose of early detection of cervical or vaginal cancer and includes a physician's interpretation of the results of the test, if the individual involved has not had such a test during the preceding 2 years, or during the preceding year in the case of a woman described in paragraph (3).

(2) The term "screening pelvic exam" means a pelvic examination provided to a woman if the woman involved has not had such an examination during the preceding 2 years, or during the preceding year in the case of a woman described in paragraph (3), and includes a clinical breast examination.

(3) A woman described in this paragraph is a woman who—

(A) is of childbearing age and has had a test described in this subsection during any of the preceding 3 years that indicated the presence of cervical or vaginal cancer or other abnormality; or

(B) is at high risk of developing cervical or vaginal cancer (as determined pursuant to factors identified by the Secretary).

Prostate Cancer Screening Tests

(oo)(1) The term "prostate cancer screening test" means a test that consists of any (or all) of the procedures described in paragraph (2) provided for the purpose of early detection of prostate cancer to a man over 50 years of age who has not had such a test during the preceding year.

(2) The procedures described in this paragraph are as follows:

(A) A digital rectal examination.

(B) A prostate–specific antigen blood test.

(C) For years beginning after 2002, such other procedures as the Secretary finds appropriate for the purpose of early detection of prostate cancer, taking into account changes in technology and standards of medical practice, availability, effectiveness, costs, and such other factors as the Secretary considers appropriate.

[430] P.L. 108–173, §736(a)(10), amended the heading, effective December 8, 2003. For the heading as it formerly read, see Vol. II, Superseded Provisions, P.L. 108-173.

Colorectal Cancer Screening Tests

(pp)(1) The term "colorectal cancer screening test" means any of the following procedures furnished to an individual for the purpose of early detection of colorectal cancer:

(A) Screening fecal–occult blood test.

(B) Screening flexible sigmoidoscopy.

(C) Screening colonoscopy.

(D) Such other tests or procedures, and modifications to tests and procedures under this subsection, with such frequency and payment limits, as the Secretary determines appropriate, in consultation with appropriate organizations.

(2) An "individual at high risk for colorectal cancer" is an individual who, because of family history, prior experience of cancer or precursor neoplastic polyps, a history of chronic digestive disease condition (including inflammatory bowel disease, Crohn's Disease, or ulcerative colitis), the presence of any appropriate recognized gene markers for colorectal cancer, or other predisposing factors, faces a high risk for colorectal cancer.[431]

Diabetes Outpatient Self–Management Training Services

(qq)(1) The term "diabetes outpatient self–management training services" means educational and training services furnished (at such times as the Secretary determines appropriate) to an individual with diabetes by a certified provider (as described in paragraph (2)(A)) in an outpatient setting by an individual or entity who meets the quality standards described in paragraph (2)(B), but only if the physician who is managing the individual's diabetic condition certifies that such services are needed under a comprehensive plan of care related to the individual's diabetic condition to ensure therapy compliance or to provide the individual with necessary skills and knowledge (including skills related to the self–administration of injectable drugs) to participate in the management of the individual's condition.

(2) In paragraph (1)—

(A) a "certified provider" is a physician, or other individual or entity designated by the Secretary, that, in addition to providing diabetes outpatient self–management training services, provides other items or services for which payment may be made under this title; and

(B) a physician, or such other individual or entity, meets the quality standards described in this paragraph if the physician, or individual or entity, meets quality standards established by the Secretary, except that the physician or other individual or entity shall be deemed to have met such standards if the physician or other individual or entity meets applicable standards originally established by the National Diabetes Advisory Board and subsequently revised by organizations who participated in the establishment of standards by such Board, or is recognized by an organization that represents individuals (including individ-

[431] See Vol. II, P.L. 105–33, §4104(a)(2), with respect to the deadline for publication of determination on coverage of screening barium enema.

uals under this title) with diabetes as meeting standards for furnishing the services.

Bone Mass Measurement

(rr)(1) The term "bone mass measurement" means a radiologic or radioisotopic procedure or other procedure approved by the Food and Drug Administration performed on a qualified individual (as defined in paragraph (2)) for the purpose of identifying bone mass or detecting bone loss or determining bone quality, and includes a physician's interpretation of the results of the procedure.

(2) For purposes of this subsection, the term "qualified individual" means an individual who is (in accordance with regulations prescribed by the Secretary)—

(A) an estrogen–deficient woman at clinical risk for osteoporosis;

(B) an individual with vertebral abnormalities;

(C) an individual receiving long–term glucocorticoid steroid therapy;

(D) an individual with primary hyperparathyroidism; or

(E) an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

(3) The Secretary shall establish such standards regarding the frequency with which a qualified individual shall be eligible to be provided benefits for bone mass measurement under this title.

Religious Nonmedical Health Care Institution

(ss)(1) The term "religious nonmedical health care institution" means an institution that—

(A) is described in subsection (c)(3) of section 501 of the Internal Revenue Code of 1986 and is exempt from taxes under subsection (a) of such section;

(B) is lawfully operated under all applicable Federal, State, and local laws and regulations;

(C) provides only nonmedical nursing items and services exclusively to patients who choose to rely solely upon a religious method of healing and for whom the acceptance of medical health services would be inconsistent with their religious beliefs;

(D) provides such nonmedical items and services exclusively through nonmedical nursing personnel who are experienced in caring for the physical needs of such patients;

(E) provides such nonmedical items and services to inpatients on a 24–hour basis;

(F) on the basis of its religious beliefs, does not provide through its personnel or otherwise medical items and services (including any medical screening, examination, diagnosis, prognosis, treatment, or the administration of drugs) for its patients;

(G)(i) is not owned by, under common ownership with, or has an ownership interest in, a provider of medical treatment or services;

(ii) is not affiliated with—

(I) a provider of medical treatment or services, or

(II) an individual who has an ownership interest in a provider of medical treatment or services;

(H) has in effect a utilization review plan which—

(i) provides for the review of admissions to the institution, of the duration of stays therein, of cases of continuous extended duration, and of the items and services furnished by the institution,

(ii) requires that such reviews be made by an appropriate committee of the institution that includes the individuals responsible for overall administration and for supervision of nursing personnel at the institution,

(iii) provides that records be maintained of the meetings, decisions, and actions of such committee, and

(iv) meets such other requirements as the Secretary finds necessary to establish an effective utilization review plan;

(I) provides the Secretary with such information as the Secretary may require to implement section 1821, including information relating to quality of care and coverage determinations; and

(J) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution.

(2) To the extent that the Secretary finds that the accreditation of an institution by a State, regional, or national agency or association provides reasonable assurances that any or all of the requirements of paragraph (1) are met or exceeded, the Secretary may treat such institution as meeting the condition or conditions with respect to which the Secretary made such finding.

(3)(A)(i) In administering this subsection and section 1821, the Secretary shall not require any patient of a religious nonmedical health care institution to undergo medical screening, examination, diagnosis, prognosis, or treatment or to accept any other medical health care service, if such patient (or legal representative of the patient) objects thereto on religious grounds.

(ii) Clause (i) shall not be construed as preventing the Secretary from requiring under section 1821(a)(2) the provision of sufficient information regarding an individual's condition as a condition for receipt of benefits under part A for services provided in such an institution.

(B)(i) In administering this subsection and section 1821, the Secretary shall not subject a religious nonmedical health care institution or its personnel to any medical supervision, regulation, or control, insofar as such supervision, regulation, or control would be contrary to the religious beliefs observed by the institution or such personnel.

(ii) Clause (i) shall not be construed as preventing the Secretary from reviewing items and services billed by the institution to the extent the Secretary determines such review to be necessary to determine whether such items and services were not covered under part A, are excessive, or are fraudulent.

(4)(A) For purposes of paragraph (1)(G)(i), an ownership interest of less than 5 percent shall not be taken into account.

(B) For purposes of paragraph (1)(G)(ii), none of the following shall be considered to create an affiliation:

(i) An individual serving as an uncompensated director, trustee, officer, or other member of the governing body of a religious nonmedical health care institution.

(ii) An individual who is a director, trustee, officer, employee, or staff member of a religious nonmedical health care institution having a family relationship with an individual who is affiliated with (or has an ownership interest in) a provider of medical treatment or services.

(iii) An individual or entity furnishing goods or services as a vendor to both providers of medical treatment or services and religious nonmedical health care institutions.

(tt)(1) The term "post–institutional home health services" means home health services furnished to an individual—

(A) after discharge from a hospital or critical access[432] hospital in which the individual was an inpatient for not less than 3 consecutive days before such discharge if such home health services were initiated within 14 days after the date of such discharge; or

(B) after discharge from a skilled nursing facility in which the individual was provided post–hospital extended care services if such home health services were initiated within 14 days after the date of such discharge.

(2) The term "home health spell of illness" with respect to any individual means a period of consecutive days—

(A) beginning with the first day (not included in a previous home health spell of illness) (i) on which such individual is furnished post–institutional home health services, and (ii) which occurs in a month for which the individual is entitled to benefits under part A, and

(B) ending with the close of the first period of 60 consecutive days thereafter on each of which the individual is neither an inpatient of a hospital or critical access[433] hospital nor an inpatient of a facility described in section 1819(a)(1) or subsection (y)(1) nor provided home health services.

(uu) The term "screening for glaucoma" means a dilated eye examination with an intraocular pressure measurement, and a direct ophthalmoscopy or a slit–lamp biomicroscopic examination for the early detection of glaucoma which is furnished by or under the direct supervision of an optometrist or ophthalmologist who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service, if the individual involved has not had such an examination in the preceding year.

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[432] P.L. 108–173, §736(a)(11), struck out "rural primary care" and substituted "critical access".
[433] P.L. 108–173, §736(a)(11), struck out "rural primary care" and substituted "critical access".

Medical Nutrition Therapy Services; Registered Dietitian or Nutrition Professional

(vv)(1)[434] The term "medical nutrition therapy services" means nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a registered dietitian or nutrition professional (as defined in paragraph (2)) pursuant to a referral by a physician (as defined in subsection (r)(1)).

(2) Subject to paragraph (3), the term "registered dietitian or nutrition professional" means an individual who—

(A) holds a baccalaureate or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics, as accredited by an appropriate national accreditation organization recognized by the Secretary for this purpose;

(B) has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional; and

(C)(i) is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed; or

(ii) in the case of an individual in a State that does not provide for such licensure or certification, meets such other criteria as the Secretary establishes.

(3) Subparagraphs (A) and (B) of paragraph (2) shall not apply in the case of an individual who, as of the date of the enactment of this subsection, is licensed or certified as a dietitian or nutrition professional by the State in which medical nutrition therapy services are performed.

Initial Preventive Physical Examination

(ww)[435] (1) The term "initial preventive physical examination" means physicians' services consisting of a physical examination (including measurement of height, weight, and blood pressure, and an electrocardiogram) with the goal of health promotion and disease detection and includes education, counseling, and referral with respect to screening and other preventive services described in paragraph (2), but does not include clinical laboratory tests.

(2) The screening and other preventive services described in this paragraph include the following:

(A) Pneumococcal, influenza, and hepatitis B vaccine and administration under subsection (s)(10).

(B) Screening mammography as defined in subsection (jj).

(C) Screening pap smear and screening pelvic exam as defined in subsection (nn).

(D) Prostate cancer screening tests as defined in subsection (oo).

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[434] See Vol. II, P.L. 106–554, §1(a)(6) [105(f)], with respect to a report to Congress with respect to the expansion of the medical nutrition therapy services benefit.

[435] P.L. 108-73, §611(b), added subsection (ww), applicable to services furnished on or after January 1, 2005, but only for individuals whose coverage period under part B begins on or after such date.

(E) Colorectal cancer screening tests as defined in subsection (pp).

(F) Diabetes outpatient self-management training services as defined in subsection (qq)(1).

(G) Bone mass measurement as defined in subsection (rr).

(H) Screening for glaucoma as defined in subsection (uu).

(I) Medical nutrition therapy services as defined in subsection (vv).

(J) Cardiovascular screening blood tests as defined in subsection (xx)(1).

(K) Diabetes screening tests as defined in subsection (yy).

Cardiovascular Screening Blood Test

(xx)[436] (1) The term "cardiovascular screening blood test" means a blood test for the early detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) that tests for the following:

(A) Cholesterol levels and other lipid or triglyceride levels.

(B) Such other indications associated with the presence of, or an elevated risk for, cardiovascular disease as the Secretary may approve for all individuals (or for some individuals determined by the Secretary to be at risk for cardiovascular disease), including indications measured by noninvasive testing. The Secretary may not approve an indication under subparagraph (B) for any individual unless a blood test for such is recommended by the United States Preventive Services Task Force.

(2) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency for each type of cardiovascular screening blood tests, except that such frequency may not be more often than once every 2 years.

Diabetes Screening Tests

(yy)[437] (1) The term "diabetes screening tests" means testing furnished to an individual at risk for diabetes (as defined in paragraph (2)) for the purpose of early detection of diabetes, including—

(A) a fasting plasma glucose test; and

(B) such other tests, and modifications to tests, as the Secretary determines appropriate, in consultation with appropriate organizations.

(2) For purposes of paragraph (1), the term "individual at risk for diabetes" means an individual who has any of the following risk factors for diabetes:

(A) Hypertension.

(B) Dyslipidemia.

(C) Obesity, defined as a body mass index greater than or equal to 30 kg/m^2 .

[436] P.L. 108-173, §612(b), added subsection (xx), applicable to tests furnished on or after January 1, 2005.

[437] P.L. 108-173, §613(b), added subsection (yy), applicable to tests furnished on or after January 1, 2005.

(D) Previous identification of an elevated impaired fasting glucose.

(E) Previous identification of impaired glucose tolerance.

(F) A risk factor consisting of at least 2 of the following characteristics:

(i) Overweight, defined as a body mass index greater than 25, but less than 30, kg/m^2 .

(ii) A family history of diabetes.

(iii) A history of gestational diabetes mellitus or delivery of a baby weighing greater than 9 pounds.

(iv) 65 years of age or older.

(3) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency of diabetes screening tests, except that such frequency may not be more often than twice within the 12-month period following the date of the most recent diabetes screening test of that individual.

Intravenous Immune Globulin

(zz)[438] The term "intravenous immune globulin" means an approved pooled plasma derivative for the treatment in the patient's home of a patient with a diagnosed primary immune deficiency disease, but not including items or services related to the administration of the derivative, if a physician determines administration of the derivative in the patient's home is medically appropriate.

Extended Care in Religious Nonmedical Health Care Institutions

(aaa)[439] (1) The term "home health agency" also includes a religious nonmedical health care institution (as defined in subsection (ss)(1)), but only with respect to items and services ordinarily furnished by such an institution to individuals in their homes, and that are comparable to items and services furnished to individuals by a home health agency that is not religious nonmedical health care institution.

(2)(A) Subject to subparagraphs (B), payment may be made with respect to services provided by such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations consistent with section 1821.

(B) Notwithstanding any other provision of this title, payment may not be made under subparagraph (A)—

(i) in a year insofar as such payments exceed $700,000; and

(ii) after December 31, 2006.

[438] P.L. 108-173, §613(b), added subsection (zz), applicable to tests furnished on or after January 1, 2005.

[439] P.L. 108-173, §706(b), added subsection (aaa), effective December 8, 2003.

EXCLUSIONS FROM COVERAGE AND MEDICARE AS SECONDARY PAYER[440]

SEC. 1862. [42 U.S.C. 1395y] (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1)(A) which, except for items and services described in a succeeding subparagraph, are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,

(B) in the case of items and services described in section 1861(s)(10), which are not reasonable and necessary for the prevention of illness,

(C) in the case of hospice care, which are not reasonable and necessary for the palliation or management of terminal illness,

(D) in the case of clinical care items and services provided with the concurrence of the Secretary and with respect to research and experimentation conducted by, or under contract with, the Medicare Payment Advisory Commission or the Secretary, which are not reasonable and necessary to carry out the purposes of section 1886(e)(6),

(E) in the case of research conducted pursuant to section 1142, which is not reasonable and necessary to carry out the purposes of that section,

(F) in the case of screening mammography, which is performed more frequently than is covered under section 1834(c)(2) or which is not conducted by a facility described in section 1834(c)(1)(B), in the case of screening pap smear and screening pelvic exam, which is performed more frequently than is provided under section 1861(nn), and, in the case of screening for glaucoma, which is performed more frequently than is provided under section 1861(uu),

(G) in the case of prostate cancer screening tests (as defined in section 1861(oo)), which are performed more frequently than is covered under such section,

(H) in the case of colorectal cancer screening tests, which are performed more frequently than is covered under section 1834(d),[441]

(I) the frequency and duration of home health services which are in excess of normative guidelines that the Secretary shall establish by regulation,[442]

(J)[443] in the case of a drug or biological specified in section 1847A(c)(6)(C) for which payment is made under part B that is furnished in a competitive area under section 1847B, that is not furnished by an entity under a contract under such section,[444]

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[440] See Vol. II, P.L. 108-173, §953(b), with respect to the annual publication of a list of national coverage determinations.

[441] P.L. 108-173, §303(i)(3)(B)(i), struck out "and".

[442] P.L. 108-173, §303(i)(3)(B)(ii), struck out the semicolon and substituted ", and"; §611(d)(1)(A)(i), struck out "and".

[443] P.L. 108-173, §303(i)(3)(B)(iii), added subparagraph (J), effective December 8, 2003.

[444] P.L. 108-173, §611(d)(1)(A)(ii), struck out the semicolon and substituted ", and"; §612(c)(1), struck out "and".

(K)[445] in the case of an initial preventive physical examination, which is performed not later than 6 months after the date the individual's first coverage period begins under part B;

(L)[446] in the case of cardiovascular screening blood tests (as defined in section 1861(xx)(1)), which are performed more frequently than is covered under section 1861(xx)(2), and[447]

(M)[448] in the case of a diabetes screening test (as defined in section 1861(yy)(1)), which is performed more frequently than is covered under section 1861(yy)(3);

(2) for which the individual furnished such items or services has no legal obligation to pay, and which no other person (by reason of such individual's membership in a prepayment plan or otherwise) has a legal obligation to provide or pay for, except in the case of Federally qualified health center services;

(3) which are paid for directly or indirectly by a governmental entity (other than under this Act and other than under a health benefits or insurance plan established for employees of such an entity), except in the case of rural health clinic services, as defined in section 1861(aa)(1), in the case of Federally qualified health center services, as defined in section 1861(aa)(3), in the case of services for which payment may be made under section 1880(e), and in such other cases as the Secretary may specify;

(4) which are not provided within the United States (except for inpatient hospital services furnished outside the United States under the conditions described in section 1814(f) and, subject to such conditions, limitations, and requirements as are provided under or pursuant to this title, physicians' services and ambulance services furnished an individual in conjunction with such inpatient hospital services but only for the period during which such inpatient hospital services were furnished);

(5) which are required as a result of war, or of an act of war, occurring after the effective date of such individual's current coverage under such part;

(6) which constitute personal comfort items (except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C));

(7) where such expenses are for routine physical checkups, eyeglasses (other than eyewear described in section 1861(s)(8)) or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, procedures performed (during the course of any eye examination) to determine the refractive state of the eyes, hearing aids or examinations therefor, or immunizations (except as otherwise allowed under section 1861(s)(10) and subparagraph (B), (F), (G), (H), or (K)[449] of paragraph (1));

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[445] P.L. 108-173, §611(d)(1)(A)(iii), added subparagraph (K), applicable to services furnished on or after January 1, 2005, but only for individuals whose coverage period under part B begining or after such date.

[446] P.L. 108-173, §612(c)(3), added subparagraph (L), applicable to tests furnished on or after January 1, 2005.

[447] P.L. 108-173, §613(c)(2), struck out the semicolon and substituted ", and".

[448] P.L. 108-173, §613(c)(3), added subparagraph (M), applicable to tests furnished on or after January 1, 2005.

[449] P.L. 108-173, §611(d)(1)(B), struck out "or (H)" and substituted "(H), or (K)", effective December 8, 2003.

(8) where such expenses are for orthopedic shoes or other supportive devices for the feet, other than shoes furnished pursuant to section 1861(s)(12);

(9) where such expenses are for custodial care (except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C));

(10) where such expenses are for cosmetic surgery or are incurred in connection therewith, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member;

(11) where such expenses constitute charges imposed by immediate relatives of such individual or members of his household;

(12) where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under part A in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services;

(13) where such expenses are for—

(A) the treatment of flat foot conditions and the prescription of supportive devices therefor,

(B) the treatment of subluxations of the foot, or

(C) routine foot care (including the cutting or removal of corns or calluses, the trimming of nails, and other routine hygienic care);

(14) which are other than physicians' services (as defined in regulations promulgated specifically for purposes of this paragraph), services described by section 1861(s)(2)(K), certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist, and which are furnished to an individual who is a patient of a hospital or critical access hospital by an entity other than the hospital or critical access hospital, unless the services are furnished under arrangements (as defined in section 1861(w)(1)) with the entity made by the hospital or critical access hospital;

(15)(A) which are for services of an assistant at surgery in a cataract operation (including subsequent insertion of an intraocular lens) unless, before the surgery is performed, the appropriate utilization and quality control peer review organization (under part B of title XI) or a carrier under section 1842 has approved of the use of such an assistant in the surgical procedure based on the existence of a complicating medical condition, or[450]

(B) which are for services of an assistant at surgery to which section 1848(i)(2)(B) applies;

(16) in the case in which funds may not be used for such items and services under the Assisted Suicide Funding Restriction Act of 1997;

(17) where the expenses are for an item or service furnished in a competitive acquisition area (as established by the Sec-

[450] See Vol. II, P.L. 99–514, §1895(b)(16)(C), with respect to deeming approval.

retary under section 1847(a)) by an entity other than an entity with which the Secretary has entered into a contract under section 1847(b) for the furnishing of such an item or service in that area, unless the Secretary finds that the expenses were incurred in a case of urgent need, or in other circumstances specified by the Secretary;

(18) which are covered skilled nursing facility services described in section 1888(e)(2)(A)(i) and which are furnished to an individual who is a resident of a skilled nursing facility during a period in which the resident is provided covered post–hospital extended care services (or, for services described in section 1861(s)(2)(D), which are furnished to such an individual without regard to such period), by an entity other than the skilled nursing facility, unless the services are furnished under arrangements (as defined in section 1861(w)(1)) with the entity made by the skilled nursing facility; or

(19) which are for items or services which are furnished pursuant to a private contract described in section 1802(b);

(20) in the case of outpatient occupational therapy services or outpatient physical therapy services furnished as an incident to a physician's professional services (as described in section 1861(s)(2)(A)), that do not meet the standards and conditions (other than any licensing requirement specified by the Secretary) under the second sentence of section 1861(p) (or under such sentence through the operation of section 1861(g)) as such standards and conditions would apply to such therapy services if furnished by a therapist;

(21) where such expenses are for home health services (including medical supplies described in section 1861(m)(5), but excluding durable medical equipment to the extent provided for in such section), furnished to an individual who is under a plan of care of the home health agency if the claim for payment for such services is not submitted by the agency; or

(22) subject to subsection (h), for which a claim is submitted other than in an electronic form specified by the Secretary.

Paragraph (7) shall not apply to Federally qualified health center services described in section 1861(aa)(3)(B). In making a national coverage determination (as defined in paragraph (1)(B) of section 1869(f)) the Secretary shall ensure consistent with subsection (l)[451] that the public is afforded notice and opportunity to comment prior to implementation by the Secretary of the determination; meetings of advisory committees[452] with respect to the determination are made on the record; in making the determination, the Secretary has considered applicable information (including clinical experience and medical, technical, and scientific evidence) with respect to the subject matter of the determination; and in the determination, provide a clear statement of the basis for the determination (including responses to comments received from the public), the assumptions underlying that basis, and make available to the public the data (other than proprietary data) considered in making the determination.

[451] P.L. 108–173, §731(a)(1)(A), inserted "consistent with subsection (l)", effective December 8, 2003, and applicable to national coverage determinations as of January 1, 2004.

[452] P.L. 108–173, §948(a)(2)(A), struck out "established under section 1114(f)", effective as if included in the enactment of BIPA.

(b) MEDICARE AS SECONDARY PAYER.—

(1) REQUIREMENTS OF GROUP HEALTH PLANS.—

(A) WORKING AGED UNDER GROUP HEALTH PLANS.—

(i) IN GENERAL.—A group health plan—

(I) may not take into account that an individual (or the individual's spouse) who is covered under the plan by virtue of the individual's current employment status with an employer is entitled to benefits under this title under section 226(a), and

(II) shall provide that any individual age 65 or older (and the spouse age 65 or older of any individual) who has current employment status with an employer shall be entitled to the same benefits under the plan under the same conditions as any such individual (or spouse) under age 65.

(ii)[453] EXCLUSION OF GROUP HEALTH PLAN OF A SMALL EMPLOYER.—Clause (i) shall not apply to a group health plan unless the plan is a plan of, or contributed to by, an employer that has 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.

(iii) EXCEPTION FOR SMALL EMPLOYERS IN MULTI-EMPLOYER OR MULTIPLE EMPLOYER GROUP HEALTH PLANS.—Clause (i) also shall not apply with respect to individuals enrolled in a multiemployer or multiple employer group health plan if the coverage of the individuals under the plan is by virtue of current employment status with an employer that does not have 20 or more individuals in current employment status for each working day in each of 20 or more calendar weeks in the current calendar year and the preceding calendar year; except that the exception provided in this clause shall only apply if the plan elects treatment under this clause.

(iv) EXCEPTION FOR INDIVIDUALS WITH END STAGE RENAL DISEASE.—Subparagraph (C) shall apply instead of clause (i) to an item or service furnished in a month to an individual if for the month the individual is, or (without regard to entitlement under section 226) would upon application be, entitled to benefits under section 226A.

(v) GROUP HEALTH PLAN DEFINED.—In this subparagraph, and subparagraph (C), the term "group health plan" has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986, without regard to section 5000(d) of such Code.

(B) DISABLED INDIVIDUALS IN LARGE GROUP HEALTH PLANS.—

(i) IN GENERAL.—A large group health plan (as defined in clause (iii)) may not take into account that an individual (or a member of the individual's family) who is covered under the plan by virtue of the individ-

[453] P.L. 108–173, §301(c)(1), moved clauses (ii) through (v) 2 ems to the left, effective as if included in the enactment of section 953 of the Omnibus Reconciliation Act of 1980 (Public Law 96-499; 94 Stat. 2647).

ual's current employment status with an employer is entitled to benefits under this title under section 226(b).

(ii) EXCEPTION FOR INDIVIDUALS WITH END STAGE RENAL DISEASE.—Subparagraph (C) shall apply instead of clause (i) to an item or service furnished in a month to an individual if for the month the individual is, or (without regard to entitlement under section 226) would upon application be, entitled to benefits under section 226A.

(iii) LARGE GROUP HEALTH PLAN DEFINED.—In this subparagraph, the term "large group health plan" has the meaning given such term in section 5000(b)(2) of the Internal Revenue Code of 1986, without regard to section 5000(d) of such Code.

(C) INDIVIDUALS WITH END STAGE RENAL DISEASE.—A group health plan (as defined in subparagraph (A)(v))—

(i) may not take into account that an individual is entitled to or eligible for benefits under this title under section 226A during the 12-month period which begins with the first month in which the individual becomes entitled to benefits under part A under the provisions of section 226A, or, if earlier, the first month in which the individual would have been entitled to benefits under such part under the provisions of section 226A if the individual had filed an application for such benefits; and

(ii) may not differentiate in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner;

except that clause (ii) shall not prohibit a plan from paying benefits secondary to this title when an individual is entitled to or eligible for benefits under this title under section 226A after the end of the 12-month period described in clause (i). Effective for items and services furnished on or after February 1, 1991, and before the date of enactment of the Balanced Budget Act of 1997[454] (with respect to periods beginning on or after February 1, 1990), this subparagraph shall be applied by substituting "18-month" for "12-month" each place it appears.[455] Effective for items and services furnished on or after the date of enactment of the Balanced Budget Act of 1997, (with respect to periods beginning on or after the date that is 18 months prior to such date), clauses (i) and (ii) shall be applied by substituting "30–month" for "12–month" each place it appears.

(D) TREATMENT OF CERTAIN MEMBERS OF RELIGIOUS ORDERS.—In this subsection, an individual shall not be considered to be employed, or an employee, with respect to the performance of services as a member of a religious order which are considered employment only by virtue of an elec-

[454] P.L. 105–33; August 5, 1997.

[455] See Vol. II, P.L. 101–508, §4203(c)(2), with respect to the GAO study of extension of secondary payer period.

tion made by the religious order under section 3121(r) of the Internal Revenue Code of 1986.[456]

(E) GENERAL PROVISIONS.—For purposes of this subsection:

(i) AGGREGATION RULES.—

(I) All employers treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 shall be treated as a single employer.

(II) All employees of the members of an affiliated service group (as defined in section 414(m) of such Code) shall be treated as employed by a single employer.

(III) Leased employees (as defined in section 414(n)(2) of such Code) shall be treated as employees of the person for whom they perform services to the extent they are so treated under section 414(n) of such Code.

In applying sections of the Internal Revenue Code of 1986 under this clause, the Secretary shall rely upon regulations and decisions of the Secretary of the Treasury respecting such sections.

(ii) CURRENT EMPLOYMENT STATUS DEFINED.—An individual has "current employment status" with an employer if the individual is an employee, is the employer, or is associated with the employer in a business relationship.

(iii) TREATMENT OF SELF-EMPLOYED PERSONS AS EMPLOYERS.—The term "employer" includes a self-employed person.

(F) LIMITATION ON BENEFICIARY LIABILITY.—An individual who is entitled to benefits under this title and is furnished an item or service for which such benefits are incorrectly paid is not liable for repayment of such benefits under this paragraph unless payment of such benefits was made to the individual.

(2) MEDICARE SECONDARY PAYER.—

(A) IN GENERAL.—Payment under this title may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that—

(i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or

(ii) payment has been made or can reasonably be expected to be made[457] under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.

In the subsection, the term "primary plan" means a group health plan or large group health plan, to the extent that

[456] See Vol. II, P.L. 103–66, §13561(f), with respect to retroactive exemption for certain situations involving religious orders.

[457] P.L. 108–173, §301(a)(1), struck out "promptly (as determined in accordance with regulations)", effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

clause (i) applies, and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies. An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.[458]

(B) CONDITIONAL PAYMENT.—

(i)[459] Authority to make conditional payment.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.

(ii)[460] REPAYMENT REQUIRED.—A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.[461] If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received[462], the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations

[458] P.L. 108–173, §301(b)(1), added this sentence, effective as if included in the enactment of section 953 of the Omnibus Reconciliation Act of 1980 (Public Law 96-499; 94 Stat. 2647).

[459] P.L. 108–173, §301(a)(2)(B), added this clause (i), effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

[460] P.L. 108–173, §301(a)(2)(A), redesignating the former clauses (i) through (v) as clauses (ii) through (vi), respectively, effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

[461] P.L. 108–173, §301(b)(2), struck out the first sentence and substituted these two sentences in clause (ii), effective as if included in the enactment of section 953 of the Omnibus Reconciliation Act of 1980 (Public Law 96-499; 94 Stat. 2647).

[462] P.L. 108–173, §301(b)(2)(B), struck out "on the date such notice or other information is received" and substituted "on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received", effective as if included in the enactment of section 953 of the Omnibus Reconciliation Act of 1980 (Public Law 96-499; 94 Stat. 2647).

of the Secretary of the Treasury applicable to charges for late payments).

(iii) ACTION BY UNITED STATES.—In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.[463] The United States may not recover from a third–party administrator under this clause in cases where the third–party administrator would not be able to recover the amount at issue from the employer or group health plan and is not employed by or under contract with the employer or group health plan at the time the action for recovery is initiated by the United States or for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.

(iv) SUBROGATION RIGHTS.—The United States shall be subrogated (to the extent of payment made under this title for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.

(v) WAIVER OF RIGHTS.—The Secretary may waive (in whole or in part) the provisions of this subparagraph in the case of an individual claim if the Secretary determines that the waiver is in the best interests of the program established under this title.

(vi) CLAIMS–FILING PERIOD.—Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3–year period beginning on the date on which the item or service was furnished.

(C) TREATMENT OF QUESTIONNAIRES.—The Secretary may not fail to make payment under subparagraph (A) solely on the ground that an individual failed to complete a questionnaire concerning the existence of a primary plan.

[463] P.L. 108–173, §301(b)(3), struck out the first sentence and substituted these first three sentences for clause (iii), effective as if included in the enactment of section 953 of the Omnibus Reconciliation Act of 1980 (Public Law 96-499; 94 Stat. 2647).

(3) ENFORCEMENT.—

(A) PRIVATE CAUSE OF ACTION.—There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with[464] paragraphs (1) and (2)(A).[465]

(B) REFERENCE TO EXCISE TAX WITH RESPECT TO NONCONFORMING GROUP HEALTH PLANS.—For provision imposing an excise tax with respect to nonconforming group health plans, see section 5000 of the Internal Revenue Code of 1986[466].

(C) PROHIBITION OF FINANCIAL INCENTIVES NOT TO ENROLL IN A GROUP HEALTH PLAN OR A LARGE GROUP HEALTH PLAN—It is unlawful for an employer or other entity to offer any financial or other incentive for an individual entitled to benefits under this title not to enroll (or to terminate enrollment) under a group health plan or a large group health plan which would (in the case of such enrollment) be a primary plan (as defined in paragraph (2)(A)). Any entity that violates the previous sentence is subject to a civil money penalty of not to exceed $5,000 for each such violation. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(4) COORDINATION OF BENEFITS.—Where payment for an item or service by a primary plan is less than the amount of the charge for such item or service and is not payment in full, payment may be made under this title (without regard to deductibles and coinsurance under this title) for the remainder of such charge, but—

(A) payment under this title may not exceed an amount which would be payable under this title for such item or service if paragraph (2)(A) did not apply; and

(B) payment under this title, when combined with the amount payable under the primary plan, may not exceed—

(i) in the case of an item or service payment for which is determined under this title on the basis of reasonable cost (or other cost-related basis) or under section 1886, the amount which would be payable under this title on such basis, and

(ii) in the case of an item or service for which payment is authorized under this title on another basis—

(I) the amount which would be payable under the primary plan (without regard to deductibles and coinsurance under such plan), or

(II) the reasonable charge or other amount which would be payable under this title (without regard to deductibles and coinsurance under this title),

[464] P.L. 108–173, §301(c)(2), struck out "such", effective as if included in the enactment of section 953 of the Omnibus Reconciliation Act of 1980 (Public Law 96-499; 94 Stat. 2647).

[465] As in original.

[466] See Vol. II, P.L. 83–591.

whichever is greater.

(5) IDENTIFICATION OF SECONDARY PAYER SITUATIONS.—

(A) REQUESTING MATCHING INFORMATION.—

(i) COMMISSIONER OF SOCIAL SECURITY.—The Commissioner of Social Security shall, not less often that annually, transmit to the Secretary of the Treasury a list of the names and TINs of medicare beneficiaries (as defined in section 6103(l)(12) of the Internal Revenue Code of 1986) and request that the Secretary disclose to the Commissioner the information described in subparagraph (A) of such section.

(ii) ADMINISTRATOR.—The Administrator of the Centers for Medicare and Medicaid Services[467] shall request, not less often than annually, the Commissioner of the Social Security Administration to disclose to the Administrator the information described in subparagraph (B) of section 6103(l)(12) of the Internal Revenue Code of 1986.

(B) DISCLOSURE TO FISCAL INTERMEDIARIES AND CARRIERS.—In addition to any other information provided under this title to fiscal intermediaries and carriers, the Administrator shall disclose to such intermediaries and carriers (or to such a single intermediary or carrier as the Secretary may designate) the information received under subparagraph (A) for purposes of carrying out this subsection.

(C) CONTACTING EMPLOYERS.—

(i) IN GENERAL.—With respect to each individual (in this subparagraph referred to as an "employee") who was furnished a written statement under section 6051 of the Internal Revenue Code of 1986 by a qualified employer (as defined in section 6103(l)(12)(E)(iii), of such Code), as disclosed under subparagraph (B)(i) the appropriate fiscal intermediary or carrier shall contact the employer in order to determine during what period the employee or employee's spouse may be (or have been) covered under a group health plan of the employer and the nature of the coverage that is or was provided under the plan (including the name, address, and identifying number of the plan).

(ii) EMPLOYER RESPONSE.—Within 30 days of the date of receipt of the inquiry, the employer shall notify the intermediary or carrier making the inquiry as to the determinations described in clause (i). An employer (other than a Federal or other governmental entity) who willfully or repeatedly fails to provide timely and accurate notice in accordance with the previous sentence shall be subject to a civil money penalty of not to exceed $1,000 for each individual with respect to which such an inquiry is made. The provision of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions

[467] P.L. 108–173, §900(e)(1)(J), struck out "Health Care Financing Administration" and substituted "Centers for Medicare and Medicaid Services".

apply to a penalty or proceeding under section 1128A(a).

(D) OBTAINING INFORMATION FROM BENEFICIARIES.—Before an individual applies for benefits under part A or enrolls under part B, the Administrator shall mail the individual a questionnaire to obtain information on whether the individual is covered under a primary plan and the nature of the coverage provided under the plan, including the name, address, and identifying number of the plan.

(6) SCREENING REQUIREMENTS FOR PROVIDER AND SUPPLIERS.—

(A) IN GENERAL.—Notwithstanding any other provisions of this title, no payment may be made for any item or service furnished under part B unless the entity furnishing such item or service completes (to the best of its knowledge and on the basis of information obtained from the individual to whom the item or service is furnished) the portion of the claim form relating to the availability of other health benefit plans.

(B) PENALTIES.—An entity that knowingly, willfully, and repeatedly fails to complete a claim form in accordance with subparagraph (A) or provides inaccurate information relating to the availability of other health benefit plans on a claim form under such subparagraph shall be subject to a civil money penalty of not to exceed $2,000 for each such incident. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(c) No payment may be made under part B for any expenses incurred for—

(1) a drug product—

(A) which is described in section 107(c)(3) of the Drug Amendments of 1962,[468]

(B) which may be dispensed only upon prescription,

(C) for which the Secretary has issued a notice of an opportunity for a hearing under subsection (e) of section 505 of the Federal Food, Drug, and Cosmetic Act[469] on a proposed order of the Secretary to withdraw approval of an application for such drug product under such section because the Secretary has determined that the drug is less than effective for all conditions of use prescribed, recommended, or suggested in its labeling, and

(D) for which the Secretary has not determined there is a compelling justification for its medical need; and

(2) any other drug product—

(A) which is identical, related, or similar (as determined in accordance with section 310.6 of title 21 of the Code of Federal Regulations) to a drug product described in paragraph (1), and

(B) for which the Secretary has not determined there is a compelling justification for its medical need,

[468] See Vol. II, P.L. 87–781.
[469] See Vol. II, P.L. 75–717.

until such time as the Secretary withdraws such proposed order.

(d)[470] For purposes of subsection (a)(1)(A), in the case of any item or service that is required to be provided pursuant to section 1867 to an individual who is entitled to benefits under this title, determinations as to whether the item or service is reasonable and necessary shall be made on the basis of the information available to the treating physician or practitioner (including the patient's presenting symptoms or complaint) at the time the item or service was ordered or furnished by the physician or practitioner (and not on the patient's principal diagnosis). When making such determinations with respect to such an item or service, the Secretary shall not consider the frequency with which the item or service was provided to the patient before or after the time of the admission or visit.

(e)(1) No payment may be made under this title with respect to any item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished—

(A) by an individual or entity during the period when such individual or entity is excluded pursuant to section 1128, 1128A, 1156 or 1842(j)(2) from participation in the program under this title; or

(B) at the medical direction or on the prescription of a physician during the period when he is excluded pursuant to section 1128, 1128A, 1156 or 1842(j)(2) from participation in the program under this title and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

(2) Where an individual eligible for benefits under this title submits a claim for payment for items or services furnished by an individual or entity excluded from participation in the programs under this title, pursuant to section 1128, 1128A, 1156, 1160 (as in effect on September 2, 1982), 1842(j)(2), 1862(d) (as in effect on the date of the enactment of the Medicare and Medicaid Patient and Program Protection Act of 1987[471]), or 1866, and such beneficiary did not know or have reason to know that such individual or entity was so excluded, then, to the extent permitted by this title, and notwithstanding such exclusion, payment shall be made for such items or services. In each such case the Secretary shall notify the beneficiary of the exclusion of the individual or entity furnishing the items or services. Payment shall not be made for items or services furnished by an excluded individual or entity to a beneficiary after a reasonable time (as determined by the Secretary in regulations) after the Secretary has notified the beneficiary of the exclusion of that individual or entity.

(f) The Secretary shall establish utilization guidelines for the determination of whether or not payment may be made, consistent with paragraph (1)(A) of subsection (a), under part A or part B for expenses incurred with respect to the provision of home health services, and shall provide for the implementation of such guidelines through a process of selective postpayment coverage review by intermediaries or otherwise.

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[470] P.L. 108–173, §944(a)(1), added subsection (d), applicable to items and services furnished on or after January 1, 2004.

[471] P.L. 100–93, approved August 18, 1987.

(g) The Secretary shall, in making the determinations under paragraphs (1) and (9) of subsection (a), and for the purposes of promoting the effective, efficient, and economical delivery of health care services, and of promoting the quality of services of the type for which payment may be made under this title, enter into contracts with utilization and quality control peer review organizations pursuant to part B of title XI of this Act.

(h)(1) THE SECRETARY—

(A) shall waive the application of subsection (a)(22) in cases in which—

(i) there is no method available for the submission of claims in an electronic form; or

(ii) the entity submitting the claim is a small provider of services or supplier; and

(B) may waive the application of such subsection in such unusual cases as the Secretary finds appropriate.

(2) For purposes of this subsection, the term "small provider of services or supplier" means—

(A) a provider of services with fewer than 25 full–time equivalent employees; or

(B) a physician, practitioner, facility, or supplier (other than provider of services) with fewer than 10 full–time equivalent employees.

(i) In order to supplement the activities of the Medicare Payment Advisory Commission under section 1886(e) in assessing the safety, efficacy, and cost-effectiveness of new and existing medical procedures, the Secretary may carry out, or award grants or contracts for, original research and experimentation of the type described in clause (ii) of section 1886(e)(6)(E) with respect to such a procedure if the Secretary finds that—

(1) such procedure is not of sufficient commercial value to justify research and experimentation by a commerical organization;

(2) research and experimentation with respect to such procedure is not of a type that may appropriately be carried out by an institute, division, or bureau of the National Institutes of Health; and

(3) such procedure has the potential to be more cost-effective in the treatment of a condition than procedures currently in use with respect to such condition.

(j)[472] (1) Any advisory committee appointed under[473] to advise the Secretary on matters relating to the interpretation, application, or implementation of subsection (a)(1)[474] shall assure the full participation of a nonvoting member in the deliberations of the advisory committee, and shall provide such nonvoting member access to all information and data made available to voting members of the advisory committee, other than information that—

(A) is exempt from disclosure pursuant to subsection (a) of section 552 of title 5, United States Code, by reason of subsection (b)(4) of such section (relating to trade secrets); or

[472] P.L. 108–173, §948(a)(1), transferred §1114(i) to section 1862 and redesignated it as the new subsection (j), effective as if included in the enactment of BIPA.

[473] P.L. 108–173, §948(a)(2)(B)(i), struck out "under subsection (f)", effective as if included in the enactment of BIPA.

[474] P.L. 108–173, §948(a)(2)(B)(ii), struck out "section 1862(a)(1)" and substitited "subsection (a)(1)", effective as if included in the enactment of BIPA.

(B) the Secretary determines would present a conflict of interest relating to such nonvoting member.

(2) If an advisory committee described in paragraph (1) organizes into panels of experts according to types of items or services considered by the advisory committee, any such panel of experts may report any recommendation with respect to such items or services directly to the Secretary without the prior approval of the advisory committee or an executive committee thereof.

(k)[475] (1) Subject to paragraph (2), a group health plan (as defined in subsection (a)(1)(A)(v)) providing supplemental or secondary coverage to individuals also entitled to services under this title shall not require a medicare claims determination under this title for dental benefits specifically excluded under subsection (a)(12) as a condition of making a claims determination for such benefits under the group health plan.

(2) A group health plan may require a claims determination under this title in cases involving or appearing to involve inpatient dental hospital services or dental services expressly covered under this title pursuant to actions taken by the Secretary.

(l)[476] NATIONAL AND LOCAL COVERAGE DETERMINATION PROCESS.—

(1) FACTORS AND EVIDENCE USED IN MAKING NATIONAL COVERAGE DETERMINATIONS.—The Secretary shall make available to the public the factors considered in making national coverage determinations of whether an item or service is reasonable and necessary. The Secretary shall develop guidance documents to carry out this paragraph in a manner similar to the development of guidance documents under section 701(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 371(h)).

(2) TIMEFRAME FOR DECISIONS ON REQUESTS FOR NATIONAL COVERAGE DETERMINATIONS.—In the case of a request for a national coverage determination that—

(A) does not require a technology assessment from an outside entity or deliberation from the Medicare Coverage Advisory Committee, the decision on the request shall be made not later than 6 months after the date of the request; or

(B) requires such an assessment or deliberation and in which a clinical trial is not requested, the decision on the request shall be made not later than 9 months after the date of the request.

(3) PROCESS FOR PUBLIC COMMENT IN NATIONAL COVERAGE DETERMINATIONS.—

(A) PERIOD FOR PROPOSED DECISION.—Not later than the end of the 6-month period (or 9-month period for requests described in paragraph (2)(B)) that begins on the date a request for a national coverage determination is made, the Secretary shall make a draft of proposed decision on the request available to the public through the Internet

[475] P.L. 108–173, §950(a), added subsection (k), effective February 8, 2004.

[476] P.L. 108–173, §731(a)(1)(B), added subsection (l), applicable to national coverage determinations made on or after July 1, 2004, and section 1862(l)(5), applicable to local coverage determinations made on or after July 1, 2004.

See Vol. II, P.L. 108–173, §731(b)(3), with respect to the rule of construction for a nonexperimental/investigational device.

website of the Centers for Medicare and Medicaid Services or other appropriate means.

(B) 30-DAY PERIOD FOR PUBLIC COMMENT.—Beginning on the date the Secretary makes a draft of the proposed decision available under subparagraph (A), the Secretary shall provide a 30-day period for public comment on such draft.

(C) 60-DAY PERIOD FOR FINAL DECISION.—Not later than 60 days after the conclusion of the 30-day period referred to under subparagraph (B), the Secretary shall—

(i) make a final decision on the request;

(ii) include in such final decision summaries of the public comments received and responses to such comments;

(iii) make available to the public the clinical evidence and other data used in making such a decision when the decision differs from the recommendations of the Medicare Coverage Advisory Committee; and

(iv) in the case of a final decision under clause (i) to grant the request for the national coverage determination, the Secretary shall assign a temporary or permanent code (whether existing or unclassified) and implement the coding change.

(4) CONSULTATION WITH OUTSIDE EXPERTS IN CERTAIN NATIONAL COVERAGE DETERMINATIONS.—With respect to a request for a national coverage determination for which there is not a review by the Medicare Coverage Advisory Committee, the Secretary shall consult with appropriate outside clinical experts.

(5) LOCAL COVERAGE DETERMINATION PROCESS.—

(A) PLAN TO PROMOTE CONSISTENCY OF COVERAGE DETERMINATIONS.—The Secretary shall develop a plan to evaluate new local coverage determinations to determine which determinations should be adopted nationally and to what extent greater consistency can be achieved among local coverage determinations.

(B) CONSULTATION.—The Secretary shall require the fiscal intermediaries or carriers providing services within the same area to consult on all new local coverage determinations within the area.

(C) DISSEMINATION OF INFORMATION.—The Secretary should serve as a center to disseminate information on local coverage determinations among fiscal intermediaries and carriers to reduce duplication of effort.

(6) NATIONAL AND LOCAL COVERAGE DETERMINATION DEFINED.—For purposes of this subsection—

(A) NATIONAL COVERAGE DETERMINATION.—The term "national coverage determination" means a determination by the Secretary with respect to whether or not a particular item or service is covered nationally under this title.

(B) LOCAL COVERAGE DETERMINATION.—The term "local coverage determination" has the meaning given that in section 1869(f)(2)(B).

(m)[477] Coverage of Routine Costs Associated With Certain Clinical Trials of Category A Devices.—

[477] P.L. 108–173, §731(b)(1), added a new subsection (m), applicable to national coverage determinations made on or after July 1, 2004, and section 1862(l)(5), applicable to local coverage determinations made on or after July 1, 2004.

(1) In general.—In the case of an individual entitled to benefits under part A, or enrolled under part B, or both who participates in a category A clinical trial, the Secretary shall not exclude under subsection (a)(1) payment for coverage of routine costs of care (as defined by the Secretary) furnished to such individual in the trial.

(2) Category a clinical trial.—For purposes of paragraph (1), a "category A clinical trial" means a trial of a medical device if—

(A) the trial is of an experimental/investigational (category A) medical device (as defined in regulations under section 405.201(b) of title 42, Code of Federal Regulations (as in effect as of September 1, 2003));

(B) the trial meets criteria established by the Secretary to ensure that the trial conforms to appropriate scientific and ethical standards; and

(C) in the case of a trial initiated before January 1, 2010, the device involved in the trial has been determined by the Secretary to be intended for use in the diagnosis, monitoring, or treatment of an immediately life-threatening disease or condition.

CONSULTATION WITH STATE AGENCIES AND OTHER ORGANIZATIONS TO DEVELOP CONDITIONS OF PARTICIPATION FOR PROVIDERS OF SERVICES

SEC. 1863. [42 U.S.C. 1395z] In carrying out his functions, relating to determination of conditions of participation by providers of services, under subsections (e)(9), (f)(4), (j)(15), (o)(6), (cc)(2)(I), and (dd)(2) of section 1861, or by ambulatory surgical centers under section 1832(a)(2)(F)(i), the Secretary shall consult with appropriate State agencies and recognized national listing or accrediting bodies, and may consult with appropriate local agencies. Such conditions prescribed under any of such subsections may be varied for different areas or different classes of institutions or agencies and may, at the request of a State, provide higher requirements for such State than for other States; except that, in the case of any State or political subdivision of a State which imposes higher requirements on institutions as a condition to the purchase of services (or of certain specified services) in such institutions under a State plan approved under title I, XVI, or XIX, the Secretary shall impose like requirements as a condition to the payment for services (or for the services specified by the State or subdivision) in such institutions in such State or subdivision.

USE OF STATE AGENCIES TO DETERMINE COMPLIANCE BY PROVIDERS OF SERVICES WITH CONDITIONS OF PARTICIPATION[478]

SEC. 1864. [42 U.S.C. 1395aa] (a) The Secretary shall make an agreement with any State which is able and willing to do so under which the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by him for the purpose of determining whether an institution therein is a hospital or skilled nursing facility, or whether an agency therein is a home health agency, or whether an agency is a hospice program or whether a facility therein is a rural health clinic as de-

[478] See Vol. II, P.L. 101–508, §4008(h)(1)(A), with respect to nurse aide training and competency evaluations.

fined in section 1861(aa)(2), a critical access hospital, as defined in section 1861(mm)(1), or a comprehensive outpatient rehabilitation facility as defined in section 1861(cc)(2), or whether a laboratory meets the requirements of paragraphs (16) and (17) of section 1861(s) or whether a clinic, rehabilitation agency or public health agency meets the requirements of subparagraph (A) or (B), as the case may be, of section 1861(p)(4), or whether an ambulatory surgical center meets the standards specified under section 1832(a)(2)(F)(i). To the extent that the Secretary finds it appropriate, an institution or agency which such a State (or local) agency certifies is a hospital, skilled nursing facility, rural health clinic, comprehensive outpatient rehabilitation facility, home health agency, or hospice program (as those terms are defined in section 1861) may be treated as such by the Secretary. Any State agency which has such an agreement may (subject to approval of the Secretary) furnish to a skilled nursing facility, after proper request by such facility, such specialized consultative services (which such agency is able and willing to furnish in a manner satisfactory to the Secretary) as such facility may need to meet one or more of the conditions specified in section 1819(a). Any such services furnished by a State agency shall be deemed to have been furnished pursuant to such agreement. Within 90 days following the completion of each survey of any health care facility, ambulatory surgical center, rural health clinic, comprehensive outpatient rehabilitation facility, laboratory, clinic, agency, or organization by the appropriate State or local agency described in the first sentence of this subsection, the Secretary shall make public in readily available form and place, and require (in the case of skilled nursing facilities) the posting in a place readily accessible to patients (and patients' representatives), the pertinent findings of each such survey relating to the compliance of each such health care facility, ambulatory surgical center, rural health clinic, comprehensive outpatient rehabilitation facility, laboratory, clinic, agency, or organization with (1) the statutory conditions of participation imposed under this title and (2) 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 health care facility, ambulatory surgical center, rural health clinic, comprehensive outpatient rehabilitation facility, laboratory, clinic, agency, or organization. Any agreement under this subsection shall provide for the appropriate State or local agency to maintain a toll–free hotline (1) to collect, maintain, and continually update information on home health agencies located in the State or locality that are certified to participate in the program established under this title (which information shall include any significant deficiencies found with respect to patient care in the most recent certification survey conducted by a State agency or accreditation survey conducted by a private accreditation agency under section 1865 with respect to the home health agency, when that survey was completed, whether corrective actions have been taken or are planned, and the sanctions, if any, imposed under this title with respect to the agency) and (2) to receive complaints (and answer questions) with respect to home health agencies in the State or locality. Any such agreement shall provide for such State or local agency to maintain a unit for investigating such complaints that possesses enforcement authority and has access to survey and certification reports, information gathered by

any private accreditation agency utilized by the Secretary under section 1865, and consumer medical records (but only with the consent of the consumer or his or her legal representative).

(b) The Secretary shall pay any such State, in advance or by way of reimbursement, as may be provided in the agreement with it (and may make adjustments in such payments on account of overpayments or underpayments previously made), for the reasonable cost of performing the functions specified in subsection (a), and for the Federal Hospital Insurance Trust Fund's fair share of the costs attributable to the planning and other efforts directed toward coordination of activities in carrying out its agreement and other activities related to the provision of services similar to those for which payment may be made under part A, or related to the facilities and personnel required for the provision of such services, or related to improving the quality of such services.

(c) The Secretary is authorized to enter into an agreement with any State under which the appropriate State or local agency which performs the certification function described in subsection (a) will survey, on a selective sample basis (or where the Secretary finds that a survey is appropriate because of substantial allegations of the existence of a significant deficiency or deficiencies which would, if found to be present, adversely affect health and safety of patients), provider entities that, pursuant to subsection (a) or (b)(1) of section 1865, are treated as meeting the conditions or requirements of this title. The Secretary shall pay for such services in the manner prescribed in subsection (b).

(d) The Secretary may not enter an agreement under this section with a State with respect to determining whether an institution therein is a skilled nursing facility unless the State meets the requirements specified in section 1819(e) and section 1819(g) and the establishment of remedies under sections 1819(h)(2)(B) and 1819(h)(2)(C) (relating to establishment and application of remedies).

(e) Notwithstanding any other provision of law, the Secretary may not impose, or require a State to impose, any fee on any facility or entity subject to a determination under subsection (a), or any renal dialysis facility subject to the requirements of section 1881(b)(1), for any such determination or any survey relating to determining the compliance of such facility or entity with any requirement of this title (other than any fee relating to section 353 of the Public Health Service Act[479]).

EFFECT OF ACCREDITATION

SEC. 1865. [42 U.S.C. 1395bb] (a) Except as provided in subsection (b) and the second sentence of section 1863, if—

(1) an institution is accredited as a hospital by the Joint Commission on Accreditation of Hospitals, and

(2)(A) such institution authorizes the Commission to release to the Secretary upon his request (or such State agency as the Secretary may designate) a copy of the most current accreditation survey of such institution made by such Commission, together with any other information directly related to the sur-

[479] See Vol. II, P.L. 78–410, §353.

vey as the Secretary may require (including corrective action plans),

(B) such Commission releases such a copy and any such information to the Secretary,

then, such institution shall be deemed to meet the requirements of the numbered paragraphs of section 1861(e); except—

(3) paragraph (6) thereof, and

(4) any standard, promulgated by the Secretary pursuant to paragraph (9) thereof, which is higher than the requirements prescribed for accreditation by such Commission.

If such Commission, as a condition for accreditation of a hospital, requires a utilization review plan (or imposes another requirement which serves substantially the same purpose), requires a discharge planning process (or imposes another requirement which serves substantially the same purpose), or imposes a standard which the Secretary determines is at least equivalent to the standard promulgated by the Secretary as described in paragraph (4) of this subsection, the Secretary is authorized to find that all institutions so accredited by such Commission comply also with clause (A) or (B) of section 1861(e)(6) or the standard described in such paragraph (4), as the case may be.

(b)(1) In addition, if the Secretary finds that accreditation of a provider entity (as defined in paragraph (4)) by the American Osteopathic Association or any other national accreditation body demonstrates that all of the applicable conditions or requirements of this title (other than the requirements of section 1834(j) or the conditions and requirements under section 1881(b)) are met or exceeded—

(A) in the case of a provider entity not described in paragraph (3)(B), the Secretary shall treat such entity as meeting those conditions or requirements with respect to which the Secretary made such finding; or

(B) in the case of a provider entity described in paragraph (3)(B), the Secretary may treat such entity as meeting those conditions or requirements with respect to which the Secretary made such finding.

(2) In making such a finding, the Secretary shall consider, among other factors with respect to a national accreditation body, its requirements for accreditation, its survey procedures, its ability to provide adequate resources for conducting required surveys and supplying information for use in enforcement activities, its monitoring procedures for provider entities found out of compliance with the conditions or requirements, and its ability to provide the Secretary with necessary data for validation.

(3)(A) Except as provided in subparagraph (B), not later than 60 days after the date of receipt of a written request for a finding under paragraph (1) (with any documentation necessary to make a determination on the request), the Secretary shall publish a notice identifying the national accreditation body making the request, describing the nature of the request, and providing a period of at least 30 days for the public to comment on the request. The Secretary shall approve or deny a request for such a finding, and shall publish notice of such approval or denial, not later than 210 days after the date of receipt of the request (with such documentation). Such an approval shall be effective

with respect to accreditation determinations made on or after such effective date (which may not be later than the date of publication of the approval) as the Secretary specifies in the publication notice.

(B) The 210–day and 60–day deadlines specified in subparagraph (A) shall not apply in the case of any request for a finding with respect to accreditation of a provider entity to which the conditions and requirements of sections 1819 and 1861(j)[480] apply.

(4) For purposes of this section, the term "provider entity" means a provider of services, supplier, facility, clinic, agency, or laboratory.

(c) The Secretary may not disclose any accreditation survey (other than a survey with respect to a home health agency) made and released to him by the Joint Commission on Accreditation of Hospitals, the American Osteopathic Association, or any other national accreditation body, of an entity accredited by such body, except that the Secretary may disclose such a survey and information related to such a survey to the extent such survey and information relate to an enforcement action taken by the Secretary.

(d) Notwithstanding any other provision of this title, if the Secretary finds that a provider entity has significant deficiencies (as defined in regulations pertaining to health and safety), the entity shall, after the date of notice of such finding to the entity and for such period as may be prescribed in regulations, be deemed not to meet the conditions or requirements the entity has been treated as meeting pursuant to subsection (a) or (b)(1).

(e) For provisions relating to validation surveys of entities that are treated as meeting applicable conditions or requirements of this title pursuant to subsection (a) or (b)(1), see section 1864(c).

AGREEMENTS WITH PROVIDERS OF SERVICES; ENROLLMENT PROCESSES[481]

SEC. 1866. [42 U.S.C. 1395cc] (a)(1)[482] Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

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

(ii) not to impose any charge that is prohibited under section 1902(n)(3),

(B) not to charge any individual or any other person for items or services for which such individual is not entitled

[480] P.L. 108–173, §736(a)(12), struck out "section 1819 and 1861(j)" and substituted "sections 1819 and 1861(j)", effective December 8, 2003.

[481] See Vol. II, P.L. 105–33, §4312(f)(2), with respect to home health agencies.

See Vol. II, P.L. 108–173, §650, with respect to a GAO study and report on the propagation of concierge care and §936(b)(1), with respect to the effective date of the enrollment process.

[482] See Vol. II, P.L. 97–248, §119, with respect to private sector review initiative and restriction against recovery from beneficiaries.

to have payment made under this title because payment for expenses incurred for such items or services may not be made by reason of the provisions of paragraph (1) or (9) of section 1862(a), but only if (i) such individual was without fault in incurring such expenses and (ii) the Secretary's determination that such payment may not be made for such items and services was made after the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title,

(C) to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person,

(D) to promptly notify the Secretary of its employment of an individual who, at any time during the year preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity (as determined by the Secretary by regulation) by an agency or organization which serves as a fiscal intermediary or carrier (for purposes of part A or part B, or both, of this title) with respect to the provider,

(E) to release data with respect to patients of such provider upon request to an organization having a contract with the Secretary under part B of title XI as may be necessary (i) to allow such organization to carry out its functions under such contract, or (ii) to allow such organization to carry out similar review functions under any contract the organization may have with a private or public agency paying for health care in the same area with respect to patients who authorize release of such data for such purposes,

(F)(i) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b), (c), or (d) of section 1886, to maintain an agreement with a professional standards review organization (if there is such an organization in existence in the area in which the hospital is located) or with a utilization and quality control peer review organization which has a contract with the Secretary under part B of title XI for the area in which the hospital is located, under which the organization will perform functions under that part with respect to the review of the validity of diagnostic information provided by such hospital, the completeness, adequacy, and quality of care provided, the appropriateness of admissions and discharges, and the appropriateness of care provided for which additional payments are sought under section 1886(d)(5), with respect to inpatient hospital services for which payment may be made under part A of this title (and for purposes of payment under this title, the cost of such agreement to the hospital shall be considered a cost incurred by such hospital in providing inpatient services under part A, and (I) shall be paid directly by the Secretary to such organization on behalf of such hospital in accordance with a rate per review established by the Sec-

retary, (II) shall be transferred from the Federal Hospital Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and (III) shall not be less in the aggregate for a fiscal year than the aggregate amount expended in fiscal year 1988 for direct and administrative costs (adjusted for inflation and for any direct or administrative costs incurred as a result of review functions added with respect to a subsequent fiscal year) of such reviews),

(ii) in the case of hospitals, critical access hospitals, skilled nursing facilities, and home health agencies, to maintain an agreement with a utilization and quality control peer review organization (which has a contract with the Secretary under part B of title XI for the area in which the hospital, facility, or agency is located) to perform the functions described in paragraph (3)(A),

(G) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b) or (d) of section 1886, not to charge any individual or any other person for inpatient hospital services for which such individual would be entitled to have payment made under part A but for a denial or reduction of payments under section 1886(f)(2),

(H)(i) in the case of hospitals which provide services for which payment may be made under this title and in the case of critical access hospitals which provide critical access hospital services, to have all items and services (other than physicians' services as defined in regulations for purposes of section 1862(a)(14), and other than services described by section 1861(s)(2)(K), certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist) (I) that are furnished to an individual who is a patient of the hospital, and (II) for which the individual is entitled to have payment made under this title, furnished by the hospital or otherwise under arrangements (as defined in section 1861(w)(1)) made by the hospital,

(ii) in the case of skilled nursing facilities which provide covered skilled nursing facility services—

(I) that are furnished to an individual who is a resident of the skilled nursing facility during a period in which the resident is provided covered post–hospital extended care services (or, for services described in section 1861(s)(2)(D), that are furnished to such an individual without regard to such period), and

(II) for which the individual is entitled to have payment made under this title, to have items and services (other than services described in section 1888(e)(2)(A)(ii)) furnished by the skilled nursing facility or otherwise under arrangements (as defined in section 1861(w)(1)) made by the skilled nursing facility,

(I) in the case of a hospital or critical access hospital—

(i) to adopt and enforce a policy to ensure compliance with the requirements of section 1867 and to meet the requirements of such section,

(ii) to maintain medical and other records related to individuals transferred to or from the hospital for a period of five years from the date of the transfer, and

(iii) to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition,

(J) in the case of hospitals which provide inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care under any health plan contracted for under section 1079 or 1086 of title 10, or under section 613 of title 38, United States Code, in accordance with admission practices, payment methodology, and amounts as prescribed under joint regulations issued by the Secretary and by the Secretaries of Defense and Transportation, in implementation of sections 1079 and 1086 of title 10, United States Code,

(K) not to charge any individual or any other person for items or services for which payment under this title is denied under section 1154(a)(2) by reason of a determination under section 1154(a)(1)(B),

(L) in the case of hospitals which provide inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care under section 603 of title 38, United States Code, in accordance with such admission practices, and such payment methodology and amounts, as are prescribed under joint regulations issued by the Secretary and by the Secretary of Veterans Affairs in implementation of such section,

(M) in the case of hospitals, to provide to each individual who is entitled to benefits under part A (or to a person acting on the individual's behalf), at or about the time of the individual's admission as an inpatient to the hospital, a written statement (containing such language as the Secretary prescribes consistent with this paragraph) which explains—

(i) the individual's rights to benefits for inpatient hospital services and for post-hospital services under this title,

(ii) the circumstances under which such an individual will and will not be liable for charges for continued stay in the hospital,

(iii) the individual's right to appeal denials of benefits for continued inpatient hospital services, including the practical steps to initiate such an appeal, and

(iv) the individual's liability for payment for services if such a denial of benefits is upheld on appeal,

and which provides such additional information as the Secretary may specify,

(N) in the case of hospitals and critical access hospitals—

(i) to make available to its patients the directory or directories of participating physicians (published

under section 1842(h)(4)) for the area served by the hospital or critical access hospital,

(ii) if hospital personnel (including staff of any emergency or outpatient department) refer a patient to a nonparticipating physician for further medical care on an outpatient basis, the personnel must inform the patient that the physician is a nonparticipating physician and, whenever practicable, must identify at least one qualified participating physician who is listed in such a directory and from whom the patient may receive the necessary services,

(iii) to post conspicuously in any emergency department a sign (in a form specified by the Secretary) specifying rights of individuals under section 1867 with respect to examination and treatment for emergency medical conditions and women in labor, and

(iv) to post conspicuously (in a form specified by the Secretary) information indicating whether or not the hospital participates in the medicaid program under a State plan approved under title XIX,

(O) to accept as payment in full for services that are covered under this title and are furnished to any individual enrolled with a Medicare+Choice organization under part C, with a PACE provider under section 1894 or 1934, or[483] with an eligible organization[484] with a risk-sharing contract under section 1876, under section 1876(i)(2)(A) (as in effect before February 1, 1985), under section 402(a) of the Social Security Amendments of 1967[485], or under section 222(a) of the Social Security Amendments of 1972[486] ,[487] which does not have a contract (or, in the case of a PACE provider, contract or other agreement)[488] establishing payment amounts for services furnished to members of the organization or PACE program eligible individuals enrolled with the PACE provider,[489] the amounts that would be made as a payment in full under this title (less any payments under sections 1886(d)(11) and 1886(h)(3)(D)) if the individuals were not so enrolled,

(P) in the case of home health agencies which provide home health services to individuals entitled to benefits under this title who require catheters, catheter supplies, ostomy bags, and supplies related to ostomy car (described in section 1861(m)(5)), to offer to furnish such supplies to such an individual as part of their furnishing of home health services,

(Q) in the case of hospitals, skilled nursing facilities, home health agencies, and hospice programs, to comply

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[483] P.L. 105-33, §4002(e)(3), added "with a Medicare+Choice organization under part C or", effective August 5, 1997.

P.L. 108–173, §236(a)(1)(A), struck out "part C or" and substituted "part C, with a PACE provider under section 1894 or 1934, or", effective December 8, 2003, applicable to services furnished on or after January 1, 2004.

[484] P.L. 108-173, §236(a)(1)(B), struck out "(i)".

[485] See Vol. II, P.L. 90–248.

[486] See Vol. II, P.L. 92–603.

[487] P.L. 108-173, §236(a)(1)(C), struck out "and (ii)".

[488] P.L. 108-173, §236(a)(1)(D), added "(or, in the case of a PACE provider, contract or other agreement)" after "have a contract".

[489] P.L. 108-173, §236(a)(1)(E), added "members of the organization or PACE program eligible individuals enrolled with the PACE provider,".

with the requirement of subsection (f) (relating to maintaining written policies and procedures respecting advance directives),[490]

(R) to contract only with a health care clearinghouse (as defined in section 1171) that meets each standard and implementation specification adopted or established under part C of title XI on or after the date on which the health care clearinghouse is required to comply with the standard or specification,[491]

(S) in the case of a hospital that has a financial interest (as specified by the Secretary in regulations) in an entity to which individuals are referred as described in section 1861(ee)(2)(H)(ii), or in which such an entity has such a financial interest, or in which another entity has such a financial interest (directly or indirectly) with such hospital and such an entity, to maintain and disclose to the Secretary (in a form and manner specified by the Secretary) information on—

(i) the nature of such financial interest,

(ii) the number of individuals who were discharged from the hospital and who were identified as requiring home health services, and

(iii) the percentage of such individuals who received such services from such provider (or another such provider).

In the case of a hospital which has an agreement in effect with an organization described in subparagraph (F), which organization's contract with the Secretary under part B of title XI is terminated on or after October 1, 1984, the hospital shall not be determined to be out of compliance with the requirement of such subparagraph during the six month period beginning on the date of the termination of that contract.

(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1813(a)(1), (a)(3), or (a)(4), section 1833(b), or section 1861(y)(3) with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under part B or which are durable medical equipment furnished as home health services (but in the case of items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary). In the case of items and services described in section 1833(c), clause (ii) of the preceding sentence shall be applied by substituting for 20 percent the proportion which is appropriate under such section. A provider of services may not impose a charge under clause (ii) of the first sentence of this subparagraph with respect to items and services described in section

[490] See Vol. II, P.L. 101–508, §4206(c), with respect to the effect on State law.
[491] P.L. 108–173, §505(b)(1), struck out "and".

1861(s)(10)(A) and with respect to clinical diagnostic laboratory tests for which payment is made under part B. Notwithstanding the first sentence of this subparagraph, a home health agency may charge such an individual or person, with respect to covered items subject to payment under section 1834(a), the amount of any deduction imposed under section 1833(b) and 20 percent of the payment basis described in section 1834(a)(1)(B). In the case of items and services for which payment is made under part B under the prospective payment system established under section 1833(t), clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge, the applicable copayment amount established under section 1833(t)(5). In the case of services described in section 1833(a)(8) or section 1833(a)(9) for which payment is made under part B under section 1834(k), clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge for such services 20 percent of the lesser of the actual charge or the applicable fee schedule amount (as defined in such section) for such services.

(B) Where a provider of services has furnished, at the request of such individual, items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this title, such provider of services may also charge such individual or other person for such more expensive items or services to the extent that the amount customarily charged by it for the items or services furnished at such request exceeds the amount customarily charged by it for the items or services with respect to which payment may be made under this title.

(C) A provider of services may in accordance with its customary practice also appropriately charge any such individual for any whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished him with respect to which a deductible is imposed under section 1813(a)(2), except that (i) any excess of such charge over the cost to such provider for the blood (or equivalent quantities of packed red blood cells, as so defined) shall be deducted from any payment to such provider under this title, (ii) no such charge may be imposed for the cost of administration of such blood (or equivalent quantities of packed red blood cells, as so defined), and (iii) such charge may not be made to the extent such blood (or equivalent quantities of packed red blood cells, as so defined) has been replaced on behalf of such individual or arrangements have been made for its replacement on his behalf. For purposes of subparagraph (C), whole blood (or equivalent quantities of packed red blood cells, as so defined) furnished an individual shall be deemed replaced when the provider of services is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is imposed under section 1813(a)(2).

(D) Where a provider of services customarily furnishes items or services which are in excess of or more expensive

than the items or services with respect to which payment may be made under this title, such provider, notwithstanding the preceding provisions of this paragraph, may not, under the authority of section 1866(a)(2)(B)(ii), charge any individual or other person any amount for such items or services in excess of the amount of the payment which may otherwise be made for such items or services under this title if the admitting physician has a direct or indirect financial interest in such provider.

(3)(A) Under the agreement required under paragraph (1)(F)(ii), the peer review organization must perform functions (other than those covered under an agreement under paragraph (1)(F)(i)) under the third sentence of section 1154(a)(4)(A) and under section 1154(a)(14) with respect to services, furnished by the hospital, critical access hospital, facility, or agency involved, for which payment may be made under this title.

(B) For purposes of payment under this title, the cost of such an agreement to the hospital, critical access hospital, facility, or agency shall be considered a cost incurred by such hospital, critical access hospital, facility, or agency in providing covered services under this title and shall be paid directly by the Secretary to the peer review organization on behalf of such hospital, critical access hospital, facility, or agency in accordance with a schedule established by the Secretary.

(C) Such payments—

(i) shall be transferred in appropriate proportions from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and

(ii) shall not be less in the aggregate for a fiscal year—

(I) in the case of hospitals, than the amount specified in paragraph (1)(F)(i)(III), and

(II) in the case of facilities, critical access hospitals, and agencies, than the amounts the Secretary determines to be sufficient to cover the costs of such organizations' conducting the activities described in subparagraph (A) with respect to such facilities, critical access hospitals, or agencies under part B of title XI,[492]

(T)[493] in the case of hospitals and critical access hospitals, to furnish to the Secretary such data as the Secretary determines appropriate pursuant to subparagraph (E) of section 1886(d)(12) to carry out such section,[494]

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[492] P.L. 108–173, §505(b)(2), struck out the period and substituted ", and".
P.L. 108–173, §506(a)(1), struck out "and".

[493] P.L. 108–173, §505(b)(3), added subparagraph (T), effective December 8, 2003, applicable to the wage index for discharges occurring on or after October 1, 2004.

[494] P.L. 108–173, §506(a)(2), struck out the period and substituted ", and".
P.L. 108–173, §947(a)(1)(A), struck out "and".

(U)[495] in the case of hospitals which furnish inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care both—

(i) under the contract health services program funded by the Indian Health Service and operated by the Indian Health Service, an Indian tribe, or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), with respect to items and services that are covered under such program and furnished to an individual eligible for such items and services under such program; and

(ii) under any program funded by the Indian Health Service and operated by an urban Indian organization with respect to the purchase of items and services for an eligible urban Indian (as those terms are defined in such section 4), in accordance with regulations promulgated by the Secretary regarding admission practices, payment methodology, and rates of payment (including the acceptance of no more than such payment rate as payment in full for such items and services, and[496]

(V)[497] in the case of hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970 (or a State occupational safety and health plan that is approved under 18(b) of such Act), to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations (or as subsequently redesignated).

(b)(1) A provider of services may terminate an agreement with the Secretary under this section at such time and upon such notice to the Secretary and the public as may be provided in regulations, except that notice of more than six months shall not be required.

(2) The Secretary may refuse to enter into an agreement under this section or, upon such reasonable notice to the provider and the public as may be specified in regulations, may refuse to renew or may terminate such an agreement after the Secretary—

(A) has determined that the provider fails to comply substantially with the provisions of the agreement, with the provisions of this title and regulations thereunder, or with a corrective action required under section 1886(f)(2)(B),

(B) has determined that the provider fails substantially to meet the applicable provisions of section 1861,

(C) has excluded the provider from participation in a program under this title pursuant to section 1128 or section 1128A, or

(D) has ascertained that the provider has been convicted of a felony under Federal or State law for an offense which the Secretary determines is detrimental to the best interests of the program or program beneficiaries.

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[495] P.L. 108–173, §506(a)(3), added subparagraph (U), effective December 8, 2003.

[496] P.L. 108–173, §947(a)(1)(B), struck out the period and substituted “, and”.
P.L. 108–173, §947(a)(1)(A), struck out “and”.

[497] P.L. 108–173, §947(a)(1)(C), added subparagraph (V), applicable to hospitals as of July 1, 2004.

(3) A termination of an agreement or a refusal to renew an agreement under this subsection shall become effective on the same date and in the same manner as an exclusion from participation under the programs under this title becomes effective under section 1128(c).

(c)(1) Where the Secretary has terminated or has refused to renew an agreement under this title with a provider of services, such provider may not file another agreement under this title unless the Secretary finds that the reason for the termination or nonrenewal has been removed and that there is reasonable assurance that it will not recur.

(2) Where the Secretary has terminated or has refused to renew an agreement under this title with a provider of services, the Secretary shall promptly notify each State agency which administers or supervises the administration of a State plan approved under title XIX of such termination or nonrenewal.

(d) If the Secretary finds that there is a substantial failure to make timely review in accordance with section 1861(k) of long-stay cases in a hospital, he may, in lieu of terminating his agreement with such hospital, decide that, with respect to any individual admitted to such hospital after a subsequent date specified by him, no payment shall be made under this title for inpatient hospital services (including inpatient psychiatric hospital services) after the 20th day of a continuous period of such services. Such decision may be made effective only after such notice to the hospital and to the public, as may be prescribed by regulations, and its effectiveness shall terminate when the Secretary finds that the reason therefor has been removed and that there is reasonable assurance that it will not recur. The Secretary shall not make any such decision except after reasonable notice and opportunity for hearing to the institution or agency affected thereby.

(e) For purposes of this section, the term "provider of services" shall include—

(1) a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A) (or meets the requirements of such section through the operation of section 1861(g)), or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B) (or meets the requirements of such section through the operation of section 1861(g)), but only with respect to the furnishing of outpatient physical therapy services (as therein defined) or (through the operation of section 1861(g)) with respect to the furnishing of outpatient occupational therapy services; and

(2) a community mental health center (as defined in section 1861(ff)(3)(B)), but only with respect to the furnishing of partial hospitalization services (as described in section 1861(ff)(1)).

(f)(1) For purposes of subsection (a)(1)(Q) and sections 1819(c)(2)(E), 1833(s), 1855(i), 1876(c)(8), and 1891(a)(6), the requirement of this subsection is that a provider of services, Medicare+Choice organization, or prepaid or eligible 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 written policies of the provider or organization respecting the implementation of such rights;

(B) to document in a prominent part of the individual's current 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 at facilities of the provider or organization; 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 skilled nursing facility, at the time of the individual's admission as a resident,

(C) in the case of a home health agency, in advance of the individual coming under the care of the agency,

(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 an eligible organization (as defined in section 1876(b)) or an organization provided payments under section 1833(a)(1)(A) or a Medicare+Choice organization, at the time of enrollment of the individual with the organization.

(3) 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.

(4) 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).

(g) Except as permitted under subsection (a)(2), any person who knowingly and willfully presents, or causes to be presented, a bill or request for payment inconsistent with an arrangement under subsection (a)(1)(H) or in violation of the requirement for such an arrangement, is subject to a civil money penalty of not to exceed

$2,000. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(h)(1)[498] Except as provided in paragraph (2), an institution or agency dissatisfied with a determination by the Secretary that it is not a provider of services or with a determination described in subsection (b)(2) shall be entitled to a hearing thereon by the Secretary (after reasonable notice) to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g), except that, in so applying such sections and in applying section 205(l) thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

(2) An institution or agency is not entitled to separate notice and opportunity for a hearing under both section 1128 and this section with respect to a determination or determinations based on the same underlying facts and issues.

(i)(1) If the Secretary determines that a psychiatric hospital which has an agreement in effect under this section no longer meets the requirements for a psychiatric hospital under this title and further finds that the hospital's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the Secretary shall terminate such agreement; or

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

(2) If a psychiatric hospital, found to have deficiencies described in paragraph (1)(B), has not complied with the requirements of this title—

(A) within 3 months after the date the hospital is found to be out of compliance with such requirements, the Secretary shall provide that no payment will be made under this title 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 payment may be made under this title with respect to any individual in the hospital until the Secretary finds that the hospital is in compliance with the requirements of this title.

(j)[499] ENROLLMENT PROCESS FOR PROVIDERS OF SERVICES AND SUPPLIERS.—

(1) ENROLLMENT PROCESS.—

(A) IN GENERAL.—The Secretary shall establish by regulation a process for the enrollment of providers of services and suppliers under this title.

(B) DEADLINES.—The Secretary shall establish by regulation procedures under which there are deadlines for ac-

[498] P.L. 108–173, §932(b) and (c), amend 1866(h)(1), applicable to appeals filed on or after October 1, 2004, pursuant to §932(d).

[499] P.L. 108–173, §936(a)(2), added subsection (j), effective December 8, 2003.

tions on applications for enrollment (and, if applicable, renewal of enrollment). The Secretary shall monitor the performance of medicare administrative contractors in meeting the deadlines established under this subparagraph.

(C)[500] CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.—The Secretary shall consult with providers of services and suppliers before making changes in the provider enrollment forms required of such providers and suppliers to be eligible to submit claims for which payment may be made under this title.

(2)[501] HEARING RIGHTS IN CASES OF DENIAL OR NON-RENEWAL.—A provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) under this title is denied may have a hearing and judicial review of such denial under the procedures that apply under subsection (h)(1)(A) to a provider of services that is dissatisfied with a determination by the Secretary.

DEMONSTRATION OF APPLICATION OF PHYSICIAN VOLUME INCREASES TO GROUP PRACTICES[502]

SEC. 1866A. [42 U.S.C. 1395cc–1] (a) DEMONSTRATION PROGRAM AUTHORIZED.—

(1) IN GENERAL.—The Secretary shall conduct demonstration projects to test and, if proven effective, expand the use of incentives to health care groups participating in the program under this title that—

(A) encourage coordination of the care furnished to individuals under the programs under parts A and B by institutional and other providers, practitioners, and suppliers of health care items and services;

(B) encourage investment in administrative structures and processes to ensure efficient service delivery; and

(C) reward physicians for improving health outcomes. Such projects shall focus on the efficiencies of furnishing health care in a group–practice setting as compared to the efficiencies of furnishing health care in other health care delivery systems.

(2) ADMINISTRATION BY CONTRACT.—Except as otherwise specifically provided, the Secretary may administer the program under this section in accordance with section 1866B.

(3) DEFINITIONS.—For purposes of this section, terms have the following meanings:

(A) PHYSICIAN.—Except as the Secretary may otherwise provide, the term "physician" means any individual who furnishes services which may be paid for as physicians' services under this title.

(B) HEALTH CARE GROUP.—The term "health care group" means a group of physicians (as defined in subparagraph (A)) organized at least in part for the purpose of providing physicians' services under this title. As the Secretary finds appropriate, a health care group may include a hospital and any other individual or entity furnishing items or

[500] See Vol. II, P.L. 108–173, §936(b)(2), with respect to the effective date for a consultation.
[501] See Vol. II, P.L. 108–173, §936(b)(3), with respect to the effective date for hearing rights.
[502] See Vol. II, P.L. 106–554, §412(b), with respect to a GAO report on the demonstration project under §1866A.

services for which payment may be made under this title that is affiliated with the health care group under an arrangement structured so that such individual or entity participates in a demonstration under this section and will share in any bonus earned under subsection (d).

(b) ELIGIBILITY CRITERIA.—

(1) IN GENERAL.—The Secretary is authorized to establish criteria for health care groups eligible to participate in a demonstration under this section, including criteria relating to numbers of health care professionals in, and of patients served by, the group, scope of services provided, and quality of care.

(2) PAYMENT METHOD.—A health care group participating in the demonstration under this section shall agree with respect to services furnished to beneficiaries within the scope of the demonstration (as determined under subsection (c))—

(A) to be paid on a fee-for-service basis; and

(B) that payment with respect to all such services furnished by members of the health care group to such beneficiaries shall (where determined appropriate by the Secretary) be made to a single entity.

(3) DATA REPORTING.—A health care group participating in a demonstration under this section shall report to the Secretary such data, at such times and in such format as the Secretary requires, for purposes of monitoring and evaluation of the demonstration under this section.

(c) PATIENTS WITHIN SCOPE OF DEMONSTRATION.—

(1) IN GENERAL.—The Secretary shall specify, in accordance with this subsection, the criteria for identifying those patients of a health care group who shall be considered within the scope of the demonstration under this section for purposes of application of subsection (d) and for assessment of the effectiveness of the group in achieving the objectives of this section.

(2) OTHER CRITERIA.—The Secretary may establish additional criteria for inclusion of beneficiaries within a demonstration under this section, which may include frequency of contact with physicians in the group or other factors or criteria that the Secretary finds to be appropriate.

(3) NOTICE REQUIREMENTS.—In the case of each beneficiary determined to be within the scope of a demonstration under this section with respect to a specific health care group, the Secretary shall ensure that such beneficiary is notified of the incentives, and of any waivers of coverage or payment rules, applicable to such group under such demonstration.

(d) INCENTIVES.—

(1) PERFORMANCE TARGET.—The Secretary shall establish for each health care group participating in a demonstration under this section—

(A) a base expenditure amount, equal to the average total payments under parts A and B for patients served by the health care group on a fee–for–service basis in a base period determined by the Secretary; and

(B) an annual per capita expenditure target for patients determined to be within the scope of the demonstration, reflecting the base expenditure amount adjusted for risk and expected growth rates.

(2) INCENTIVE BONUS.—The Secretary shall pay to each participating health care group (subject to paragraph (4)) a bonus for each year under the demonstration equal to a portion of the medicare savings realized for such year relative to the performance target.

(3) ADDITIONAL BONUS FOR PROCESS AND OUTCOME IMPROVEMENTS.—At such time as the Secretary has established appropriate criteria based on evidence the Secretary determines to be sufficient, the Secretary shall also pay to a participating health care group (subject to paragraph (4)) an additional bonus for a year, equal to such portion as the Secretary may designate of the saving to the program under this title resulting from process improvements made by and patient outcome improvements attributable to activities of the group.

(4) LIMITATION.—The Secretary shall limit bonus payments under this section as necessary to ensure that the aggregate expenditures under this title (inclusive of bonus payments) with respect to patients within the scope of the demonstration do not exceed the amount which the Secretary estimates would be expended if the demonstration projects under this section were not implemented.

PROVISIONS FOR ADMINISTRATION OF DEMONSTRATION PROGRAM

SEC. 1866B. [42 U.S.C. 1395cc–2] (a) GENERAL ADMINISTRATIVE AUTHORITY.—

(1) BENEFICIARY ELIGIBILITY.—Except as otherwise provided by the Secretary, an individual shall only be eligible to receive benefits under the program under section 1866A (in this section referred to as the "demonstration program") if such individual—

(A) is enrolled under the program under part B and entitled to benefits under part A; and

(B) is not enrolled in a Medicare+Choice plan under part C, an eligible organization under a contract under section 1876 (or a similar organization operating under a demonstration project authority), an organization with an agreement under section 1833(a)(1)(A), or a PACE program under section 1894.

(2) SECRETARY'S DISCRETION AS TO SCOPE OF PROGRAM.—The Secretary may limit the implementation of the demonstration program to—

(A) a geographic area (or areas) that the Secretary designates for purposes of the program, based upon such criteria as the Secretary finds appropriate;

(B) a subgroup (or subgroups) of beneficiaries or individuals and entities furnishing items or services (otherwise eligible to participate in the program), selected on the basis of the number of such participants that the Secretary finds consistent with the effective and efficient implementation of the program;

(C) an element (or elements) of the program that the Secretary determines to be suitable for implementation; or

(D) any combination of any of the limits described in subparagraphs (A) through (C).

(3) VOLUNTARY RECEIPT OF ITEMS AND SERVICES.—Items and services shall be furnished to an individual under the demonstration program only at the individual's election.

(4) AGREEMENTS.—The Secretary is authorized to enter into agreements with individuals and entities to furnish health care items and services to beneficiaries under the demonstration program.

(5) PROGRAM STANDARDS AND CRITERIA.—The Secretary shall establish performance standards for the demonstration program including, as applicable, standards for quality of health care items and services, cost–effectiveness, beneficiary satisfaction, and such other factors as the Secretary finds appropriate. The eligibility of individuals or entities for the initial award, continuation, and renewal of agreements to provide health care items and services under the program shall be conditioned, at a minimum, on performance that meets or exceeds such standards.

(6) ADMINISTRATIVE REVIEW OF DECISIONS AFFECTING INDIVIDUALS AND ENTITIES FURNISHING SERVICES.—An individual or entity furnishing services under the demonstration program shall be entitled to a review by the program administrator (or, if the Secretary has not contracted with a program administrator, by the Secretary) of a decision not to enter into, or to terminate, or not to renew, an agreement with the entity to provide health care items or services under the program.

(7) SECRETARY'S REVIEW OF MARKETING MATERIALS.—An agreement with an individual or entity furnishing services under the demonstration program shall require the individual or entity to guarantee that it will not distribute materials that market items or services under the program without the Secretary's prior review and approval.

(8) PAYMENT IN FULL.—

(A) IN GENERAL.—Except as provided in subparagraph (B), an individual or entity receiving payment from the Secretary under a contract or agreement under the demonstration program shall agree to accept such payment as payment in full, and such payment shall be in lieu of any payments to which the individual or entity would otherwise be entitled under this title.

(B) COLLECTION OF DEDUCTIBLES AND COINSURANCE.—Such individual or entity may collect any applicable deductible or coinsurance amount from a beneficiary.

(b) CONTRACTS FOR PROGRAM ADMINISTRATION.—

(1) IN GENERAL.—The Secretary may administer the demonstration program through a contract with a program administrator in accordance with the provisions of this subsection.

(2) SCOPE OF PROGRAM ADMINISTRATOR CONTRACTS.—The Secretary may enter into such contracts for a limited geographic area, or on a regional or national basis.

(3) ELIGIBLE CONTRACTORS.—The Secretary may contract for the administration of the program with—

(A) an entity that, under a contract under section 1816 or 1842, determines the amount of and makes payments for health care items and services furnished under this title; or

(B) any other entity with substantial experience in managing the type of program concerned.

(4) CONTRACT AWARD, DURATION, AND RENEWAL.—

(A) IN GENERAL.—A contract under this subsection shall be for an initial term of up to three years, renewable for additional terms of up to three years.

(B) NONCOMPETITIVE AWARD AND RENEWAL FOR ENTITIES ADMINISTERING PART A OR PART B PAYMENTS.—The Secretary may enter or renew a contract under this subsection with an entity described in paragraph (3)(A) without regard to the requirements of section 5 of title 41, United States Code.

(5) APPLICABILITY OF FEDERAL ACQUISITION REGULATION.—The Federal Acquisition Regulation shall apply to program administration contracts under this subsection.

(6) PERFORMANCE STANDARDS.—The Secretary shall establish performance standards for the program administrator including, as applicable, standards for the quality and cost–effectiveness of the program administered, and such other factors as the Secretary finds appropriate. The eligibility of entities for the initial award, continuation, and renewal of program administration contracts shall be conditioned, at a minimum, on performance that meets or exceeds such standards.

(7) FUNCTIONS OF PROGRAM ADMINISTRATOR.—A program administrator shall perform any or all of the following functions, as specified by the Secretary:

(A) AGREEMENTS WITH ENTITIES FURNISHING HEALTH CARE ITEMS AND SERVICES.—Determine the qualifications of entities seeking to enter or renew agreements to provide services under the demonstration program, and as appropriate enter or renew (or refuse to enter or renew) such agreements on behalf of the Secretary.

(B) ESTABLISHMENT OF PAYMENT RATES.—Negotiate or otherwise establish, subject to the Secretary's approval, payment rates for covered health care items and services.

(C) PAYMENT OF CLAIMS OR FEES.—Administer payments for health care items or services furnished under the program.

(D) PAYMENT OF BONUSES.—Using such guidelines as the Secretary shall establish, and subject to the approval of the Secretary, make bonus payments as described in subsection (c)(2)(B)[503] to entities furnishing items or services for which payment may be made under the program.

(E) OVERSIGHT.—Monitor the compliance of individuals and entities with agreements under the program with the conditions of participation.

(F) ADMINISTRATIVE REVIEW.—Conduct reviews of adverse determinations specified in subsection (a)(6).

(G) REVIEW OF MARKETING MATERIALS.—Conduct a review of marketing materials proposed by an entity furnishing services under the program.

(H) ADDITIONAL FUNCTIONS.—Perform such other functions as the Secretary may specify.

[503] P.L. 108–173, §736(c)(5)(C), struck out "(c)(2)(A)(ii)" and substituted "(c)(2)(B)", effective December 8, 2003.

(8) LIMITATION OF LIABILITY.—The provisions of section 1157(b) shall apply with respect to activities of contractors and their officers, employees, and agents under a contract under this subsection.

(9) INFORMATION SHARING.—Notwithstanding section 1106 and section 552a of title 5, United States Code, the Secretary is authorized to disclose to an entity with a program administration contract under this subsection such information (including medical information) on individuals receiving health care items and services under the program as the entity may require to carry out its responsibilities under the contract.

(c) RULES APPLICABLE TO BOTH PROGRAM AGREEMENTS AND PROGRAM ADMINISTRATION CONTRACTS.—

(1) RECORDS, REPORTS, AND AUDITS.—The Secretary is authorized to require entities with agreements to provide health care items or services under the demonstration program, and entities with program administration contracts under subsection (b), to maintain adequate records, to afford the Secretary access to such records (including for audit purposes), and to furnish such reports and other materials (including audited financial statements and performance data) as the Secretary may require for purposes of implementation, oversight, and evaluation of the program and of individuals' and entities' effectiveness in performance of such agreements or contracts.

(2) BONUSES.—Notwithstanding any other provision of law, but subject to subparagraph (B)(ii), the Secretary may make bonus payments under the demonstration program from the Federal Health Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in amounts that do not exceed the amounts authorized under the program in accordance with the following:

(A) PAYMENTS TO PROGRAM ADMINISTRATORS.—The Secretary may make bonus payments under the program to program administrators.

(B) PAYMENTS TO ENTITIES FURNISHING SERVICES.—

(i) IN GENERAL.—Subject to clause (ii), the Secretary may make bonus payments to individuals or entities furnishing items or services for which payment may be made under the demonstration program, or may authorize the program administrator to make such bonus payments in accordance with such guidelines as the Secretary shall establish and subject to the Secretary's approval.

(ii) LIMITATIONS.—The Secretary may condition such payments on the achievement of such standards related to efficiency, improvement in processes or outcomes of care, or such other factors as the Secretary determines to be appropriate.

(3) ANTIDISCRIMINATION LIMITATION.—The Secretary shall not enter into an agreement with an entity to provide health care items or services under the demonstration program, or with an entity to administer the program, unless such entity guarantees that it will not deny, limit, or condition the coverage or provision of benefits under the program, for individuals eligible to be enrolled under such program, based on any

health status–related factor described in section 2702(a)(1) of the Public Health Service Act.

(d) LIMITATIONS ON JUDICIAL REVIEW.—The following actions and determinations with respect to the demonstration program shall not be subject to review by a judicial or administrative tribunal:

(1) Limiting the implementation of the program under subsection (a)(2).

(2) Establishment of program participation standards under subsection (a)(5) or the denial or termination of, or refusal to renew, an agreement with an entity to provide health care items and services under the program.

(3) Establishment of program administration contract performance standards under subsection (b)(6), the refusal to renew a program administration contract, or the noncompetitive award or renewal of a program administration contract under subsection (b)(4)(B).

(4) Establishment of payment rates, through negotiation or otherwise, under a program agreement or a program administration contract.

(5) A determination with respect to the program (where specifically authorized by the program authority or by subsection (c)(2))—

(A) as to whether cost savings have been achieved, and the amount of savings; or

(B) as to whether, to whom, and in what amounts bonuses will be paid.

(e) APPLICATION LIMITED TO PARTS A AND B.—None of the provisions of this section or of the demonstration program shall apply to the programs under part C.

(f) REPORTS TO CONGRESS.—Not later than two years after the date of the enactment of this section, and biennially thereafter for six years, the Secretary shall report to Congress on the use of authorities under the demonstration program. Each report shall address the impact of the use of those authorities on expenditures, access, and quality under the programs under this title.

HEALTH CARE QUALITY DEMONSTRATION PROGRAM [504]

SEC. 1866C. [42 U.S.C. 1395cc-3] (a) DEFINITIONS.—In this section:

(1) Beneficiary.—The term "beneficiary" means an individual who is entitled to benefits under part A and enrolled under part B, including any individual who is enrolled in a Medicare Advantage plan under part C.

(2) Health care group.—

(A) IN GENERAL.—The term "health care group" means—

(i) a group of physicians that is organized at least in part for the purpose of providing physician's services under this title;

(ii) an integrated health care delivery system that delivers care through coordinated hospitals, clinics, home health agencies, ambulatory surgery centers, skilled nursing facilities, rehabilitation facilities and

[504] P.L. 108-173, §646, added §1866C, effective December 8, 2003.

clinics, and employed, independent, or contracted physicians; or

(iii) an organization representing regional coalitions of groups or systems described in clause (i) or (ii).

(B) INCLUSION.—As the Secretary determines appropriate, a health care group may include a hospital or any other individual or entity furnishing items or services for which payment may be made under this title that is affiliated with the health care group under an arrangement structured so that such hospital, individual, or entity participates in a demonstration project under this section.

(3) PHYSICIAN.—Except as otherwise provided for by the Secretary, the term "physician" means any individual who furnishes services that may be paid for as physicians' services under this title.

(b) Demonstration Projects.—The Secretary shall establish a 5-year demonstration program under which the Secretary shall approve demonstration projects that examine health delivery factors that encourage the delivery of improved quality in patient care, including—

(1) the provision of incentives to improve the safety of care provided to beneficiaries;

(2) the appropriate use of best practice guidelines by providers and services by beneficiaries;

(3) reduced scientific uncertainty in the delivery of care through the examination of variations in the utilization and allocation of services, and outcomes measurement and research;

(4) encourage shared decision making between providers and patients;

(5) the provision of incentives for improving the quality and safety of care and achieving the efficient allocation of resources;

(6) the appropriate use of culturally and ethnically sensitive health care delivery; and

(7) the financial effects on the health care marketplace of altering the incentives for care delivery and changing the allocation of resources.

(c) Administration by Contract.—

(1) IN GENERAL.—Except as otherwise provided in this section, the Secretary may administer the demonstration program established under this section in a manner that is similar to the manner in which the demonstration program established under section 1866A is administered in accordance with section 1866B.

(2) ALTERNATIVE PAYMENT SYSTEMS.—A health care group that receives assistance under this section may, with respect to the demonstration project to be carried out with such assistance, include proposals for the use of alternative payment systems for items and services provided to beneficiaries by the group that are designed to—

(A) encourage the delivery of high quality care while accomplishing the objectives described in subsection (b); and

(B) streamline documentation and reporting requirements otherwise required under this title.

(3) BENEFITS.—A health care group that receives assistance under this section may, with respect to the demonstration

project to be carried out with such assistance, include modifications to the package of benefits available under the original medicare fee-for-service program under parts A and B or the package of benefits available through a Medicare Advantage plan under part C. The criteria employed under the demonstration program under this section to evaluate outcomes and determine best practice guidelines and incentives shall not be used as a basis for the denial of medicare benefits under the demonstration program to patients against their wishes (or if the patient is incompetent, against the wishes of the patient's surrogate) on the basis of the patient's age or expected length of life or of the patient's present or predicted disability, degree of medical dependency, or quality of life.

(d) ELIGIBILITY CRITERIA.—To be eligible to receive assistance under this section, an entity shall

(1) be a health care group;

(2) meet quality standards established by the Secretary, including—

(A) the implementation of continuous quality improvement mechanisms that are aimed at integrating community-based support services, primary care, and referral care;

(B) the implementation of activities to increase the delivery of effective care to beneficiaries;

(C) encouraging patient participation in preference-based decisions;

(D) the implementation of activities to encourage the coordination and integration of medical service delivery; and

(E) the implementation of activities to measure and document the financial impact on the health care marketplace of altering the incentives of health care delivery and changing the allocation of resources; and

(3) meet such other requirements as the Secretary may establish.

(e) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII as may be necessary to carry out the purposes of the demonstration program established under this section.

(f) BUDGET NEUTRALITY.—With respect to the 5-year period of the demonstration program under subsection (b), the aggregate expenditures under this title for such period shall not exceed the aggregate expenditures that would have been expended under this title if the program established under this section had not been implemented.

(g) NOTICE REQUIREMENTS.—In the case of an individual that receives health care items or services under a demonstration program carried out under this section, the Secretary shall ensure that such individual is notified of any waivers of coverage or payment rules that are applicable to such individual under this title as a result of the participation of the individual in such program.

(h) PARTICIPATION AND SUPPORT BY FEDERAL AGENCIES.—In carrying out the demonstration program under this section, the Secretary may direct—

(1) the Director of the National Institutes of Health to expand the efforts of the Institutes to evaluate current medical

technologies and improve the foundation for evidence-based practice;

(2) the Administrator of the Agency for Healthcare Research and Quality to, where possible and appropriate, use the program under this section as a laboratory for the study of quality improvement strategies and to evaluate, monitor, and disseminate information relevant to such program; and

(3) the Administrator of the Centers for Medicare and Medicaid Services and the Administrator of the Center for Medicare Choices to support linkages of relevant medicare data to registry information from participating health care groups for the beneficiary populations served by the participating groups, for analysis supporting the purposes of the demonstration program, consistent with the applicable provisions of the Health Insurance Portability and Accountability Act of 1996.

EXAMINATION AND TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND WOMEN IN LABOR[505]

SEC. 1867. [42 U.S.C. 1395dd] (a) MEDICAL SCREENING REQUIREMENT.—In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this title) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists.

(b) NECESSARY STABILIZING TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND LABOR.—

(1) IN GENERAL.—If any individual (whether or not eligible for benefits under this title) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c).

(2) REFUSAL TO CONSENT TO TREATMENT.—A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.

[505] See Vol. II, P.L. 108-173, §945, with respect to an emergency medical treatment and labor act technical advisory group and §1011, with respect to the Federal reimbursement of emergency health services furnished to undocumented aliens.

(3) REFUSAL TO CONSENT TO TRANSFER.—A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.

(c) RESTRICTING TRANSFERS UNTIL INDIVIDUAL STABILIZED.—

(1) RULE.—If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B)), the hospital may not transfer the individual unless—

(A)(i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,

(ii) a physician (within the meaning of section 1861(r)(1)) has signed a certification that based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or

(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1861(r)(1)), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.

(2) APPROPRIATE TRANSFER.—An appropriate transfer to a medical facility is a transfer—

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(B) in which the receiving facility—

(i) has available space and qualified personnel for the treatment of the individual, and

(ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including

records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(1)(C)) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

(D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

(d) ENFORCEMENT.—

(1) CIVIL MONETARY PENALTIES.—(A) A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds) for each such violation. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1128A(a).

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who—

(i) signs a certification under subsection (c)(1)(A) that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

(ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section,

is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is[506] gross and flagrant or is repeated, to exclusion from participation in this title and State health care programs. The provisions of section 1128A (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1128A(a).

(C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1866(a)(1)(I)) and notifies the on-call physician and the on-call physician fails

[506] P.L. 108–173, §736(a)(14)(A), struck out "is is" and substituted "is".

or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.

(2) CIVIL ENFORCEMENT.—

(A) PERSONAL HARM.—Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(B) FINANCIAL LOSS TO OTHER MEDICAL FACILITY.—Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(C) LIMITATIONS ON ACTIONS.—No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(3) CONSULTATION WITH PEER REVIEW ORGANIZATIONS.—In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1) or in terminating a hospital's participation under this title[507], the Secretary shall request the appropriate utilization and quality control peer review organization (with a contract under part B of title XI) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least 60 days for such review. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this title for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.[508]

[507] P.L. 108–173, §944(c)(1)(A), added "or in terminating a hospital's participation under this title", applicable to terminations of participation initiated on or after December 8, 2003.

[508] P.L. 108–173, §944(c)(1)(B), added "Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making

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(4)[509] NOTICE UPON CLOSING AN INVESTIGATION.—The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.

(e) DEFINITIONS.—In this section:

(1) The term "emergency medical condition" means—

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant woman[510] who is having contractions—

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

(2) The term "participating hospital" means a hospital[511] that has entered into a provider agreement under section 1866.

(3)(A) The term "to stabilize" means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

(B) The term "stabilized" means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

(4) The term "transfer" means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

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a compliance determination as part of the process of terminating a hospital's participation under this title for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.", applicable to terminations of participation initiated on or after December 8, 2003.

[509] P.L. 108–173, §944(b), added paragraph (4), effective December 8, 2003.

[510] P.L. 108–173, §736(a)(14)(B), struck out "a pregnant women" and substituted "a pregnant woman".

[511] P.L. 108–173, §736(a)(14)(C), struck out "means hospital" and substituted "means a hospital".

(5) The term "hospital" includes a critical access hospital (as defined in section 1861(mm)(1)).

(f) PREEMPTION.—The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

(g) NONDISCRIMINATION.—A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

(h) NO DELAY IN EXAMINATION OR TREATMENT.—A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) or further medical examination and treatment required under subsection (b) in order to inquire about the individual's method of payment or insurance status.

(i) WHISTLEBLOWER PROTECTIONS.—A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.

PRACTICING PHYSICIANS ADVISORY COUNCIL; COUNCIL FOR TECHNOLOGY AND INNOVATION[512]

SEC. 1868. [42 U.S.C. 1395ee] (a) PRACTICING PHYSICIANS ADVISORY COUNCIL.—

(1)[513] The Secretary shall appoint, based upon nominations submitted by medical organizations representing physicians, a Practicing Physicians Advisory Council (in this subsection[514] referred to as the "Council") to be composed of 15 physicians, each of whom has submitted at least 250 claims for physicians' services under this title in the previous year. At least 11 of the members of the Council shall be physicians described in section 1861(r)(1) and the members of the Council shall include both participating and nonparticipating physicians and physicians practicing in rural areas and underserved urban areas.

(2)[515] The Council shall meet once during each calendar quarter to discuss certain proposed changes in regulations and carrier manual instructions related to physician services identified by the Secretary. To the extent feasible and consistent with statutory deadlines, such consultation shall occur before the publication of such proposed changes.

(3) Members of the Council shall be entitled to receive reimbursement of expenses and per diem in lieu of subsistence in the same manner as other members of advisory councils ap-

[512] P.L. 108–173, §942(a)(1), added "; COUNCIL FOR TECHNOLOGY AND INNOVATION".

[513] P.L. 108–173, §942(a)(1), added "PRACTICING PHYSICIANS ADVISORY COUNCIL.—(1)", effective December 8, 2003.

[514] P.L. 108–173, §942(a)(2), struck out "in this section" and substituted "in this subsection", effective December 8, 2003.

[515] P.L. 108–173, §942(a)(4), redesignated the former subsections (b) and (c) as paragraphs (2) and (3), respectively, effective December 8, 2003.

pointed by the Secretary are provided such reimbursement and per diem under this title.

(b)[516] COUNCIL FOR TECHNOLOGY AND INNOVATION.—

(1) ESTABLISHMENT.—The Secretary shall establish a Council for Technology and Innovation within the Centers for Medicare and Medicaid Services (in this section referred to as "CMS").

(2) COMPOSITION.—The Council shall be composed of senior CMS staff and clinicians and shall be chaired by the Executive Coordinator for Technology and Innovation (appointed or designated under paragraph (4)).

(3) DUTIES.—The Council shall coordinate the activities of coverage, coding, and payment processes under this title with respect to new technologies and procedures, including new drug therapies, and shall coordinate the exchange of information on new technologies between CMS and other entities that make similar decisions.

(4) EXECUTIVE COORDINATOR FOR TECHNOLOGY AND INNOVATION.—The Secretary shall appoint (or designate) a noncareer appointee (as defined in section 3132(a)(7) of title 5, United States Code) who shall serve as the Executive Coordinator for Technology and Innovation. Such executive coordinator shall report to the Administrator of CMS, shall chair the Council, shall oversee the execution of its duties, and shall serve as a single point of contact for outside groups and entities regarding the coverage, coding, and payment processes under this title.

DETERMINATIONS; APPEALS[517]

SEC. 1869. [42 U.S.C. 1395ff] (a) INITIAL DETERMINATIONS.—

(1) PROMULGATIONS OF REGULATIONS.— The Secretary shall promulgate regulations and make initial determinations with respect to benefits under part A or part B in accordance with those regulations for the following:

(A) The initial determination of whether an individual is entitled to benefits under such parts.

(B) The initial determination of the amount of benefits available to the individual under such parts.

(C) Any other initial determination with respect to a claim for benefits under such parts, including an initial determination by the Secretary that payment may not be made, or may no longer be made, for an item or service under such parts, an initial determination made by a utilization and quality control peer review organization under section 1154(a)(2), and an initial determination made by an entity pursuant to a contract (other than a contract under section 1852) with the Secretary to administer provisions of this title or title XI.

(2) DEADLINES FOR MAKING INITIAL DETERMINATIONS.—

(A) IN GENERAL.—Subject to subparagraph (B), in promulgating regulations under paragraph (1), initial determinations shall be concluded by not later than the 45–day period beginning on the date the fiscal intermediary or the

[516] P.L. 108–173, §942(a)(5), added subsection (b), effective December 8, 2003.

[517] See Vol. II, P.L. 108-173, §931(a) - (c), with respect to the transfer of responsibility for Medicare appeals; and §937, with respect to a process for corrections of minor errors and omissions without pursuing appeals process.

carrier, as the case may be, receives a claim for benefits from an individual as described in paragraph (1). Notice of such determination shall be mailed to the individual filing the claim before the conclusion of such 45–day period.

(B) CLEAN CLAIMS.—Subparagraph (A) shall not apply with respect to any claim that is subject to the requirements of section 1816(c)(2) or 1842(c)(2).

(3) REDETERMINATIONS.—:

(A) IN GENERAL.—In promulgating regulations under paragraph (1) with respect to initial determinations, such regulations shall provide for a fiscal intermediary or a carrier to make a redetermination with respect to a claim for benefits that is denied in whole or in part.

(B) LIMITATIONS.—

(i) APPEAL RIGHTS.— No initial determination may be reconsidered or appealed under subsection (b) unless the fiscal intermediary or carrier has made a redetermination of that initial determination under this paragraph.

(ii) DECISIONMAKER.—No redetermination may be made by any individual involved in the initial determination.

(C) DEADLINES.—

(i) FILING FOR REDETERMINATION.—A redetermination under subparagraph (A) shall be available only if notice is filed with the Secretary to request the redetermination by not later than the end of the 120–day period beginning on the date the individual receives notice of the initial determination under paragraph (2).

(ii) CONCLUDING REDETERMINATIONS.— Redeterminations shall be concluded by not later than the 60–day period[518] beginning on the date the fiscal intermediary or the carrier, as the case may be, receives a request for a redetermination. Notice of such determination shall be mailed to the individual filing the claim before the conclusion of such 60–day period[519].

(D) CONSTRUCTION.—For purposes of the succeeding provisions of this section a redetermination under this paragraph shall be considered to be part of the initial determination.

(4)[520] REQUIREMENTS OF NOTICE OF DETERMINATIONS.—With respect to an initial determination insofar as it results in a denial of a claim for benefits—

(A) the written notice on the determination shall include—

(i) the reasons for the determination, including whether a local medical review policy or a local coverage determination was used;

[518] P.L. 108–173, §940(a)(1), struck out "30-day period" and substituted "60-day period", effective December 8, 2003.

[519] P.L. 108–173, §940(a)(1), struck out "30-day period" and substituted "60-day period", effective December 8, 2003.

[520] P.L. 108–173, §933(c)(1), added paragraph (4), effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA (114 Stat. 2763A-534).

(ii) the procedures for obtaining additional information concerning the determination, including the information described in subparagraph (B); and

(iii) notification of the right to seek a redetermination or otherwise appeal the determination and instructions on how to initiate such a redetermination under this section;

(B) such written notice shall be provided in printed form and written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both; and

(C) the individual provided such written notice may obtain, upon request, information on the specific provision of the policy, manual, or regulation used in making the redetermination.

(5)[521] REQUIREMENTS OF NOTICE OF REDETERMINATIONS.—With respect to a redetermination insofar as it results in a denial of a claim for benefits—

(A) the written notice on the redetermination shall include—

(i) the specific reasons for the redetermination;

(ii) as appropriate, a summary of the clinical or scientific evidence used in making the redetermination;

(iii) a description of the procedures for obtaining additional information concerning the redetermination; and

(iv) notification of the right to appeal the redetermination and instructions on how to initiate such an appeal under this section;

(B) such written notice shall be provided in printed form and written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both; and

(C) the individual provided such written notice may obtain, upon request, information on the specific provision of the policy, manual, or regulation used in making the redetermination.

(b) APPEAL RIGHTS.—

(1) IN GENERAL.—

(A) RECONSIDERATION OF INITIAL DETERMINATION.— Subject to subparagraph (D), any individual dissatisfied with any initial determination under subsection (a)(1) shall be entitled to reconsideration of the determination, and, subject to subparagraphs (D) and (E), a hearing thereon by the Secretary to the same extent as is provided in section 205(b) and, subject to paragraph (2),[522] to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). For purposes of the preceding sentence, any reference to the "Commissioner of Social Security" or the "Social Security Administration" in subsection (g) or (l) of section 205 shall be considered a ref-

[521] P.L. 108–173, §933(c)(1), added paragraph (5), effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA (114 Stat. 2763A-534).

[522] P.L. 108–173, §932(a)(1)(A), inserted ", subject to paragraph (2),", effective December 8, 2003.

erence to the "Secretary" or the "Department of Health and Human Services", respectively.

(B) REPRESENTATION BY PROVIDER OR SUPPLIER.—

(i) IN GENERAL.—Sections 206(a), 1102, and 1871 shall not be construed as authorizing the Secretary to prohibit an individual from being represented under this section by a person that furnishes or supplies the individual, directly or indirectly, with services or items, solely on the basis that the person furnishes or supplies the individual with such a service or item.

(ii) MANDATORY WAIVER OF RIGHT TO PAYMENT FROM BENEFICIARY.—Any person that furnishes services or items to an individual may not represent an individual under this section with respect to the issue described in section 1879(a)(2) unless the person has waived any rights for payment from the beneficiary with respect to the services or items involved in the appeal.

(iii) PROHIBITION ON PAYMENT FOR REPRESENTATION.—If a person furnishes services or items to an individual and represents the individual under this section, the person may not impose any financial liability on such individual in connection with such representation.

(iv) REQUIREMENTS FOR REPRESENTATIVES OF A BENEFICIARY.—The provisions of section 205(j) and of section 206 (other than subsection (a)(4) of such section) regarding representation of claimants shall apply to representation of an individual with respect to appeals under this section in the same manner as they apply to representation of an individual under those sections.

(C) SUCCESSION OF RIGHTS IN CASES OF ASSIGNMENT.—The right of an individual to an appeal under this section with respect to an item or service may be assigned to the provider of services or supplier of the item or service upon the written consent of such individual using a standard form established by the Secretary for such an assignment.

(D) TIME LIMITS FOR FILING APPEALS.—

(i) RECONSIDERATIONS.—Reconsideration under subparagraph (A) shall be available only if the individual described in subparagraph (A) files notice with the Secretary to request reconsideration by not later than the end of the 180–day period beginning on the date the individual receives notice of the redetermination under subsection (a)(3), or within such additional time as the Secretary may allow.

(ii) HEARINGS CONDUCTED BY THE SECRETARY.— The Secretary shall establish in regulations time limits for the filing of a request for a hearing by the Secretary in accordance with provisions in sections 205 and 206.

(E) AMOUNTS IN CONTROVERSY.—

(i) IN GENERAL.—A hearing (by the Secretary) shall not be available to an individual under this section if the amount in controversy is less than $100, and judicial review shall not be available to the individual if the amount in controversy is less than $1,000.

(ii) AGGREGATION OF CLAIMS.—In determining the amount in controversy, the Secretary, under regulations, shall allow two or more appeals to be aggregated if the appeals involve.—

(I) the delivery of similar or related services to the same individual by one or more providers of services or suppliers, or

(II) common issues of law and fact arising from services furnished to two or more individuals by one or more providers of services or suppliers.

(iii)[523] ADJUSTMENT OF DOLLAR AMOUNTS.—For requests for hearings or judicial review made in a year after 2004, the dollar amounts specified in clause (i) shall be equal to such dollar amounts increased by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount determined under the previous sentence that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

(F) EXPEDITED PROCEEDINGS.—

(i) EXPEDITED DETERMINATION.—In the case of an individual who has received notice from a provider of services that such provider plans—

(I) to terminate services provided to an individual and a physician certifies that failure to continue the provision of such services is likely to place the individual's health at significant risk, or

(II) to discharge the individual from the provider of services, the individual may request, in writing or orally, an expedited determination or an expedited reconsideration of an initial determination made under subsection (a)(1), as the case may be, and the Secretary shall provide such expedited determination or expedited reconsideration.

(ii) EXPEDITED HEARING.—In a hearing by the Secretary under this section, in which the moving party alleges that no material issues of fact are in dispute, the Secretary shall make an expedited determination as to whether any such facts are in dispute and, if not, shall render a decision expeditiously.

(G) REOPENING AND REVISION OF DETERMINATIONS.—The Secretary may reopen or revise any initial determination or reconsidered determination described in this subsection under guidelines established by the Secretary in regulations.

(2)[524] EXPEDITED ACCESS TO JUDICIAL REVIEW.—

(A) IN GENERAL.—The Secretary shall establish a process under which a provider of services or supplier that furnishes an item or service or an individual entitled to benefits under part A or enrolled under part B, or both, who has filed an appeal under paragraph (1) (other than an ap-

[523] P.L. 108–173, §940(b)(1), added clause (iii), effective December 8, 2003.

[524] P.L. 108–173, §932(a)(1)(B), added this paragraph (2), applicable to appeals filed on or after October 1, 2004.

peal filed under paragraph (1)(F)(i)) may obtain access to judicial review when a review entity (described in subparagraph (D)), on its own motion or at the request of the appellant, determines that the Departmental Appeals Board does not have the authority to decide the question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute. The appellant may make such request only once with respect to a question of law or regulation for a specific matter in dispute in a case of an appeal.

(B) PROMPT DETERMINATIONS.—If, after or coincident with appropriately filing a request for an administrative hearing, the appellant requests a determination by the appropriate review entity that the Departmental Appeals Board does not have the authority to decide the question of law or regulations relevant to the matters in controversy and that there is no material issue of fact in dispute, and if such request is accompanied by the documents and materials as the appropriate review entity shall require for purposes of making such determination, such review entity shall make a determination on the request in writing within 60 days after the date such review entity receives the request and such accompanying documents and materials. Such a determination by such review entity shall be considered a final decision and not subject to review by the Secretary.

(C) ACCESS TO JUDICIAL REVIEW.—

(i) IN GENERAL.—If the appropriate review entity—

(I) determines that there are no material issues of fact in dispute and that the only issues to be adjudicated are ones of law or regulation that the Departmental Appeals Board does not have authority to decide; or

(II) fails to make such determination within the period provided under subparagraph (B), then the appellant may bring a civil action as described in this subparagraph.

(ii) DEADLINE FOR FILING.—Such action shall be filed, in the case described in—

(I) clause (i)(I), within 60 days of the date of the determination described in such clause; or

(II) clause (i)(II), within 60 days of the end of the period provided under subparagraph (B) for the determination.

(iii) VENUE.—Such action shall be brought in the district court of the United States for the judicial district in which the appellant is located (or, in the case of an action brought jointly by more than one applicant, the judicial district in which the greatest number of applicants are located) or in the District Court for the District of Columbia.

(iv) INTEREST ON ANY AMOUNTS IN CONTROVERSY.—Where a provider of services or supplier is granted judicial review pursuant to this paragraph, the amount in controversy (if any) shall be subject to annual interest beginning on the first day of the first month begin-

ning after the 60-day period as determined pursuant to clause (ii) and equal to the rate of interest on obligations issued for purchase by the Federal Supplementary Medical Insurance Trust Fund for the month in which the civil action authorized under this paragraph is commenced, to be awarded by the reviewing court in favor of the prevailing party. No interest awarded pursuant to the preceding sentence shall be deemed income or cost for the purposes of determining reimbursement due providers of services or suppliers under this title.

(D) REVIEW ENTITY DEFINED.—For purposes of this subsection, the term "review entity" means an entity of up to three reviewers who are administrative law judges or members of the Departmental Appeals Board selected for purposes of making determinations under this paragraph.

(c) CONDUCT OF RECONSIDERATIONS BY INDEPENDENT CONTRACTORS.—

(1) IN GENERAL.—The Secretary shall enter into contracts with qualified independent contractors to conduct reconsiderations of initial determinations made under subparagraphs (B) and (C) of subsection (a)(1). Contracts shall be for an initial term of three years and shall be renewable on a triennial basis thereafter.

(2) QUALIFIED INDEPENDENT CONTRACTOR.—For purposes of this subsection, the term "qualified independent contractor" means an entity or organization that is independent of any organization under contract with the Secretary that makes initial determinations under subsection (a)(1), and that meets the requirements established by the Secretary consistent with paragraph (3).

(3) REQUIREMENTS.—Any qualified independent contractor entering into a contract with the Secretary under this subsection shall meet all of the following requirements:

(A) IN GENERAL.—The qualified independent contractor shall perform such duties and functions and assume such responsibilities as may be required by the Secretary to carry out the provisions of this subsection, and shall have sufficient medical, legal, and other expertise (including knowledge of the program under this title) and sufficient staffing[525] to make reconsiderations under this subsection.

(B) RECONSIDERATIONS.—

(i) IN GENERAL.—The qualified independent contractor shall review initial determinations. Where an initial determination is made with respect to whether an item or service is reasonable and necessary for the diagnosis or treatment of illness or injury (under section 1862(a)(1)(A)), such review shall include consideration of the facts and circumstances of the initial determination by a panel of physicians or other appropriate health care professionals and any decisions with respect to the reconsideration shall be based on applica-

[525] P.L. 108–173, §933(d)(1)(A), struck out "sufficient training and expertise in medical science and legal matters" and substituted "sufficient medical, legal, and other expertise (including knowledge of the program under this title) and sufficient staffing", effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA (114 Stat. 2763A-534).

ble information, including clinical experience (including the medical records of the individual involved)[526] and medical, technical, and scientific evidence.

(ii) EFFECT OF NATIONAL AND LOCAL COVERAGE DETERMINATIONS.—

(I) NATIONAL COVERAGE DETERMINATIONS.—If the Secretary has made a national coverage determination pursuant to the requirements established under the third sentence of section 1862(a), such determination shall be binding on the qualified independent contractor in making a decision with respect to a reconsideration under this section.

(II) LOCAL COVERAGE DETERMINATIONS.—If the Secretary has made a local coverage determination, such determination shall not be binding on the qualified independent contractor in making a decision with respect to a reconsideration under this section. Notwithstanding the previous sentence, the qualified independent contractor shall consider the local coverage determination in making such decision.

(III) ABSENCE OF NATIONAL OR LOCAL COVERAGE DETERMINATION.—In the absence of such a national coverage determination or local coverage determination, the qualified independent contractor shall make a decision with respect to the reconsideration based on applicable information, including clinical experience and medical, technical, and scientific evidence.

(C) DEADLINES FOR DECISIONS.—

(i) RECONSIDERATIONS.—Except as provided in clauses (iii) and (iv), the qualified independent contractor shall conduct and conclude a reconsideration under subparagraph (B), and mail the notice of the decision with respect to the reconsideration by not later than the end of the 60–day period[527] beginning on the date a request for reconsideration has been timely filed.

(ii) CONSEQUENCES OF FAILURE TO MEET DEADLINE.—In the case of a failure by the qualified independent contractor to mail the notice of the decision by the end of the period described in clause (i) or to provide notice by the end of the period described in clause (iii), as the case may be, the party requesting the reconsideration or appeal may request a hearing before the Secretary, notwithstanding any requirements for a reconsidered determination for purposes of the party's right to such hearing.

[526] P.L. 108–173, §933(b), inserted "including the medical records of the individual involved)", effective December 8, 2003.

[527] P.L. 108–173, §940(a)(2), struck out "30-day period" and substituted "60-day period", effective December 8, 2003.

(iii) EXPEDITED RECONSIDERATIONS.—The qualified independent contractor shall perform an expedited reconsideration under subsection (b)(1)(F) as follows:

(I) DEADLINE FOR DECISION.—Notwithstanding section 216(j) and subject to clause (iv), not later than the end of the 72–hour period beginning on the date the qualified independent contractor has received a request for such reconsideration and has received such medical or other records needed for such reconsideration, the qualified independent contractor shall provide notice (by telephone and in writing) to the individual and the provider of services and attending physician of the individual of the results of the reconsideration. Such reconsideration shall be conducted regardless of whether the provider of services or supplier will charge the individual for continued services or whether the individual will be liable for payment for such continued services.

(II) CONSULTATION WITH BENEFICIARY.—In such reconsideration, the qualified independent contractor shall solicit the views of the individual involved.

(III) SPECIAL RULE FOR HOSPITAL DISCHARGES.—A reconsideration of a discharge from a hospital shall be conducted under this clause in accordance with the provisions of paragraphs (2), (3), and (4) of section 1154(e) as in effect on the date that precedes the date of the enactment of this subparagraph.

(iv) EXTENSION.—An individual requesting a reconsideration under this subparagraph may be granted such additional time as the individual specifies (not to exceed 14 days) for the qualified independent contractor to conclude the reconsideration. The individual may request such additional time orally or in writing.

(D)[528] QUALIFICATIONS FOR REVIEWERS.—The requirements of subsection (g) shall be met (relating to qualifications of reviewing professionals).

(E) EXPLANATION OF DECISION.—Any decision with respect to a reconsideration of a qualified independent contractor shall be in writing, be written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both, and shall include (to the extent appropriate)[529] and shall include a detailed explanation of the decision as well as a discussion of the pertinent facts and applicable regulations applied in making such decision, and a notification of the right to appeal such determination and instructions on

[528] P.L. 108–173, §933(d)(2)(A), amended subsection (c)(3)(D) in its entirety, effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA (114 Stat. 2763A-534).

[529] P.L. 108–173, §933(c)(2)(A), inserted "be written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both, and shall include (to the extent appropriate)", effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA (114 Stat. 2763A-534).

how to initiate such appeal under this section[530] and in the case of a determination of whether an item or service is reasonable and necessary for the diagnosis or treatment of illness or injury (under section 1862(a)(1)(A)) an explanation of the medical and scientific rationale for the decision.

(F) NOTICE REQUIREMENTS.—Whenever a qualified independent contractor makes a decision with respect to a reconsideration under this subsection, the qualified independent contractor shall promptly notify the entity responsible for the payment of claims under part A or part B of such decision.

(G) DISSEMINATION OF DECISIONS ON RECONSIDERATIONS.—Each qualified independent contractor shall make available all decisions with respect to reconsiderations of such qualified independent contractors to fiscal intermediaries (under section 1816), carriers (under section 1842), peer review organizations (under part B of title XI), Medicare+Choice organizations offering Medicare+Choice plans under part C, other entities under contract with the Secretary to make initial determinations under part A or part B or title XI, and to the public. The Secretary shall establish a methodology under which qualified independent contractors shall carry out this subparagraph.

(H) ENSURING CONSISTENCY IN DECISIONS.—Each qualified independent contractor shall monitor its decisions with respect to reconsiderations to ensure the consistency of such decisions with respect to requests for reconsideration of similar or related matters.

(I) DATA COLLECTION.—

(i) IN GENERAL.—Consistent with the requirements of clause (ii), a qualified independent contractor shall collect such information relevant to its functions, and keep and maintain such records in such form and manner as the Secretary may require to carry out the purposes of this section and shall permit access to and use of any such information and records as the Secretary may require for such purposes.

(ii) TYPE OF DATA COLLECTED.—Each qualified independent contractor shall keep accurate records of each decision made, consistent with standards established by the Secretary for such purpose. Such records shall be maintained in an electronic database in a manner that provides for identification of the following:

(I) Specific claims that give rise to appeals.

(II) Situations suggesting the need for increased education for providers of services, physicians, or suppliers.

[530] P.L. 108–173, §933(c)(2)(B), inserted "and a notification of the right to appeal such determination and instructions on how to initiate such appeal under this section", effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA (114 Stat. 2763A-534).

(III) Situations suggesting the need for changes in national or local coverage determination[531].

(IV) Situations suggesting the need for changes in local coverage determinations[532].

(iii) ANNUAL REPORTING.—Each qualified independent contractor shall submit annually to the Secretary (or otherwise as the Secretary may request) records maintained under this paragraph for the previous year.

(J) HEARINGS BY THE SECRETARY.—The qualified independent contractor shall (i) submit[533] such information as is required for an appeal of a decision of the contractor[534], and (ii) participate in such hearings as required by the Secretary.

(K)[535] INDEPENDENCE REQUIREMENTS.—

(i) IN GENERAL.—Subject to clause (ii), a qualified independent contractor shall not conduct any activities in a case unless the entity—

(I) is not a related party (as defined in subsection (g)(5));

(II) does not have a material familial, financial, or professional relationship with such a party in relation to such case; and

(III) does not otherwise have a conflict of interest with such a party.

(ii) EXCEPTION FOR REASONABLE COMPENSATION.—Nothing in clause (i) shall be construed to prohibit receipt by a qualified independent contractor of compensation from the Secretary for the conduct of activities under this section if the compensation is provided consistent with clause (iii).

(iii) LIMITATIONS ON ENTITY COMPENSATION.—Compensation provided by the Secretary to a qualified independent contractor in connection with reviews under this section shall not be contingent on any decision rendered by the contractor or by any reviewing professional.

(4) NUMBER OF QUALIFIED INDEPENDENT CONTRACTORS.—The Secretary shall enter into contracts with a sufficient number of qualified independent contractors (but not fewer than 4 such contractors) to conduct reconsiderations consistent with the timeframes applicable under this subsection[536].

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[531] P.L. 108–173, §948(b)(1)(A), struck out "policy" and substituted "determination", effective as if included in the enactment of BIPA.

[532] P.L. 108–173, §948(b)(1)(B), struck out "medical review policies" and substituted "coverage determinations", effective as if included in the enactment of BIPA.

[533] P.L. 108–173, §933(c)(4), struck out "prepare" and substituted "submit", effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA (114 Stat. 2763A-534).

[534] P.L. 108–173, §933(c)(4), struck out "with respect to a reconsideration to the Secretary for a hearing, including as necessary, explanations of issues involved in the decision and relevant policies", effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA (114 Stat. 2763A-534).

[535] P.L. 108–173, §933(d)(1)(B), added subparagraph (K), effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA (114 Stat. 2763A-534).

[536] P.L. 108–173, §933(d)(3), struck out "not fewer than 12 qualified independent contractors under this subsection" and substituted "a sufficient number of qualified independent contractors (but not fewer than 4 such contractors) to conduct reconsiderations consistent with the timeframes applicable under this subsection", effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA (114 Stat. 2763A-534).

(5) LIMITATION ON QUALIFIED INDEPENDENT CONTRACTOR LIABILITY.—No qualified independent contractor having a contract with the Secretary under this subsection and no person who is employed by, or who has a fiduciary relationship with, any such qualified independent contractor or who furnishes professional services to such qualified independent contractor, shall be held by reason of the performance of any duty, function, or activity required or authorized pursuant to this subsection or to a valid contract entered into under this subsection, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) provided due care was exercised in the performance of such duty, function, or activity.

(d) DEADLINES FOR HEARINGS BY THE SECRETARY; NOTICE [537].—

(1) HEARING BY ADMINISTRATIVE LAW JUDGE.—

(A) IN GENERAL.—Except as provided in subparagraph (B), an administrative law judge shall conduct and conclude a hearing on a decision of a qualified independent contractor under subsection (c) and render a decision on such hearing by not later than the end of the 90–day period beginning on the date a request for hearing has been timely filed.

(B) WAIVER OF DEADLINE BY PARTY SEEKING HEARING.—The 90–day period under subparagraph (A) shall not apply in the case of a motion or stipulation by the party requesting the hearing to waive such period.

(2) DEPARTMENTAL APPEALS BOARD REVIEW.—

(A) IN GENERAL.—The Departmental Appeals Board of the Department of Health and Human Services shall conduct and conclude a review of the decision on a hearing described in paragraph (1) and make a decision or remand the case to the administrative law judge for reconsideration by not later than the end of the 90–day period beginning on the date a request for review has been timely filed.

(B) DAB HEARING PROCEDURE.—In reviewing a decision on a hearing under this paragraph, the Departmental Appeals Board shall review the case de novo.

(3) CONSEQUENCES OF FAILURE TO MEET DEADLINES.—

(A) HEARING BY ADMINISTRATIVE LAW JUDGE.—In the case of a failure by an administrative law judge to render a decision by the end of the period described in paragraph (1), the party requesting the hearing may request a review by the Departmental Appeals Board of the Department of Health and Human Services, notwithstanding any requirements for a hearing for purposes of the party's right to such a review.

(B) DEPARTMENTAL APPEALS BOARD REVIEW.—In the case of a failure by the Departmental Appeals Board to render a decision by the end of the period described in paragraph (2), the party requesting the hearing may seek judicial review, notwithstanding any requirements for a hearing for purposes of the party's right to such judicial review.

[537] P.L. 108–173, §933(c)(3)(A), inserted "; NOTICE", effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA (114 Stat. 2763A-534).

(4)[538] NOTICE.—Notice of the decision of an administrative law judge shall be in writing in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both, and shall include—

(A) the specific reasons for the determination (including, to the extent appropriate, a summary of the clinical or scientific evidence used in making the determination);

(B) the procedures for obtaining additional information concerning the decision; and

(C) notification of the right to appeal the decision and instructions on how to initiate such an appeal under this section.

(e) ADMINISTRATIVE PROVISIONS.—

(1) LIMITATION ON REVIEW OF CERTAIN REGULATIONS.—A regulation or instruction that relates to a method for determining the amount of payment under part B and that was initially issued before January 1, 1981, shall not be subject to judicial review.

(2) OUTREACH.—The Secretary shall perform such outreach activities as are necessary to inform individuals entitled to benefits under this title and providers of services and suppliers with respect to their rights of, and the process for, appeals made under this section. The Secretary shall use the toll–free telephone number maintained by the Secretary under section 1804(b) to provide information regarding appeal rights and respond to inquiries regarding the status of appeals.

(3) CONTINUING EDUCATION REQUIREMENT FOR QUALIFIED INDEPENDENT CONTRACTORS AND ADMINISTRATIVE LAW JUDGES.—The Secretary shall provide to each qualified independent contractor, and, in consultation with the Commissioner of Social Security, to administrative law judges that decide appeals of reconsiderations of initial determinations or other decisions or determinations under this section, such continuing education with respect to coverage of items and services under this title or policies of the Secretary with respect to part B of title XI as is necessary for such qualified independent contractors and administrative law judges to make informed decisions with respect to appeals.

(4) REPORTS.—

(A) ANNUAL REPORT TO CONGRESS.—The Secretary shall submit to Congress an annual report describing the number of appeals for the previous year, identifying issues that require administrative or legislative actions, and including any recommendations of the Secretary with respect to such actions. The Secretary shall include in such report an analysis of determinations by qualified independent contractors with respect to inconsistent decisions and an analysis of the causes of any such inconsistencies.

(B) SURVEY.—Not less frequently than every 5 years, the Secretary shall conduct a survey of a valid sample of individuals entitled to benefits under this title who have filed appeals of determinations under this section, providers of services, and suppliers to determine the satisfaction of

[538] P.L. 108–173, §933(c)(3)(B), added paragraph (4), effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA (114 Stat. 2763A-534).

such individuals or entities with the process for appeals of determinations provided for under this section and education and training provided by the Secretary with respect to that process. The Secretary shall submit to Congress a report describing the results of the survey, and shall include any recommendations for administrative or legislative actions that the Secretary determines appropriate.

(f) REVIEW OF COVERAGE DETERMINATIONS.—

(1) NATIONAL COVERAGE DETERMINATIONS.—

(A) IN GENERAL.—Review of any national coverage determination shall be subject to the following limitations:

(i) Such a determination shall not be reviewed by any administrative law judge.

(ii) Such a determination shall not be held unlawful or set aside on the ground that a requirement of section 553 of title 5, United States Code, or section 1871(b) of this title, relating to publication in the Federal Register or opportunity for public comment, was not satisfied.

(iii) Upon the filing of a complaint by an aggrieved party, such a determination shall be reviewed by the Departmental Appeals Board of the Department of Health and Human Services. In conducting such a review, the Departmental Appeals Board—

(I) shall review the record and shall permit discovery and the taking of evidence to evaluate the reasonableness of the determination, if the Board determines that the record is incomplete or lacks adequate information to support the validity of the determination;

(II) may, as appropriate, consult with appropriate scientific and clinical experts; and

(III) shall defer only to the reasonable findings of fact, reasonable interpretations of law, and reasonable applications of fact to law by the Secretary.

(iv) The Secretary shall implement a decision of the Departmental Appeals Board within 30 days of receipt of such decision.

(v) A decision of the Departmental Appeals Board constitutes a final agency action and is subject to judicial review.

(B) DEFINITION OF NATIONAL COVERAGE DETERMINATION.—For purposes of this section, the term "national coverage determination" means a determination by the Secretary with respect to whether or not a particular item or service is covered nationally under this title, but does not include a determination of what code, if any, is assigned to a particular item or service covered under this title or a determination with respect to the amount of payment made for a particular item or service so covered.

(2) LOCAL COVERAGE DETERMINATION.—

(A) IN GENERAL.—Review of any local coverage determination shall be subject to the following limitations:

(i) Upon the filing of a complaint by an aggrieved party, such a determination shall be reviewed by an

administrative law judge[539]. The administrative law judge.—

(I) shall review the record and shall permit discovery and the taking of evidence to evaluate the reasonableness of the determination, if the administrative law judge determines that the record is incomplete or lacks adequate information to support the validity of the determination;

(II) may, as appropriate, consult with appropriate scientific and clinical experts; and

(III) shall defer only to the reasonable findings of fact, reasonable interpretations of law, and reasonable applications of fact to law by the Secretary.

(ii) Upon the filing of a complaint by an aggrieved party, a decision of an administrative law judge under clause (i) shall be reviewed by the Departmental Appeals Board of the Department of Health and Human Services.

(iii) The Secretary shall implement a decision of the administrative law judge or the Departmental Appeals Board within 30 days of receipt of such decision.

(iv) A decision of the Departmental Appeals Board constitutes a final agency action and is subject to judicial review.

(B) DEFINITION OF LOCAL COVERAGE DETERMINATION.—For purposes of this section, the term "local coverage determination" means a determination by a fiscal intermediary or a carrier under part A or part B, as applicable, respecting whether or not a particular item or service is covered on an intermediary–or carrier–wide basis under such parts, in accordance with section 1862(a)(1)(A).

(3) NO MATERIAL ISSUES OF FACT IN DISPUTE.—In the case of a determination that may otherwise be subject to review under paragraph (1)(A)(iii) or paragraph (2)(A)(i), where the moving party alleges that—

(A) there are no material issues of fact in dispute, and

(B) the only issue of law is the constitutionality of a provision of this title, or that a regulation, determination, or ruling by the Secretary is invalid, the moving party may seek review by a court of competent jurisdiction without filing a complaint under such paragraph and without otherwise exhausting other administrative remedies.

(4) PENDING NATIONAL COVERAGE DETERMINATIONS.—

(A) IN GENERAL.—In the event the Secretary has not issued a national coverage or noncoverage determination with respect to a particular type or class of items or services, an aggrieved person (as described in paragraph (5)) may submit to the Secretary a request to make such a determination with respect to such items or services. By not later than the end of the 90–day period beginning on the date the Secretary receives such a request (notwithstanding the receipt by the Secretary of new evidence (if any)

[539] P.L. 108–173, §931(d), struck out "of the Social Security Administration" , effective December 8, 2003.

during such 90–day period), the Secretary shall take one of the following actions:

(i) Issue a national coverage determination, with or without limitations.

(ii) Issue a national noncoverage determination.

(iii) Issue a determination that no national coverage or noncoverage determination is appropriate as of the end of such 90–day period with respect to national coverage of such items or services.

(iv) Issue a notice that states that the Secretary has not completed a review of the request for a national coverage determination and that includes an identification of the remaining steps in the Secretary's review process and a deadline by which the Secretary will complete the review and take an action described in clause (i), (ii), or (iii)[540].

(B) DEEMED ACTION BY THE SECRETARY.—In the case of an action described in subparagraph (A)(iv)[541], if the Secretary fails to take an action referred to in such clause by the deadline specified by the Secretary under such clause, then the Secretary is deemed to have taken an action described in subparagraph (A)(iii)[542] as of the deadline.

(C) EXPLANATION OF DETERMINATION.—When issuing a determination under subparagraph (A)[543], the Secretary shall include an explanation of the basis for the determination. An action taken under subparagraph (A)[544] (other than clause (iv)[545]) is deemed to be a national coverage determination for purposes of review under paragraph (1)(A)[546].

(5) STANDING.—An action under this subsection seeking review of a national coverage determination or local coverage determination may be initiated only by individuals entitled to benefits under part A, or enrolled under part B, or both, who are in need of the items or services that are the subject of the coverage determination.

(6) PUBLICATION ON THE INTERNET OF DECISIONS OF HEARINGS OF THE SECRETARY.—Each decision of a hearing by the Secretary with respect to a national coverage determination shall be made public, and the Secretary shall publish each decision on the Medicare Internet site of the Department of Health and Human Services. The Secretary shall remove from such decision any information that would identify any individual, provider of services, or supplier.

(7) ANNUAL REPORT ON NATIONAL COVERAGE DETERMINATIONS.—

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[540] P.L. 108–173, §948(c)(1), struck out "subclause (I), (II), or (III)" and substituted "clause (i), (ii), or (iii)", effective as if included in the enactment of BIPA.

[541] P.L. 108–173, §948(c)(2), struck out "clause (i)(IV)" and substituted "subparagraph (A)(iv)", effective as if included in the enactment of BIPA.

[542] P.L. 108–173, §948(c)(2), struck out "clause (i)(III)" and substituted "subparagraph (A)(iii)", effective as if included in the enactment of BIPA.

[543] P.L. 108–173, §948(c)(3), struck out "clause (i)" and substituted "subparagraph (A)", effective as if included in the enactment of BIPA.

[544] P.L. 108–173, §948(c)(3), struck out "clause (i)" and substituted "subparagraph (A)", effective as if included in the enactment of BIPA.

[545] P.L. 108–173, §948(c)(3), struck out "subclause (IV)" and substituted "clause (iv)", effective as if included in the enactment of BIPA.

[546] P.L. 108–173, §948(c)(3), struck out "subparagraph (A)" and substituted "paragraph (1)(A)", effective as if included in the enactment of BIPA.

(A) IN GENERAL.—Not later than December 1 of each year, beginning in 2001, the Secretary shall submit to Congress a report that sets forth a detailed compilation of the actual time periods that were necessary to complete and fully implement national coverage determinations that were made in the previous fiscal year for items, services, or medical devices not previously covered as a benefit under this title, including, with respect to each new item, service, or medical device, a statement of the time taken by the Secretary to make and implement the necessary coverage, coding, and payment determinations, including the time taken to complete each significant step in the process of making and implementing such determinations.

(B) PUBLICATION OF REPORTS ON THE INTERNET.—The Secretary shall publish each report submitted under clause (i) on the medicare Internet site of the Department of Health and Human Services.

(8) CONSTRUCTION.—Nothing in this subsection shall be construed as permitting administrative or judicial review pursuant to this section insofar as such review is explicitly prohibited or restricted under another provision of law.

(g)[547] QUALIFICATIONS OF REVIEWERS.—

(1) IN GENERAL.—In reviewing determinations under this section, a qualified independent contractor shall assure that—

(A) each individual conducting a review shall meet the qualifications of paragraph (2);

(B) compensation provided by the contractor to each such reviewer is consistent with paragraph (3); and

(C) in the case of a review by a panel described in subsection (c)(3)(B) composed of physicians or other health care professionals (each in this subsection referred to as a "reviewing professional"), a reviewing professional meets the qualifications described in paragraph (4) and, where a claim is regarding the furnishing of treatment by a physician (allopathic or osteopathic) or the provision of items or services by a physician (allopathic or osteopathic), a reviewing professional shall be a physician (allopathic or osteopathic).

(2) INDEPENDENCE.—

(A) IN GENERAL.—Subject to subparagraph (B), each individual conducting a review in a case shall—

(i) not be a related party (as defined in paragraph (5));

(ii) not have a material familial, financial, or professional relationship with such a party in the case under review; and

(iii) not otherwise have a conflict of interest with such a party.

(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

(i) prohibit an individual, solely on the basis of a participation agreement with a fiscal intermediary,

[547] P.L. 108–173, §933(d)(2)(B), added subsection (g), effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA (114 Stat. 2763A-534).

carrier, or other contractor, from serving as a reviewing professional if—

(I) the individual is not involved in the provision of items or services in the case under review;

(II) the fact of such an agreement is disclosed to the Secretary and the individual entitled to benefits under part A or enrolled under part B, or both, or such individual's authorized representative, and neither party objects; and

(III) the individual is not an employee of the intermediary, carrier, or contractor and does not provide services exclusively or primarily to or on behalf of such intermediary, carrier, or contractor;

(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as a reviewer merely on the basis of having such staff privileges if the existence of such privileges is disclosed to the Secretary and such individual (or authorized representative), and neither party objects; or

(iii) prohibit receipt of compensation by a reviewing professional from a contractor if the compensation is provided consistent with paragraph (3).

For purposes of this paragraph, the term "participation agreement" means an agreement relating to the provision of health care services by the individual and does not include the provision of services as a reviewer under this subsection.

(3) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by a qualified independent contractor to a reviewer in connection with a review under this section shall not be contingent on the decision rendered by the reviewer.

(4) LICENSURE AND EXPERTISE.—Each reviewing professional shall be—

(A) a physician (allopathic or osteopathic) who is appropriately credentialed or licensed in one or more States to deliver health care services and has medical expertise in the field of practice that is appropriate for the items or services at issue; or

(B) a health care professional who is legally authorized in one or more States (in accordance with State law or the State regulatory mechanism provided by State law) to furnish the health care items or services at issue and has medical expertise in the field of practice that is appropriate for such items or services.

(5) RELATED PARTY DEFINED.—For purposes of this section, the term "related party" means, with respect to a case under this title involving a specific individual entitled to benefits under part A or enrolled under part B, or both, any of the following:

(A) The Secretary, the medicare administrative contractor involved, or any fiduciary, officer, director, or employee of the Department of Health and Human Services, or of such contractor.

(B) The individual (or authorized representative).

(C) The health care professional that provides the items or services involved in the case.

(D) The institution at which the items or services (or treatment) involved in the case are provided.

(E) The manufacturer of any drug or other item that is included in the items or services involved in the case.

(F) Any other party determined under any regulations to have a substantial interest in the case involved.

(h)[548] PRIOR DETERMINATION PROCESS FOR CERTAIN ITEMS AND SERVICES.—

(1) ESTABLISHMENT OF PROCESS.—

(A) IN GENERAL.—With respect to a medicare administrative contractor that has a contract under section 1874A that provides for making payments under this title with respect to physicians' services (as defined in section 1848(j)(3)), the Secretary shall establish a prior determination process that meets the requirements of this subsection and that shall be applied by such contractor in the case of eligible requesters.

(B) ELIGIBLE REQUESTER.—For purposes of this subsection, each of the following shall be an eligible requester:

(i) A participating physician, but only with respect to physicians' services to be furnished to an individual who is entitled to benefits under this title and who has consented to the physician making the request under this subsection for those physicians' services.

(ii) An individual entitled to benefits under this title, but only with respect to a physicians' service for which the individual receives, from a physician, an advance beneficiary notice under section 1879(a).

(2) SECRETARIAL FLEXIBILITY.—The Secretary shall establish by regulation reasonable limits on the physicians' services for which a prior determination of coverage may be requested under this subsection. In establishing such limits, the Secretary may consider the dollar amount involved with respect to the physicians' service, administrative costs and burdens, and other relevant factors.

(3) REQUEST FOR PRIOR DETERMINATION.—

(A) IN GENERAL.—Subject to paragraph (2), under the process established under this subsection an eligible requester may submit to the contractor a request for a determination, before the furnishing of a physicians' service, as to whether the physicians' service is covered under this title consistent with the applicable requirements of section 1862(a)(1)(A) (relating to medical necessity).

(B) ACCOMPANYING DOCUMENTATION.—The Secretary may require that the request be accompanied by a description of the physicians' service, supporting documentation relating to the medical necessity for the physicians' service, and any other appropriate documentation. In the case of a request submitted by an eligible requester who is described in paragraph (1)(B)(ii), the Secretary may require

[548] P.L. 108–173, §938(a), adds subsection (h), effective not later than 18 months after December 8, 2003, pursuant to §938(b)(1). For the effective date and other provisions relating to the prior determination process and advance beneficiary notices, see Vol. II, P.L. 108-173, §938(b) and (c).

that the request also be accompanied by a copy of the advance beneficiary notice involved.

(4) RESPONSE TO REQUEST.—

(A) IN GENERAL.— Under such process, the contractor shall provide the eligible requester with written notice of a determination as to whether—

(i) the physicians' service is so covered;

(ii) the physicians' service is not so covered; or

(iii) the contractor lacks sufficient information to make a coverage determination with respect to the physicians' service.

(B) CONTENTS OF NOTICE FOR CERTAIN DETERMINATIONS.—

(i) NONCOVERAGE.—If the contractor makes the determination described in subparagraph (A)(ii), the contractor shall include in the notice a brief explanation of the basis for the determination, including on what national or local coverage or noncoverage determination (if any) the determination is based, and a description of any applicable rights under subsection (a).

(ii) INSUFFICIENT INFORMATION.—If the contractor makes the determination described in subparagraph (A)(iii), the contractor shall include in the notice a description of the additional information required to make the coverage determination.

(C) DEADLINE TO RESPOND.—Such notice shall be provided within the same time period as the time period applicable to the contractor providing notice of initial determinations on a claim for benefits under subsection (a)(2)(A).

(D) INFORMING BENEFICIARY IN CASE OF PHYSICIAN REQUEST.—In the case of a request by a participating physician under paragraph (1)(B)(i), the process shall provide that the individual to whom the physicians' service is proposed to be furnished shall be informed of any determination described in subparagraph (A)(ii) (relating to a determination of non-coverage) and the right (referred to in paragraph (6)(B)) to obtain the physicians' service and have a claim submitted for the physicians' service.

(5) BINDING NATURE OF POSITIVE DETERMINATION.—If the contractor makes the determination described in paragraph (4)(A)(i), such determination shall be binding on the contractor in the absence of fraud or evidence of misrepresentation of facts presented to the contractor.

(6) LIMITATION ON FURTHER REVIEW.—

(A) IN GENERAL.—Contractor determinations described in paragraph (4)(A)(ii) or (4)(A)(iii) (relating to pre-service claims) are not subject to further administrative appeal or judicial review under this section or otherwise.

(B) DECISION NOT TO SEEK PRIOR DETERMINATION OR NEGATIVE DETERMINATION DOES NOT IMPACT RIGHT TO OBTAIN SERVICES, SEEK REIMBURSEMENT, OR APPEAL RIGHTS.—Nothing in this subsection shall be construed as affecting the right of an individual who—

(i) decides not to seek a prior determination under this subsection with respect to physicians' services; or

(ii) seeks such a determination and has received a determination described in paragraph (4)(A)(ii), from receiving (and submitting a claim for) such physicians' services and from obtaining administrative or judicial review respecting such claim under the other applicable provisions of this section. Failure to seek a prior determination under this subsection with respect to physicians' service shall not be taken into account in such administrative or judicial review.

(C) NO PRIOR DETERMINATION AFTER RECEIPT OF SERVICES.—Once an individual is provided physicians' services, there shall be no prior determination under this subsection with respect to such physicians' services.

(i)[549] MEDIATION PROCESS FOR LOCAL COVERAGE DETERMINATIONS.—

(1) ESTABLISHMENT OF PROCESS.—The Secretary shall establish a mediation process under this subsection through the use of a physician trained in mediation and employed by the Centers for Medicare and Medicaid Services.

(2) RESPONSIBILITY OF MEDIATOR.—Under the process established in paragraph (1), such a mediator shall mediate in disputes between groups representing providers of services, suppliers (as defined in section 1861(d)), and the medical director for a medicare administrative contractor whenever the regional administrator (as defined by the Secretary) involved determines that there was a systematic pattern and a large volume of complaints from such groups regarding decisions of such director or there is a complaint from the co-chair of the advisory committee for that contractor to such regional administrator regarding such dispute.

OVERPAYMENT ON BEHALF OF INDIVIDUALS AND SETTLEMENT OF CLAIMS FOR BENEFITS ON BEHALF OF DECEASED INDIVIDUALS

SEC. 1870. [42 U.S.C. 1395gg] (a) Any payment under this title to any provider of services or other person with respect to any items or services furnished any individual shall be regarded as a payment to such individual.

(b) Where—

(1) more than the correct amount is paid under this title to a provider of services or other person for items or services furnished an individual and the Secretary determines (A) that, within such period as he may specify, the excess over the correct amount cannot be recouped from such provider of services or other person, or (B) that such provider of services or other person was without fault with respect to the payment of such excess over the correct amount, or

(2) any payment has been made under section 1814(e) to a provider of services or other person for items or services furnished an individual,

proper adjustments shall be made, under regulations prescribed (after consultation with the Railroad Retirement Board) by the Secretary, by decreasing subsequent payments—

[549] P.L. 108–173, §940A(a), added subsection (i), effective December 8, 2003.

(3) to which such individual is entitled under title II of this Act or under the Railroad Retirement Act of 1974[550], as the case may be, or

(4) if such individual dies before such adjustment has been completed, to which any other individual is entitled under title II of this Act or under the Railroad Retirement Act of 1974, as the case may be, with respect to the wages and self-employment income or the compensation constituting the basis of the benefits of such deceased individual under title II of such Act.

As soon as practicable after any adjustment under paragraph (3) or (4) is determined to be necessary, the Secretary, for purposes of this section, section 1817(g), and section 1841(f), shall certify (to the Railroad Retirement Board if the adjustment is to be made by decreasing subsequent payments under the Railroad Retirement Act of 1974) the amount of the overpayment as to which the adjustment is to be made. For purposes of clause (B) of paragraph (1), such provider of services or such other person shall, in the absence of evidence to the contrary, be deemed to be without fault if the Secretary's determination that more than such correct amount was paid was made subsequent to the third year following the year in which notice was sent to such individual that such amount had been paid; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title.

(c) There shall be no adjustment as provided in subsection (b) (nor shall there be recovery) in any case where the incorrect payment has been made (including payments under section 1814(e)) with respect to an individual who is without fault or where the adjustment (or recovery) would be made by decreasing payments to which another person who is without fault is entitled as provided in subsection (b)(4), if such adjustment (or recovery) would defeat the purposes of title II or title XVIII or would be against equity and good conscience. Adjustment or recovery of an incorrect payment (or only such part of an incorrect payment as the Secretary determines to be inconsistent with the purposes of this title) against an individual who is without fault shall be deemed to be against equity and good conscience if (A) the incorrect payment was made for expenses incurred for items or services for which payment may not be made under this title by reason of the provisions of paragraph (1) or (9) of section 1862(a) and (B) if the Secretary's determination that such payment was incorrect was made subsequent to the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title.

(d) No certifying or disbursing officer shall be held liable for any amount certified or paid by him to any provider of services or other person where the adjustment or recovery of such amount is waived under subsection (c) or where adjustment under subsection (b) is not completed prior to the death of all persons against whose benefits such adjustment is authorized.

(e) If an individual, who received services for which payment may be made to such individual under this title, dies, and payment for such services was made (other than under this title), and the

[550] P.L. 75–162 [as amended by P.L. 93–445].

individual died before any payment due him under this title with respect to such services was completed, payment of the amount due (including the amount of any unnegotiated checks) shall be made—

(1) if the payment for such services was made (before or after such individual's death) by a person other than the deceased individual, to the person or persons determined by the Secretary under regulations to have paid for such services, or if the payment for such services was made by the deceased individual before his death, to the legal representative of the estate of such deceased individual, if any;

(2) if there is no person who meets the requirements of paragraph (1), to the person, if any, who is determined by the Secretary to be the surviving spouse of the deceased individual and who was either living in the same household with the deceased at the time of his death or was, for the month in which the deceased individual died, entitled to a monthly benefit on the basis of the same wages and self-employment income as was the deceased individual;

(3) if there is no person who meets the requirements of paragraph (1) or (2), or if the person who meets such requirements dies before the payment due him under this title is completed, to the child or children, if any, of the deceased individual who were, for the month in which the deceased individual died, entitled to monthly benefits on the basis of the same wages and self-employment income as was the deceased individual (and, in case there is more than one such child, in equal parts to each such child);

(4) if there is no person who meets the requirements of paragraph (1), (2), or (3), or if each person who meets such requirements dies before the payment due him under this title is completed, to the parent or parents, if any, of the deceased individual who were, for the month in which the deceased individual died, entitled to monthly benefits on the basis of the same wages and self-employment income as was the deceased individual (and, in case there is more than one such parent, in equal parts to each such parent);

(5) if there is no person who meets the requirements of paragraph (1), (2), (3), or (4), or if each person who meets such requirements dies before the payment due him under this title is completed, to the person, if any, determined by the Secretary to be the surviving spouse of the deceased individual;

(6) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), or (5), or if each person who meets such requirements dies before the payment due him under this title is completed, to the person or persons, if any, determined by the Secretary to be the child or children of the deceased individual (and, in case there is more than one such child, in equal parts to each such child);

(7) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), (5), or (6), or if each person who meets such requirements dies before the payment due him under this title is completed, to the parent or parents, if any, of the deceased individual (and, in case there is more than one such parent, in equal parts to each such parent); or

(8) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), (5), (6), or (7), or if each person who

meets such requirements dies before the payment due him under this title is completed, to the legal representatives of the estate of the deceased individual, if any.

(f)[551] If an individual who received medical and other health services for which payment may be made under section 1832(a)(1) dies, and no assignment of the right to payment for such services was made by such individual before his death, and payment for such services has not been made—

(1) if the person or persons who furnished the services agree to the terms of assignment specified in section 1842(b)(3)(B)(ii) with respect to the services, payment for such services shall be made to such person or persons, and

(2) if the person or persons who furnished the services do not agree to the terms of assignment specified in section 1842(b)(3)(B)(ii) with respect to the services, payment for such services shall be made on the basis of an itemized bill to the person who has agreed to assume the legal obligation to make payment for such services and files a request for payment (with such accompanying evidence of such legal obligation as may be required in regulations),

but only in such amount and subject to such conditions as would be applicable if the individual who received the services had not died.

(g) If an individual, who is enrolled under section 1818(c) of the Social Security Act or under section 1837, dies, and premiums with respect to such enrollment have been received with respect to such individual for any month after the month of his death, such premiums shall be refunded to the person or persons determined by the Secretary under regulations to have paid such premiums or if payment for such premiums was made by the deceased individual before his death, to the legal representative of the estate of such deceased individual, if any. If there is no person who meets the requirements of the preceding sentence such premiums shall be refunded to the person or persons in the priorities specified in paragraphs (2) through (7) of subsection (e).

(h)[552] Notwithstanding subsection (f) or any other provision of law, the Secretary shall permit a provider of services or supplier to appeal any determination of the Secretary under this title relating to services rendered under this title to an individual who subsequently dies if there is no other party available to appeal such determination.

REGULATIONS

SEC. 1871. [42 U.S.C. 1395hh] (a)(1) The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this title. When used in this title, the term "regulations" means, unless the context otherwise requires, regulations prescribed by the Secretary.

(2) No rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of

[551] See Vol. II, P.L. 99–177, §256, with respect to special rules applicable to the Medicare program.

[552] P.L. 108–173, §939(a), added subsection (h), effective December 8, 2003 and applicable to items and services furnished on or after December 8, 2003.

benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this title shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1).

(3)[553](A) The Secretary, in consultation with the Director of the Office of Management and Budget, shall establish and publish a regular timeline for the publication of final regulations based on the previous publication of a proposed regulation or an interim final regulation.

(B) Such timeline may vary among different regulations based on differences in the complexity of the regulation, the number and scope of comments received, and other relevant factors, but shall not be longer than 3 years except under exceptional circumstances. If the Secretary intends to vary such timeline with respect to the publication of a final regulation, the Secretary shall cause to have published in the Federal Register notice of the different timeline by not later than the timeline previously established with respect to such regulation. Such notice shall include a brief explanation of the justification for such variation.

(C) In the case of interim final regulations, upon the expiration of the regular timeline established under this paragraph for the publication of a final regulation after opportunity for public comment, the interim final regulation shall not continue in effect unless the Secretary publishes (at the end of the regular timeline and, if applicable, at the end of each succeeding 1-year period) a notice of continuation of the regulation that includes an explanation of why the regular timeline (and any subsequent 1-year extension) was not complied with. If such a notice is published, the regular timeline (or such timeline as previously extended under this paragraph) for publication of the final regulation shall be treated as having been extended for 1 additional year.

(D) The Secretary shall annually submit to Congress a report that describes the instances in which the Secretary failed to publish a final regulation within the applicable regular timeline under this paragraph and that provides an explanation for such failures.

(4)[554] If the Secretary publishes a final regulation that includes a provision that is not a logical outgrowth of a previously published notice of proposed rulemaking or interim final rule, such provision shall be treated as a proposed regulation and shall not take effect until there is the further opportunity for public comment and a publication of the provision again as a final regulation.

(b)(1) Except as provided in paragraph (2), before issuing in final form any regulation under subsection (a), the Secretary shall provide for notice of the proposed regulation in the Federal Register and a period of not less than 60 days for public comment thereon.

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[553] P.L. 108–173, §902(a)(1), added paragraph (3), effective December 8, 2003 and "The Secretary shall provide for an appropriate transition to take into account the backlog of previously published interim final regulations.", pursuant to §902(a)(2).

[554] P.L. 108–173, §902(b)(1), added paragraph (4), effective December 8, 2003 and applicable to final regulations published on or after December 8, 2003.

(2) Paragraph (1) shall not apply where—

(A) a statute specifically permits a regulation to be issued in interim final form or otherwise with a shorter period for public comment,

(B) a statute establishes a specific deadline for the implementation of a provision and the deadline is less than 150 days after the date of the enactment of the statute in which the deadline is contained, or

(C) subsection (b) of section 553 of title 5, United States Code[555], does not apply pursuant to subparagraph (B) of such subsection.

(c)(1) The Secretary shall publish in the Federal Register, not less frequently than every 3 months, a list of all manual instructions, interpretative rules, statements of policy, and guidelines of general applicability which—

(A) are promulgated to carry out this title, but

(B) are not published pursuant to subsection (a)(1) and have not been previously published in a list under this subsection.

(2) Effective June 1, 1988, each fiscal intermediary and carrier administering claims for extended care, post-hospital extended care, home health care, and durable medical equipment benefits under this title shall make available to the public all interpretative materials, guidelines, and clarifications of policies which relate to payments for such benefits.

(3) The Secretary shall to the extent feasible make such changes in automated data collection and retrieval by the Secretary and fiscal intermediaries with agreements under section 1816 as are necessary to make easily accessible for the Secretary and other appropriate parties a data base which fairly and accurately reflects the provision of extended care, post-hospital extended care and home health care benefits pursuant to this title, including such categories as benefit denials, results of appeals, and other relevant factors, and selectable by such categories and by fiscal intermediary, service provider, and region.

(e)[556] (1)(A) A substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this title shall not be applied (by extrapolation or otherwise) retroactively to items and services furnished before the effective date of the change, unless the Secretary determines that—

(i) such retroactive application is necessary to comply with statutory requirements; or

(ii) failure to apply the change retroactively would be contrary to the public interest.

(B)[557](i) Except as provided in clause (ii), a substantive change referred to in subparagraph (A) shall not become effective before the end of the 30-day period that begins on

[555] See Vol. II, Title 5, §553.

[556] As in original. There is no subsection (d).

P.L. 108–173, §903(a)(1), added subsection (e), applicable to substantive changes issued on or after December 8, 2003.

[557] P.L. 108–173, §903(b)(1), added subparagraph (B), effective December 8, 2003 and applicable to compliance actions undertaken on or after December 8, 2003.

the date that the Secretary has issued or published, as the case may be, the substantive change.

(ii) The Secretary may provide for such a substantive change to take effect on a date that precedes the end of the 30-day period under clause (i) if the Secretary finds that waiver of such 30-day period is necessary to comply with statutory requirements or that the application of such 30-day period is contrary to the public interest. If the Secretary provides for an earlier effective date pursuant to this clause, the Secretary shall include in the issuance or publication of the substantive change a finding described in the first sentence, and a brief statement of the reasons for such finding.

(C) No action shall be taken against a provider of services or supplier with respect to noncompliance with such a substantive change for items and services furnished before the effective date of such a change.

(2)[558](A) If—

(i) a provider of services or supplier follows the written guidance (which may be transmitted electronically) provided by the Secretary or by a medicare contractor (as defined in section 1889(g)) acting within the scope of the contractor's contract authority, with respect to the furnishing of items or services and submission of a claim for benefits for such items or services with respect to such provider or supplier;

(ii) the Secretary determines that the provider of services or supplier has accurately presented the circumstances relating to such items, services, and claim to the contractor in writing; and

(iii) the guidance was in error;

the provider of services or supplier shall not be subject to any penalty or interest under this title or the provisions of title XI insofar as they relate to this title (including interest under a repayment plan under section 1893 or otherwise) relating to the provision of such items or service or such claim if the provider of services or supplier reasonably relied on such guidance.

(B) Subparagraph (A) shall not be construed as preventing the recoupment or repayment (without any additional penalty) relating to an overpayment insofar as the overpayment was solely the result of a clerical or technical operational error.

(f)[559] (1) Not later than 2 years after the date of the enactment of this subsection, and every 3 years thereafter, the Secretary shall submit to Congress a report with respect to the administration of this title and areas of inconsistency or conflict among the various provisions under law and regulation.

(2) In preparing a report under paragraph (1), the Secretary shall collect—

(A) information from individuals entitled to benefits under part A or enrolled under part B, or both, providers of services, and suppliers and from the Medicare Bene-

[558] P.L. 108–173, §903(c)(1), added paragraph (2), applicable to a penalty or interest imposed with respect to guidance provided on or after July 24, 2003.

[559] P.L. 108–173, §904(b), added subsection (f), effective December 8, 2003.

ficiary Ombudsman with respect to such areas of inconsistency and conflict; and

(B) information from medicare contractors that tracks the nature of written and telephone inquiries.

(3) A report under paragraph (1) shall include a description of efforts by the Secretary to reduce such inconsistency or conflicts, and recommendations for legislation or administrative action that the Secretary determines appropriate to further reduce such inconsistency or conflicts.

APPLICATION OF CERTAIN PROVISIONS OF TITLE II

SEC. 1872. [42 U.S.C. 1395ii] The provisions of sections 206 and 216(j), and of subsections (a), (d), (e), (h), (i), (j), (k), and (l) of section 205, shall also apply with respect to this title to the same extent as they are applicable with respect to title II, except that, in applying such provisions with respect to this title, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

DESIGNATION OF ORGANIZATION OR PUBLICATION BY NAME

SEC. 1873. [42 U.S.C. 1395jj] Designation in this title, by name, of any nongovernmental organization or publication shall not be affected by change of name of such organization or publication, and shall apply to any successor organization or publication which the Secretary finds serves the purpose for which such designation is made.

ADMINISTRATION

SEC. 1874. [42 U.S.C. 1395kk] (a) Except as otherwise provided in this title and in the Railroad Retirement Act of 1974[560], the insurance programs established by this title shall be administered by the Secretary. The Secretary may perform any of his functions under this title directly, or by contract providing for payment in advance or by way of reimbursement, and in such installments, as the Secretary may deem necessary.

(b) The Secretary may contract with any person, agency, or institution to secure on a reimbursable basis such special data, actuarial information, and other information as may be necessary in the carrying out of his functions under this title.

(c) In the course of any hearing, investigation, or other proceeding that he is authorized to conduct under this title, the Secretary may administer oaths and affirmations.

CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS[561]

SEC. 1874A. [42 U.S.C. 1395kk-1] (a) AUTHORITY.—

(1) AUTHORITY TO ENTER INTO CONTRACTS.—The Secretary may enter into contracts with any eligible entity to serve as a

[560] P.L. 75–162 [as amended by P.L. 93–445].

[561] P.L. 108-173, §911(a)(1), adds §1874A, to be effective October 1, 2005, pursuant to §911(d). For §911(d), see Vol. II, P.L. 108-173.

See Vol. II, P.L. 108-173, §901(a), with respect to construction of title IX of P.L. 108-173; §911(f), with respect to the Secretary's submission of a legislative proposal; §911(g), with respect

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medicare administrative contractor with respect to the performance of any or all of the functions described in paragraph (4) or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other entities).

(2) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract with respect to the performance of a particular function described in paragraph (4) only if—

(A) the entity has demonstrated capability to carry out such function;

(B) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement;

(C) the entity has sufficient assets to financially support the performance of such function; and

(D) the entity meets such other requirements as the Secretary may impose.

(3) MEDICARE ADMINISTRATIVE CONTRACTOR DEFINED.—For purposes of this title and title XI—

(A) IN GENERAL.—The term "medicare administrative contractor" means an agency, organization, or other person with a contract under this section.

(B) APPROPRIATE MEDICARE ADMINISTRATIVE CONTRACTOR.—With respect to the performance of a particular function in relation to an individual entitled to benefits under part A or enrolled under part B, or both, a specific provider of services or supplier (or class of such providers of services or suppliers), the "appropriate" medicare administrative contractor is the medicare administrative contractor that has a contract under this section with respect to the performance of that function in relation to that individual, provider of services or supplier or class of provider of services or supplier.

(4) FUNCTIONS DESCRIBED.—The functions referred to in paragraphs (1) and (2) are payment functions (including the function of developing local coverage determinations, as defined in section 1869(f)(2)(B)), provider services functions, and functions relating to services furnished to individuals entitled to benefits under part A or enrolled under part B, or both, as follows:

(A) DETERMINATION OF PAYMENT AMOUNTS.—Determining (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this title to be made to providers of services, suppliers and individuals.

(B) MAKING PAYMENTS.—Making payments described in subparagraph (A) (including receipt, disbursement, and accounting for funds in making such payments).

(C) BENEFICIARY EDUCATION AND ASSISTANCE.—Providing education and outreach to individuals entitled to benefits under part A or enrolled under part B, or both, and providing assistance to those individuals with specific issues, concerns, or problems.

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to reports on the plan for, and status of, implementation of §1874A and §941A, with respect to policy development regarding evaluation and management documentation guidelines.

(D) PROVIDER CONSULTATIVE SERVICES.—Providing consultative services to institutions, agencies, and other persons to enable them to establish and maintain fiscal records necessary for purposes of this title and otherwise to qualify as providers of services or suppliers.

(E) COMMUNICATION WITH PROVIDERS.—Communicating to providers of services and suppliers any information or instructions furnished to the medicare administrative contractor by the Secretary, and facilitating communication between such providers and suppliers and the Secretary.

(F) PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.—Performing the functions relating to provider education, training, and technical assistance.

(G) ADDITIONAL FUNCTIONS.—Performing such other functions, including (subject to paragraph (5)) functions under the Medicare Integrity Program under section 1893, as are necessary to carry out the purposes of this title.

(5) RELATIONSHIP TO MIP CONTRACTS.—

(A) NONDUPLICATION OF DUTIES.—In entering into contracts under this section, the Secretary shall assure that functions of medicare administrative contractors in carrying out activities under parts A and B do not duplicate activities carried out under a contract entered into under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5) (relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).

(B) CONSTRUCTION.—An entity shall not be treated as a medicare administrative contractor merely by reason of having entered into a contract with the Secretary under section 1893.

(6) APPLICATION OF FEDERAL ACQUISITION REGULATION.—Except to the extent inconsistent with a specific requirement of this section, the Federal Acquisition Regulation applies to contracts under this section.

(b)[562] CONTRACTING REQUIREMENTS.—

(1) USE OF COMPETITIVE PROCEDURES.—

(A) IN GENERAL.—Except as provided in laws with general applicability to Federal acquisition and procurement or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts with medicare administrative contractors under this section, taking into account performance quality as well as price and other factors.

(B) RENEWAL OF CONTRACTS.—The Secretary may renew a contract with a medicare administrative contractor under this section from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the medicare administrative contractor has met or exceeded the performance requirements applicable with respect to the contract and contractor, except that the Secretary shall provide for the

[562] See Vol. II, P.L. 108-173, §911(a)(2), with respect to consideration of incorporation of current law standards.

application of competitive procedures under such a contract not less frequently than once every 5 years.

(C) TRANSFER OF FUNCTIONS.—The Secretary may transfer functions among medicare administrative contractors consistent with the provisions of this paragraph. The Secretary shall ensure that performance quality is considered in such transfers. The Secretary shall provide public notice (whether in the Federal Register or otherwise) of any such transfer (including a description of the functions so transferred, a description of the providers of services and suppliers affected by such transfer, and contact information for the contractors involved).

(D) INCENTIVES FOR QUALITY.—The Secretary shall provide incentives for medicare administrative contractors to provide quality service and to promote efficiency.

(2) COMPLIANCE WITH REQUIREMENTS.—No contract under this section shall be entered into with any medicare administrative contractor unless the Secretary finds that such medicare administrative contractor will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, quality of services provided, and other matters as the Secretary finds pertinent.

(3) PERFORMANCE REQUIREMENTS.—

(A) DEVELOPMENT OF SPECIFIC PERFORMANCE REQUIREMENTS.—

(i) IN GENERAL.—The Secretary shall develop contract performance requirements to carry out the specific requirements applicable under this title to a function described in subsection (a)(4) and shall develop standards for measuring the extent to which a contractor has met such requirements.

Such requirements shall include specific performance duties expected of a medical director of a medicare administrative contractor, including requirements relating to professional relations and the availability of such director to conduct medical determination activities within the jurisdiction of such a contractor

(ii) CONSULTATION.—In developing such performance requirements and standards for measurement, the Secretary shall consult with providers of services, organizations representative of beneficiaries under this title, and organizations and agencies performing functions necessary to carry out the purposes of this section with respect to such performance requirements.

(iii) PUBLICATION OF STANDARDS.—The Secretary shall make such performance requirements and measurement standards available to the public.

(B) CONSIDERATIONS.—The Secretary shall include, as one of the standards developed under subparagraph (A), provider and beneficiary satisfaction levels.

(C) INCLUSION IN CONTRACTS.—All contractor performance requirements shall be set forth in the contract between the Secretary and the appropriate medicare administrative contractor. Such performance requirements—

(i) shall reflect the performance requirements published under subparagraph (A), but may include additional performance requirements;

(ii) shall be used for evaluating contractor performance under the contract; and

(iii) shall be consistent with the written statement of work provided under the contract.

(4) INFORMATION REQUIREMENTS.—The Secretary shall not enter into a contract with a medicare administrative contractor under this section unless the contractor agrees—

(A) to furnish to the Secretary such timely information and reports as the Secretary may find necessary in performing his functions under this title; and

(B) to maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (A) and otherwise to carry out the purposes of this title.

(5) SURETY BOND.—A contract with a medicare administrative contractor under this section may require the medicare administrative contractor, and any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

(c) TERMS AND CONDITIONS.—

(1) IN GENERAL.—A contract with any medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the medicare administrative contractor for the making of payments by it under subsection (a)(4)(B).

(2) PROHIBITION ON MANDATES FOR CERTAIN DATA COLLECTION.—The Secretary may not require, as a condition of entering into, or renewing, a contract under this section, that the medicare administrative contractor match data obtained other than in its activities under this title with data used in the administration of this title for purposes of identifying situations in which the provisions of section 1862(b) may apply.

(d) LIMITATION ON LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTORS AND CERTAIN OFFICERS.—

(1) CERTIFYING OFFICER.—No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of the reckless disregard of the individual's obligations or the intent by that individual to defraud the United States, be liable with respect to any payments certified by the individual under this section.

(2) DISBURSING OFFICER.—No disbursing officer shall, in the absence of the reckless disregard of the officer's obligations or the intent by that officer to defraud the United States, be liable with respect to any payment by such officer under this section if it was based upon an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General of the United States) of a certifying officer designated as provided in paragraph (1) of this subsection.

(3) LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTOR.—

(A) IN GENERAL.—No medicare administrative contractor shall be liable to the United States for a payment by a certifying or disbursing officer unless, in connection with such payment, the medicare administrative contractor acted with reckless disregard of its obligations under its medicare administrative contract or with intent to defraud the United States.

(B) RELATIONSHIP TO FALSE CLAIMS ACT.—Nothing in this subsection shall be construed to limit liability for conduct that would constitute a violation of sections 3729 through 3731 of title 31, United States Code[563].

(4) INDEMNIFICATION BY SECRETARY.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (D), in the case of a medicare administrative contractor (or a person who is a director, officer, or employee of such a contractor or who is engaged by the contractor to participate directly in the claims administration process) who is made a party to any judicial or administrative proceeding arising from or relating directly to the claims administration process under this title, the Secretary may, to the extent the Secretary determines to be appropriate and as specified in the contract with the contractor, indemnify the contractor and such persons.

(B) CONDITIONS.—The Secretary may not provide indemnification under subparagraph (A) insofar as the liability for such costs arises directly from conduct that is determined by the judicial proceeding or by the Secretary to be criminal in nature, fraudulent, or grossly negligent. If indemnification is provided by the Secretary with respect to a contractor before a determination that such costs arose directly from such conduct, the contractor shall reimburse the Secretary for costs of indemnification.

(C) SCOPE OF INDEMNIFICATION.—Indemnification by the Secretary under subparagraph (A) may include payment of judgments, settlements (subject to subparagraph (D)), awards, and costs (including reasonable legal expenses).

(D) WRITTEN APPROVAL FOR SETTLEMENTS OR COMPROMISES.—A contractor or other person described in subparagraph (A) may not propose to negotiate a settlement or compromise of a proceeding described in such subparagraph without the prior written approval of the Secretary to negotiate such settlement or compromise. Any indemnification under subparagraph (A) with respect to amounts paid under a settlement or compromise of a proceeding described in such subparagraph are conditioned upon prior written approval by the Secretary of the final settlement or compromise.

(E) CONSTRUCTION.—Nothing in this paragraph shall be construed—

(i) to change any common law immunity that may be available to a medicare administrative contractor or person described in subparagraph (A); or

[563] See Vol. II, Title 31, §§3729 - 3731.

(ii) to permit the payment of costs not otherwise allowable, reasonable, or allocable under the Federal Acquisition Regulation.

(e)[564] REQUIREMENTS FOR INFORMATION SECURITY.—

(1) DEVELOPMENT OF INFORMATION SECURITY PROGRAM.—A medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) shall implement a contractor-wide information security program to provide information security for the operation and assets of the contractor with respect to such functions under this title. An information security program under this paragraph shall meet the requirements for information security programs imposed on Federal agencies under paragraphs (1) through (8) of section 3544(b) of title 44, United States Code (other than the requirements under paragraphs (2)(D)(i), (5)(A), and (5)(B) of such section).

(2) INDEPENDENT AUDITS.—

(A) PERFORMANCE OF ANNUAL EVALUATIONS.—Each year a medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) shall undergo an evaluation of the information security of the contractor with respect to such functions under this title. The evaluation shall—

(i) be performed by an entity that meets such requirements for independence as the Inspector General of the Department of Health and Human Services may establish; and

(ii) test the effectiveness of information security control techniques of an appropriate subset of the contractor's information systems (as defined in section 3502(8) of title 44, United States Code) relating to such functions under this title and an assessment of compliance with the requirements of this subsection and related information security policies, procedures, standards and guidelines, including policies and procedures as may be prescribed by the Director of the Office of Management and Budget and applicable information security standards promulgated under section 11331 of title 40, United States Code.

(B) DEADLINE FOR INITIAL EVALUATION.—

(i) NEW CONTRACTORS.—In the case of a medicare administrative contractor covered by this subsection that has not previously performed the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) as a fiscal intermediary or carrier under section 1816 or 1842, the first independent evaluation conducted pursuant to subparagraph (A) shall be completed prior to commencing such functions.

(ii) OTHER CONTRACTORS.—In the case of a medicare administrative contractor covered by this subsection

[564] P.L. 108-173, §912(a), added subsection (e), effective December 8, 2003.
See Vol. II, P.L. 108-173, §912(b) with respect to the application of requirements to fiscal intermediaries and carriers.

that is not described in clause (i), the first independent evaluation conducted pursuant to subparagraph (A) shall be completed within 1 year after the date the contractor commences functions referred to in clause (i) under this section.

(C) REPORTS ON EVALUATIONS.—

(i) TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.—The results of independent evaluations under subparagraph (A) shall be submitted promptly to the Inspector General of the Department of Health and Human Services and to the Secretary.

(ii) TO CONGRESS.—The Inspector General of the Department of Health and Human Services shall submit to Congress annual reports on the results of such evaluations, including assessments of the scope and sufficiency of such evaluations.

(iii) AGENCY REPORTING.—The Secretary shall address the results of such evaluations in reports required under section 3544(c) of title 44, United States Code.

(f)[565] INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE IN PROVIDER EDUCATION AND OUTREACH.—The Secretary shall use specific claims payment error rates or similar methodology of medicare administrative contractors in the processing or reviewing of medicare claims in order to give such contractors an incentive to implement effective education and outreach programs for providers of services and suppliers.

(g)[566] COMMUNICATIONS WITH BENEFICIARIES, PROVIDERS OF SERVICES AND SUPPLIERS.—

(1) Communication strategy.—THE SECRETARY SHALL DEVELOP A STRATEGY FOR COMMunications with individuals entitled to benefits under part A or enrolled under part B, or both, and with providers of services and suppliers under this title.

(2) RESPONSE TO WRITTEN INQUIRIES.—Each medicare administrative contractor shall, for those providers of services and suppliers which submit claims to the contractor for claims processing and for those individuals entitled to benefits under part A or enrolled under part B, or both, with respect to whom claims are submitted for claims processing, provide general written responses (which may be through electronic transmission) in a clear, concise, and accurate manner to inquiries of providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, concerning the programs under this title within 45 business days of the date of receipt of such inquiries.

(3) RESPONSE TO TOLL-FREE LINES.—The Secretary shall ensure that each medicare administrative contractor shall provide, for those providers of services and suppliers which submit claims to the contractor for claims processing and for those individuals entitled to benefits under part A or enrolled under part B, or both, with respect to whom claims are submitted for

[565] P.L. 108–173, §921(b)(1), added subsection (f), effective December 8, 2003.

See Vol. II, P.L. 108-173, §921(b)(2), with respect to the application to fiscal intermediaries and carriers, §921(b)(3), with respect to a GAO report on adequacy of methodology, and §921(b)(4), with respect to a report on use of methodology in assessing contractor performance.

[566] P.L. 108-173, §921(c)(1), added subsection (g), effective October 1, 2004.

claims processing, a toll-free telephone number at which such individuals, providers of services, and suppliers may obtain information regarding billing, coding, claims, coverage, and other appropriate information under this title.

(4) Monitoring of contractor responses.—

(A) IN GENERAL.—Each medicare administrative contractor shall, consistent with standards developed by the Secretary under subparagraph (B)—

(i) maintain a system for identifying who provides the information referred to in paragraphs (2) and (3); and

(ii) monitor the accuracy, consistency, and timeliness of the information so provided.

(B) DEVELOPMENT OF STANDARDS.—

(i) IN GENERAL.—The Secretary shall establish and make public standards to monitor the accuracy, consistency, and timeliness of the information provided in response to written and telephone inquiries under this subsection. Such standards shall be consistent with the performance requirements established under subsection (b)(3).

(ii) EVALUATION.—In conducting evaluations of individual medicare administrative contractors, the Secretary shall take into account the results of the monitoring conducted under subparagraph (A) taking into account as performance requirements the standards established under clause (i). The Secretary shall, in consultation with organizations representing providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, establish standards relating to the accuracy, consistency, and timeliness of the information so provided.

(C) DIRECT MONITORING.—Nothing in this paragraph shall be construed as preventing the Secretary from directly monitoring the accuracy, consistency, and timeliness of the information so provided.

(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this subsection.

(h)[567] Conduct of Prepayment Review.—

(1) CONDUCT OF RANDOM PREPAYMENT REVIEW.—

(A) IN GENERAL.—A medicare administrative contractor may conduct random prepayment review only to develop a contractor-wide or program-wide claims payment error rates or under such additional circumstances as may be provided under regulations, developed in consultation with providers of services and suppliers.

(B) USE OF STANDARD PROTOCOLS WHEN CONDUCTING PREPAYMENT REVIEWS.—When a medicare administrative contractor conducts a random prepayment review, the contractor may conduct such review only in accordance with

[567] P.L. 108-173, §934(a), added subsection (h). For the effective date, see Vol. II, P.L. 108-173, §934(b).

See Vol. II, P.L. 108-173, §934(c), with respect to the application to fiscal intermediaries and carriers.

a standard protocol for random prepayment audits developed by the Secretary.

(C) CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing the denial of payments for claims actually reviewed under a random prepayment review.

(D) RANDOM PREPAYMENT REVIEW.—For purposes of this subsection, the term "random prepayment review" means a demand for the production of records or documentation absent cause with respect to a claim.

(2) Limitations on non-random prepayment review.—

(A) LIMITATIONS ON INITIATION OF NON-RANDOM PREPAYMENT REVIEW.—A medicare administrative contractor may not initiate non-random prepayment review of a provider of services or supplier based on the initial identification by that provider of services or supplier of an improper billing practice unless there is a likelihood of sustained or high level of payment error under section 1893(f)(3)(A).

(B) TERMINATION OF NON-RANDOM PREPAYMENT REVIEW.—The Secretary shall issue regulations relating to the termination, including termination dates, of non-random prepayment review. Such regulations may vary such a termination date based upon the differences in the circumstances triggering prepayment review.

STUDIES AND RECOMMENDATIONS [568]

SEC. 1875. [42 U.S.C. 1395ll] (a) The Secretary shall carry on studies and develop recommendations to be submitted from time to time to the Congress relating to health care of the aged and the disabled, including studies and recommendations concerning (1) the adequacy of existing personnel and facilities for health care for purposes of the programs under parts A and B; (2) methods for encouraging the further development of efficient and economical forms of health care which are a constructive alternative to inpatient hospital care; and (3) the effects of the deductibles and coinsurance provisions upon beneficiaries, persons who provide health services, and the financing of the program.

(b) The Secretary shall make a continuing study of the operation and administration of this title [569] (including a validation of the accreditation process of the Joint Commission on Accreditation of Hospitals, the operation and administration of health maintenance organizations authorized by section 226 of the Social Security Amendments of 1972, [570] the experiments and demonstration projects authorized by section 402 of the Social Security Amendments of 1967 [571] and the experiments and demonstration projects authorized by section 222(a) of the Social Security Amendments of

[568] See Vol. II, P.L. 106–113, §1000(a)(6) [211(c)], with respect to a study and report regarding the utilization of physicians' services by Medicare beneficiaries.

See Vol. II, P.L. 106–554, §1(a)(6) [413], with respect to a study on enrollment procedures for groups that retain independent contractor physicians and [437], with respect to GAO studies and reports on Medicare payments.

See Vol. II, P.L. 108-173, §238, with respect to the Institute of Medicine evaluation and a report on health care performance measures and §604, with respect to a GAO study on access to physicians' services.

[569] P.L. 108–173, §101(e)(7), struck out "the insurance programs under parts A and B" and substituted "this title", effective December 8, 2003.

[570] See Vol. II, P.L. 92–603.

[571] See Vol. II, P.L. 90–248.

1972), and shall transmit to the Congress annually a report concerning the operation of such programs.

PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS[572]

SEC. 1876. [42 U.S.C. 1395mm] (a)(1)(A) The Secretary shall annually determine, and shall announce (in a manner intended to provide notice to interested parties) not later than September 7 before the calendar year concerned—

(i) a per capita rate of payment for each class of individuals who are enrolled under this section with an eligible organization which has entered into a risk-sharing contract and who are entitled to benefits under part A and enrolled under part B, and

(ii) a per capita rate of payment for each class of individuals who are so enrolled with such an organization and who are enrolled under part B only.

For purposes of this section, the term "risk-sharing contract" means a contract entered into under subsection (g) and the term "reasonable cost reimbursement contract" means a contract entered into under subsection (h).

(B) The Secretary shall define appropriate classes of members, based on age, disability status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such classes, if such changes will improve the determination of actuarial equivalence.

(C) The annual per capita rate of payment for each such class shall be equal to 95 percent of the adjusted average per capita cost (as defined in paragraph (4)) for that class.

(D) In the case of an eligible organization with a risk-sharing contract, the Secretary shall make monthly payments in advance and in accordance with the rate determined under subparagraph (C) and except as provided in subsection (g)(2), to the organization for each individual enrolled with the organization under this section.

(E)(i) The amount of payment under this paragraph may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled in the plan under this section and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

(ii)(I) Subject to subclause (II), the Secretary may make retroactive adjustments under clause (i) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with an eligible organization (which has a risk-sharing contract under this section) under a health benefit plan operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is en-

[572] See Vol. II, P.L. 99–509, §9312(h), with respect to disenrollment.
See Vol. II, P.L. 100–203, §4012(c), with respect to data which the Secretary shall provide to eligible organizations.

rolled in the plan under this section, except that for purposes of making such retroactive adjustments under this clause, such period may not exceed 90 days.

(II) No adjustment may be made under subclause (I) with respect to any individual who does not certify that the organization provided the individual with the explanation described in subsection (c)(3)(E) at the time the individual enrolled with the organization.

(F)(i) At least 45 days before making the announcement under subparagraph (A) for a year (beginning with the announcement for 1991), the Secretary shall provide for notice to eligible organizations of proposed changes to be made in the methodology or benefit coverage assumptions from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

(ii) In each announcement made under subparagraph (A) for a year (beginning with the announcement for 1991), the Secretary shall include an explanation of the assumptions (including any benefit coverage assumptions) and changes in methodology used in the announcement in sufficient detail so that eligible organizations can compute per capita rates of payment for classes of individuals located in each county (or equivalent area) which is in whole or in part within the service area of such an organization.

(2) With respect to any eligible organization which has entered into a reasonable cost reimbursement contract, payments shall be made to such plan in accordance with subsection (h)(2) rather than paragraph (1).

(3) Subject to subsections (c)(2)(B)(ii) and (c)(7) payments under a contract to an eligible organization under paragraph (1) or (2) shall be instead of the amounts which (in the absence of the contract) would be otherwise payable, pursuant to sections 1814(b) and 1833(a), for services furnished by or through the organization to individuals enrolled with the organization under this section.

(4) For purposes of this section, the term "adjusted average per capita cost" means the average per capita amount that the Secretary estimates in advance (on the basis of actual experience, or retrospective actuarial equivalent based upon an adequate sample and other information and data, in a geographic area served by an eligible organization or in a similar area, with appropriate adjustments to assure actuarial equivalence) would be payable in any contract year for services covered under parts A and B, or part B only, and types of expenses otherwise reimbursable under parts A and B, or part B only (including administrative costs incurred by organizations described in sections 1816 and 1842), if the services were to be furnished by other than an eligible organization or, in the case of services covered only under section 1861(s)(2)(H), if the services were to be furnished by a physician or as an incident to a physician's service.

(5) The payment to an eligible organization under this section for individuals enrolled under this section with the organi-

zation and entitled to benefits under part A and enrolled under part B shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund The portion of that payment to the organization for a month to be paid by each trust fund shall be determined as follows:

(A) In regard to expenditures by eligible organizations having risk-sharing contracts, the allocation shall be determined each year by the Secretary based on the relative weight that benefits from each fund contribute to the adjusted average per capita cost.

(B) In regard to expenditures by eligible organizations operating under a reasonable cost reimbursement contract, the initial allocation shall be based on the plan's most recent budget, such allocation to be adjusted, as needed, after cost settlement to reflect the distribution of actual expenditures.

The remainder of that payment shall be paid by the former trust fund.

(6) Subject to subsections (c)(2)(B)(ii) and (c)(7), if an individual is enrolled under this section with an eligible organization having a risk-sharing contract, only the eligible organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.[573]

(b) For purposes of this section, the term "eligible organization" means a public or private entity (which may be a health maintenance organization or a competitive medical plan), organized under the laws of any State, which—

(1) is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act[574]), or

(2) meets the following requirements:

(A) The entity provides to enrolled members at least the following health care services:

(i) Physicians' services performed by physicians (as defined in section 1861(r)(1)).

(ii) Inpatient hospital services.

(iii) Laboratory, X-ray, emergency, and preventive services.

(iv) Out-of-area coverage.

(B) The entity is compensated (except for deductibles, coinsurance, and copayments) for the provision of health care services to enrolled members by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health care service actually provided to a member.

(C) The entity provides physicians' services primarily (i) directly through physicians who are either employees or partners of such organization, or (ii) through contracts with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis).

[573] See Vol. II, P.L. 99–177, §256, with respect to special rules applicable to the Medicare program.

[574] See Vol. II, P.L. 78–410.

(D) The entity assumes full financial risk on a prospective basis for the provision of the health care services listed in subparagraph (A), except that such entity may—

(i) obtain insurance or make other arrangements for the cost of providing to any enrolled member health care services listed in subparagraph (A) the aggregate value of which exceeds $5,000 in any year,

(ii) obtain insurance or make other arrangements for the cost of health care service listed in subparagraph (A) provided to its enrolled members other than through the entity because medical necessity required their provision before they could be secured through the entity,

(iii) obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for such fiscal year, and

(iv) make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions.

(E) The entity has made adequate provision against the risk of insolvency, which provision is satisfactory to the Secretary.

Paragraph (2)(A)(ii) shall not apply to an entity which had contracted with a single State agency administering a State plan approved under title XIX for the provision of services (other than inpatient hospital services) to individuals eligible for such services under such State plan on a prepaid risk basis prior to 1970.

(c)(1) The Secretary may not enter into a contract under this section with an eligible organization unless it meets the requirements of this subsection and subsection (e) with respect to members enrolled under this section.

(2)(A) The organization must provide to members enrolled under this section, through providers and other persons that meet the applicable requirements of this title and part A of title XI—

(i) only those services covered under parts A and B of this title, for those members entitled to benefits under part A and enrolled under part B, or

(ii) only those services covered under part B, for those members enrolled only under such part,

which are available to individuals residing in the geographic area served by the organization, except that (I) the organization may provide such members with such additional health care services as the members may elect, at their option, to have covered, and (II) in the case of an organization with a risk-sharing contract, the organization may provide such members with such additional health care services as the Secretary may approve. The Secretary shall approve any such additional health care services which the organization proposes to offer to such members, unless the Secretary determines that including such additional services will substantially discourage enrollment by covered individuals with the organization.

(B) If there is a national coverage determination made in the period beginning on the date of an announcement under subsection (a)(1)(A) and ending on the date of the next announcement under such subsection that the Secretary projects will result in a significant[575] change in the costs to the organization of providing the benefits that are the subject of such national coverage determination and that was not incorporated in the determination of the per capita rate of payment included in the announcement made at the beginning of such period—

(i) such determination shall not apply to risk-sharing contracts under this section until the first contract year that begins after the end of such period; and

(ii) if such coverage determination provides for coverage of additional benefits or under additional circumstances, subsection (a)(3) shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period,

unless otherwise required by law.

(3)(A)(i) Each eligible organization must have an open enrollment period, for the enrollment of individuals under this section, of at least 30 days duration every year and including the period or periods specified under clause (ii), and must provide that at any time during which enrollments are accepted, the organization will accept up to the limits of its capacity (as determined by the Secretary) and without restrictions, except as may be authorized in regulations, individuals who are eligible to enroll under subsection (d) in the order in which they apply for enrollment, unless to do so would result in failure to meet the requirements of subsection (f) or would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the population in the geographic area served by the organization.

(ii)(I) If a risk-sharing contract under this section is not renewed or is otherwise terminated, eligible organizations with risk-sharing contracts under this section and serving a part of the same service area as under the terminated contract are required to have an open enrollment period for individuals who were enrolled under the terminated contract as of the date of notice of such termination. If a risk-sharing contract under this section is renewed in a manner that discontinues coverage for individuals residing in part of the service area, eligible organizations with risk-sharing contracts under this section and enrolling individuals residing in that part of the service area are required to have an open enrollment period for individuals residing in the part of the service area who were enrolled under the contract as of the date of notice of such discontinued coverage.

(II) The open enrollment periods required under subclause (I) shall be for 30 days and shall begin

[575] P.L. 108–173, §736(d)(2)(A), struck out "signifcant" and substituted "significant".

30 days after the date that the Secretary provides notice of such requirement.

(III) Enrollment under this clause shall be effective 30 days after the end of the open enrollment period, or, if the Secretary determines that such date is not feasible, such other date as the Secretary specifies.

(B) An individual may enroll under this section with an eligible organization in such manner as may be prescribed in regulations and may terminate his enrollment with the eligible organization as of the beginning of the first calendar month following the date on which the request is made for such termination (or, in the case of financial insolvency of the organization, as may be prescribed by regulations) or, in the case of such an organization with a reasonable cost reimbursement contract, as may be prescribed by regulations. In the case of an individual's termination of enrollment, the organization shall provide the individual with a copy of the written request for termination of enrollment and a written explanation of the period (ending on the effective date of the termination) during which the individual continues to be enrolled with the organization and may not receive benefits under this title other than through the organization.

(C) The Secretary may prescribe the procedures and conditions under which an eligible organization that has entered into a contract with the Secretary under this subsection may inform individuals eligible to enroll under this section with the organization about the organization, or may enroll such individuals with the organization. No brochures, application forms, or other promotional or informational material may be distributed by an organization to (or for the use of) individuals eligible to enroll with the organization under this section unless (i) at least 45 days before its distribution, the organization has submitted the material to the Secretary for review and (ii) the Secretary has not disapproved the distribution of the material. The Secretary shall review all such material submitted and shall disapprove such material if the Secretary determines, in the Secretary's discretion, that the material is materially inaccurate or misleading or otherwise makes a material misrepresentation.

(D) The organization must provide assurances to the Secretary that it will not expel or refuse to re-enroll any such individual because of the individual's health status or requirements for health care services, and that it will notify each such individual of such fact at the time of the individual's enrollment.

(E) Each eligible organization shall provide each enrollee, at the time of enrollment and not less frequently than annually thereafter, an explanation of the enrollee's rights under this section, including an explanation of—

(i) the enrollee's rights to benefits from the organization,

(ii) the restrictions on payments under this title for services furnished other than by or through the organization,

(iii) out-of-area coverage provided by the organization,

(iv) the organization's coverage of emergency services and urgently needed care, and

(v) appeal rights of enrollees.

(F) Each eligible organization that provides items and services pursuant to a contract under this section shall provide assurances to the Secretary that in the event the organization ceases to provide such items and services, the organization shall provide or arrange for supplemental coverage of benefits under this title related to a pre-existing condition with respect to any exclusion period, to all individuals enrolled with the entity who receive benefits under this title, for the lesser of six months or the duration of such period.

(G)(i) Each eligible organization having a risk-sharing contract under this section shall notify individuals eligible to enroll with the organization under this section and individuals enrolled with the organization under this section that—

(I) the organization is authorized by law to terminate or refuse to renew the contract, and

(II) termination or nonrenewal of the contract may result in termination of the enrollments of individuals enrolled with the organization under this section.

(ii) The notice required by clause (i) shall be included in—

(I) any marketing materials described in subparagraph (C) that are distributed by an eligible organization to individuals eligible to enroll under this section with the organization, and

(II) any explanation provided to enrollees by the organization pursuant to subparagraph (E).

(4) The organization must—

(A) make the services described in paragraph (2) (and such other health care services as such individuals have contracted for) (i) available and accessible to each such individual, within the area served by the organization, with reasonable promptness and in a manner which assures continuity, and (ii) when medically necessary, available and accessible twenty-four hours a day and seven days a week, and

(B) provide for reimbursement with respect to services which are described in subparagraph (A) and which are provided to such an individual other than through the organization, if (i) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition and (ii) it was not reasonable given the circumstances to obtain the services through the organization.

(5)(A) The organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and members enrolled with the organization under this section.

(B) A member enrolled with an eligible organization under this section who is dissatisfied by reason of his failure to receive any health service to which he believes he is entitled and at no greater charge than he believes he is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 205(b), and in any such hearing the Secretary shall make the eligible organization a party. If the amount in controversy is $1,000 or more, the individual or eligible organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and both the individual and the eligible organization shall be entitled to be parties to that judicial review. In applying sections 205(b) and 205(g) as provided in this subparagraph, and in applying section 205(l) thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively. The provisions of section 1869(b)(1)(E)(iii) shall apply with respect to dollar amounts specified in the first 2 sentences of this subparagraph in the same manner as they apply to the dollar amounts specified in section 1869(b)(1)(E)(i).[576]

(6) The organization must have arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for health care services it provides to such individuals, which program (A) stresses health outcomes and (B) provides review by physicians and other health care professionals of the process followed in the provision of such health care services.

(7) A risk-sharing contract under this section shall provide that in the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B)) as of the effective date of the individual's—

(A) enrollment with an eligible organization under this section—

(i) payment for such services until the date of the individual's discharge shall be made under this title as if the individual were not enrolled with the organization,

(ii) the organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge, and

(iii) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this section; or

[576] P.L. 108-173, §940(b)(2)(B), added this sentence beginning "The Provisions ... section 1869(b)(1)(E)(i)"; to §1876(b)(5)(B), effective December 8, 2003. Executed as if §940(b)(2)(B) amended §1876(c)(5)(B).

(B) termination of enrollment with an eligible organization under this section—

(i) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge,

(ii) payment for such services during the stay shall not be made under section 1886(d), and

(iii) the organization shall not receive any payment with respect to the individual under this section during the period the individual is not enrolled.

(8) A contract under this section shall provide that the eligible organization shall meet the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).[577]

(d) Subject to the provisions of subsection (c)(3), every individual entitled to benefits under part A and enrolled under part B or enrolled under part B only (other than an individual medically determined to have end-stage renal disease) shall be eligible to enroll under this section with any eligible organization with which the Secretary has entered into a contract under this section and which serves the geographic area in which the individual resides.

(e)(1) In no case may—

(A) the portion of an eligible organization's premium rate and the actuarial value of its deductibles, coinsurance, and copayments charged (with respect to services covered under parts A and B) to individuals who are enrolled under this section with the organization and who are entitled to benefits under part A and enrolled under part B, or

(B) the portion of its premium rate and the actuarial value of its deductibles, coinsurance, and copayments charged (with respect to services covered under part B) to individuals who are enrolled under this section with the organization and enrolled under part B only

exceed the actuarial value of the coinsurance and deductibles that would be applicable on the average to individuals enrolled under this section with the organization (or, if the Secretary finds that adequate data are not available to determine that actuarial value, the actuarial value of the coinsurance and deductibles applicable on the average to individuals in the area, in the State, or in the United States, eligible to enroll under this section with the organization, or other appropriate data) and entitled to benefits under part A and enrolled under part B, or enrolled under part B only, respectively, if they were not members of an eligible organization.

(2) If the eligible organization provides to its members enrolled under this section services in addition to services covered under parts A and B of this title, election of coverage for such additional services (unless such services have been approved by the Secretary under subsection (c)(2)) shall be optional for such members and such organization shall furnish such members with information on the portion of its premium rate or other charges applicable to such additional services. In no case may the sum of—

[577] See Vol. II, P.L. 101–508, §4206(c), with respect to the effect on State law.

(A) the portion of such organization's premium rate charged, with respect to such additional services, to members enrolled under this section, and

(B) the actuarial value of its deductibles, coinsurance, and copayments charged, with respect to such services to such members

exceed the adjusted community rate for such services.

(3) For purposes of this section, the term "adjusted community rate" for a service or services means, at the election of an eligible organization, either—

(A) the rate of payment for that service or services which the Secretary annually determines would apply to a member enrolled under this section with an eligible organization if the rate of payment were determined under a "community rating system" (as defined in section 1302(8) of the Public Health Service Act[578], other than subparagraph (C)), or

(B) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to a member enrolled under this section with the eligible organization, as the Secretary annually estimates is attributable to that service or services,

but adjusted for differences between the utilization characteristics of the members enrolled with the eligible organization under this section and the utilization characteristics of the other members of the organization (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of members in other eligible organizations, or individuals in the area, in the State, or in the United States, eligible to enroll under this section with an eligible organization and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

(4) Notwithstanding any other provision of law, the eligible organization may (in the case of the provision of services to a member enrolled under this section for an illness or injury for which the member is entitled to benefits under a workmen's compensation law or plan of the United States or a State, under an automobile or liability insurance policy or plan, including a self-insured plan, or under no fault insurance) charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law or policy—

(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or

(B) such member to the extent that the member has been paid under such law, plan, or policy for such services.

(f)(1) For contract periods beginning before January 1, 1999, each eligible organization with which the Secretary enters into a contract under this section shall have, for the duration of such contract, an enrolled membership at least one-half of which consists of individuals who are not entitled to benefits under this title.

(2) Subject to paragraph (4), the Secretary may modify or waive the requirement imposed by paragraph (1) only—

[578] See Vol. II, P.L. 78–410.

(A) to the extent that more than 50 percent of the population of the area served by the organization consists of individuals who are entitled to benefits under this title or under a State plan approved under title XIX, or

(B) in the case of an eligible organization that is owned and operated by a governmental entity, only with respect to a period of three years beginning on the date the organization first enters into a contract under this section, and only if the organization has taken and is making reasonable efforts to enroll individuals who are not entitled to benefits under this title or under a State plan approved under title XIX.

(3) If the Secretary determines that an eligible organization has failed to comply with the requirements of this subsection, the Secretary may provide for the suspension of enrollment of individuals under this section or of payment to the organization under this section for individuals newly enrolled with the organization, after the date the Secretary notifies the organization of such noncompliance.[579]

(4) Effective for contract periods beginning after December 31, 1996, the Secretary may waive or modify the requirement imposed by paragraph (1) to the extent the Secretary finds that it is in the public interest.

(g)(1) The Secretary may enter a risk-sharing contract with any eligible organization, as defined in subsection (b), which has at least 5,000 members, except that the Secretary may enter into such a contract with an eligible organization that has fewer members if the organization primarily serves members residing outside of urbanized areas.

(2) Each risk-sharing contract shall provide that—

(A) if the adjusted community rate, as defined in subsection (e)(3), for services under parts A and B (as reduced for the actuarial value of the coinsurance and deductibles under those parts) for members enrolled under this section with the organization and entitled to benefits under part A and enrolled in part B, or

(B) if the adjusted community rate for services under part B (as reduced for the actuarial value of the coinsurance and deductibles under that part) for members enrolled under this section with the organization and entitled to benefits under part B only

is less than the average of the per capita rates of payment to be made under subsection (a)(1) at the beginning of an annual contract period for members enrolled under this section with the organization and entitled to benefits under part A and enrolled in part B, or enrolled in part B only, respectively, the eligible organization shall provide to members enrolled under a risk-sharing contract under this section with the organization and entitled to benefits under part A and enrolled in part B, or enrolled in part B only, respectively, the additional benefits described in paragraph (3) which are selected by the eligible organization and which the Secretary finds are at least equal in value to the difference between that average per capita payment and the adjusted community rate (as so reduced); except that this paragraph shall not apply with respect

[579] See Vol. II, P.L. 99–509, §9312(c)(3)(C), with respect to treatment of waivers.

to any organization which elects to receive a lesser payment to the extent that there is no longer a difference between the average per capita payment and adjusted community rate (as so reduced) and except that an organization (with the approval of the Secretary) may provide that a part of the value of such additional benefits be withheld and reserved by the Secretary as provided in paragraph (5). If the Secretary finds that there is insufficient enrollment experience to determine an average of the per capita rates of payment to be made under subsection (a)(1) at the beginning of a contract period, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this section.

(3) The additional benefits referred to in paragraph (2) are—

(A) the reduction of the premium rate or other charges made with respect to services furnished by the organization to members enrolled under this section, or

(B) the provision of additional health benefits,

or both.

(4) [Repealed.[580]]

(5) An organization having a risk-sharing contract under this section may (with the approval of the Secretary) provide that a part of the value of additional benefits otherwise required to be provided by reason of paragraph (2) be withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate) by the Secretary for subsequent annual contract periods, to the extent required to stabilize and prevent undue fluctuations in the additional benefits offered in those subsequent periods by the organization in accordance with paragraph (3). Any of such value of additional benefits which is not provided to members of the organization in accordance with paragraph (3) prior to the end of such period, shall revert for the use of such trust funds.

(6)(A) A risk-sharing contract under this section shall require the eligible organization to provide prompt payment (consistent with the provisions of sections 1816(c)(2) and 1842(c)(2)) of claims submitted for services and supplies furnished to individuals pursuant to such contract, if the services or supplies are not furnished under a contract between the organization and the provider or supplier.

(B) In the case of an eligible organization which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with subparagraph (A), the Secretary may provide for direct payment of the amounts owed to providers and suppliers for such covered services furnished to individuals enrolled under this section under the contract. If the Secretary provides for such direct payments, the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the organization under this section to reflect the amount of the Secretary's payments (and costs incurred by the Secretary in making such payments).

[580] P.L. 100–203, §4012(b); 101 Stat. 1330–61.

(h)(1) If—

(A) the Secretary is not satisfied that an eligible organization has the capacity to bear the risk of potential losses under a risk-sharing contract under this section, or

(B) the eligible organization so elects or has an insufficient number of members to be eligible to enter into a risk-sharing contract under subsection (g)(1),

the Secretary may, if he is otherwise satisfied that the eligible organization is able to perform its contractual obligations effectively and efficiently, enter into a contract with such organization pursuant to which such organization is reimbursed on the basis of its reasonable cost (as defined in section 1861(v)) in the manner prescribed in paragraph (3).

(2) A reasonable cost reimbursement contract under this subsection may, at the option of such organization, provide that the Secretary—

(A) will reimburse hospitals and skilled nursing facilities either for the reasonable cost (as determined under section 1861(v)) or for payment amounts determined in accordance with section 1886, as applicable, of services furnished to individuals enrolled with such organization pursuant to subsection (d), and

(B) will deduct the amount of such reimbursement from payment which would otherwise be made to such organization.

If such an eligible organization pays a hospital or skilled nursing facility directly, the amount paid shall not exceed the reasonable cost of the services (as determined under section 1861(v)) or the amount determined under section 1886, as applicable, unless such organization demonstrates to the satisfaction of the Secretary that such excess payments are justified on the basis of advantages gained by the organization.

(3) Payments made to an organization with a reasonable cost reimbursement contract shall be subject to appropriate retroactive corrective adjustment at the end of each contract year so as to assure that such organization is paid for the reasonable cost actually incurred (excluding any part of incurred cost found to be unnecessary in the efficient delivery of health services) or the amounts otherwise determined under section 1886 for the types of expenses otherwise reimbursable under this title for providing services covered under this title to individuals described in subsection (a)(1).

(4) Any reasonable cost reimbursement contract with an eligible organization under this subsection shall provide that the Secretary shall require, at such time following the expiration of each accounting period of the eligible organization (and in such form and in such detail) as he may prescribe—

(A) that the organization report to him in an independently certified financial statement its per capita incurred cost based on the types of components of expenses otherwise reimbursable under this title for providing services described in subsection (a)(1), including therein, in accordance with accounting procedures prescribed by the Secretary, its methods of allocating costs between individuals enrolled under this section and other individuals enrolled with such organization;

(B) that failure to report such information as may be required may be deemed to constitute evidence of likely overpayment on the basis of which appropriate collection action may be taken;

(C) that in any case in which an eligible organization is related to another organization by common ownership or control, a consolidated financial statement shall be filed and that the allowable costs for such organization may not include costs for the types of expense otherwise reimbursable under this title, in excess of those which would be determined to be reasonable in accordance with regulations (providing for limiting reimbursement to costs rather than charges to the eligible organization by related organizations and owners) issued by the Secretary; and

(D) that in any case in which compensation is paid by an eligible organization substantially in excess of what is normally paid for similar services by similar practitioners (regardless of method of compensation), such compensation may as appropriate be considered to constitute a distribution of profits.

(5)(A) After the date of the enactment of this paragraph, the Secretary may not enter into a reasonable cost reimbursement contract under this subsection (if the contract is not in effect as of such date), except for a contract with an eligible organization which, immediately previous to entering into such contract, had an agreement in effect under section 1833(a)(1)(A).

(B) Subject to subparagraph (C), the Secretary shall approve an application for a modification to a reasonable cost contract under this section in order to expand the service area of such contract if—

(i) such application is submitted to the Secretary on or before September 1, 2003; and

(ii) the Secretary determines that the organization with the contract continues to meet the requirements applicable to such organizations and contracts under this section.

(C)[581](i) Subject to clause (ii), a reasonable cost reimbursement contract under this subsection may be extended or renewed indefinitely.

(ii) For any period beginning on or after January 1, 2008, a reasonable cost reimbursement contract under this subsection may not be extended or renewed for a service area insofar as such area during the entire previous year was within the service area of--

(I) 2 or more MA regional plans described in clause (iii); or

(II) 2 or more MA local plans described in clause (iii).

(iii) A plan described in this clause for a year for a service area is a plan described in section 1851(a)(2)(A)(i) if the service area for the year meets the following minimum enrollment requirements:

[581] P.L. 108-173, §234, amended subparagraph (C) in its entirety, effective December 8, 2003. For subparagraph (C) as it formerly read, see Vol. II, Appendix J, Superseded Provisions, Pl. 108-173.

(I) With respect to any portion of the area involved that is within a Metropolitan Statistical Area with a population of more than 250,000 and counties contiguous to such Metropolitan Statistical Area, 5,000 individuals.

(II) With respect to any other portion of such area, 1,500 individuals.

(i)(1) Each contract under this section shall be for a term of at least one year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that in accordance with procedures established under paragraph (9), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in paragraph (6)(B) or (6)(C) (whichever is applicable) on the eligible organization if the Secretary determines that the organization—

(A) has failed substantially carry out the contract;

(B) is carrying out the contract in a manner substantially inconsistent with the efficient and effective administration of this section; or

(C) no longer substantially meets the applicable conditions of subsections (b), (c), (e), and (f).

(2) The effective date of any contract executed pursuant to this section shall be specified in the contract.

(3) Each contract under this section—

(A) shall provide that the Secretary, or any person or organization designated by him—

(i) shall have the right to inspect or otherwise evaluate (I) the quality, appropriateness, and timeliness of services performed under the contract and (II) the facilities of the organization when there is reasonable evidence of some need for such inspection, and

(ii) shall have the right to audit and inspect any books and records of the eligible organization that pertain (I) to the ability of the organization to bear the risk of potential financial losses, or (II) to services performed or determinations of amounts payable under the contract;

(B) shall require the organization with a risk-sharing contract to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this title, to each individual enrolled under this section with the organization; and

(C)(i) shall require the organization to comply with subsections (a) and (c) of section 1318 of the Public Health Service Act[582] (relating to disclosure of certain financial information) and with the requirement of section 1301(c)(8) of such Act (relating to liability arrangements to protect members);

(ii) shall require the organization to provide and supply information (described in section 1866(b)(2)(C)(ii)) in the manner such information is required to be provided or supplied under that section;

[582] See Vol. II, P.L. 78–410.

(iii) shall require the organization to notify the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties; and

(D) shall contain such other terms and conditions not inconsistent with this section (including requiring the organization to provide the Secretary with such information) as the Secretary may find necessary and appropriate.

(4) The Secretary may not enter into a risk-sharing contract with an eligible organization if a previous risk-sharing contract with that organization under this section was terminated at the request of the organization within the preceding five-year period, except in circumstances which warrant special consideration, as determined by the Secretary.

(5) The authority vested in the Secretary by this section may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.

(6)(A) If the Secretary determines that an eligible organization with a contract under this section—

(i) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

(ii) imposes premiums on individuals enrolled under this section in excess of the premiums permitted;

(iii) acts to expel or to refuse to re-enroll an individual in violation of the provisions of this section;

(iv) engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this section) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

(v) misrepresents or falsifies information that is furnished—

(I) to the Secretary under this section, or

(II) to an individual or to any other entity under this section;

(vi) fails to comply with the requirements of subsection (g)(6)(A) or paragraph (8); or

(vii) in the case of a risk-sharing contract, 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;

the Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in subparagraph (B).

(B) The remedies described in this subparagraph are—

(i) civil money penalties of not more than $25,000 for each determination under subparagraph (A) or, with respect to a determination under clause (iv) or (v)(I) of such subparagraph, of not more than $100,000 for each such determination, plus, with respect to a determination under subparagraph (A)(ii), double the excess amount charged in violation of such subparagraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under subparagraph (A)(iv), $15,000 for each individual not enrolled as a result of the practice involved,

(ii) suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur, or

(iii) suspension of payment to the organization under this section for individuals enrolled after the date the Secretary notifies the organization of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

(C) In the case of an eligible organization for which the Secretary makes a determination under paragraph (1), the basis of which is not described in subparagraph (A), the Secretary may apply the following intermediate sanctions:

(i) Civil money penalties of not more than $25,000 for each determination under paragraph (1) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

(ii) Civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under paragraph (9) during which the deficiency that is the basis of a determination under paragraph (1) exists.

(iii) Suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.

(D) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subparagraph (B)(i) or (C)(i) in the same manner as such provisions apply to a civil money penalty or proceeding under section 1128A(a).

(7)(A) Each risk-sharing contract with an eligible organization under this section shall provide that the organization will maintain a written agreement with a utilization and quality control peer review organization (which has a contract with the Secretary under part B of title XI for the area in which the eli-

gible organization is located) or with an entity selected by the Secretary under section 1154(a)(4)(C) under which the review organization will perform functions under section 1154(a)(4)(B) and section 1154(a)(14) (other than those performed under contracts described in section 1866(a)(1)(F)) with respect to services, furnished by the eligible organization, for which payment may be made under this title.

(B) For purposes of payment under this title, the cost of such agreement to the eligible organization shall be considered a cost incurred by a provider of services in providing covered services under this title and shall be paid directly by the Secretary to the review organization on behalf of such eligible organization in accordance with a schedule established by the Secretary.

(C) Such payments—

(i) shall be transferred in appropriate proportions from the Federal Hospital Insurance Trust Fund and from the Supplementary Medical Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and

(ii) shall not be less in the aggregate for such organizations for a fiscal year than the amounts the Secretary determines to be sufficient to cover the costs of such organizations' conducting activities described in subparagraph (A) with respect to such eligible organizations under part B of title XI.

(8)(A) Each contract with an eligible organization under this section shall provide that the organization may not operate any physician incentive plan (as defined in subparagraph (B)) unless the following requirements are met:

(i) No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization.

(ii) If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the organization—

(I) provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or the physician group, and

(II) conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the organization to determine the degree of access of such individuals to services provided by the organization and satisfaction with the quality of such services.

(iii) The organization provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this subparagraph.

(B) In this paragraph, the term "physician incentive plan" means any compensation arrangement between an eligible organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization.

(9) The Secretary may terminate a contract with an eligible organization under this section or may impose the intermediate sanctions described in paragraph (6) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

(A) the Secretary first provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under paragraph (1) and the organization fails to develop or implement such a plan;

(B) in deciding whether to impose sanctions, the Secretary considers aggravating factors such as whether an organization has a history of deficiencies or has not taken action to correct deficiencies the Secretary has brought to the organization's attention;

(C) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract.

(j)(1)(A) In the case of physicians' services or renal dialysis services described in paragraph (2) which are furnished by a participating physician or provider of services or renal dialysis facility to an individual enrolled with an eligible organization under this section and enrolled under part B, the applicable participation agreement is deemed to provide that the physician or provider of services or renal dialysis facility will accept as payment in full from the eligible organization the amount that would be payable to the physician or provider of services or renal dialysis facility under part B and from the individual under such part, if the individual were not enrolled with an eligible organization under this section.

(B) In the case of physicians' services described in paragraph (2) which are furnished by a nonparticipating physician, the limitations on actual charges for such services otherwise applicable under part B (to services furnished by individuals not enrolled with an eligible organization under this section) shall apply in the same manner as such limitations apply to services furnished to individuals not enrolled with such an organization.

(2) The physicians' services or renal dialysis services described in this paragraph are physicians' services or renal dialysis services which are furnished to an enrollee of an eligible

organization under this section[583] by a physician, provider of services, or renal dialysis facility who is not under a contract with the organization.

(k)(1) Except as provided in paragraph (2)—

(A) on or after the date standards for Medicare+Choice organizations and plans are first established under section 1856(b)(1), the Secretary shall not enter into any risk–sharing contract under this section with an eligible organization; and

(B) for any contract year beginning on or after January 1, 1999, the Secretary shall not renew any such contract.

(2) An individual who is enrolled in part B only and is enrolled in an eligible organization with a risk–sharing contract under this section on December 31, 1998, may continue enrollment in such organization in accordance with regulations described in section 1856(b)(1).

(3) Notwithstanding subsection (a), the Secretary shall provide that payment amounts under risk–sharing contracts under this section for months in a year (beginning with January 1998) shall be computed—

(A) with respect to individuals entitled to benefits under both parts A and B, by substituting payment rates under section 1853(a) for the payment rates otherwise established under section 1876(a), and

(B) with respect to individuals only entitled to benefits under part B, by substituting an appropriate proportion of such rates (reflecting the relative proportion of payments under this title attributable to such part) for the payment rates otherwise established under subsection (a).

(4) The following requirements shall apply to eligible organizations with risk–sharing contracts under this section in the same manner as they apply to Medicare+Choice organizations under part C:

(A) Data collection requirements under section 1853(a)(3)(B).

(B) Restrictions on imposition of premium taxes under section 1854(g) in relating to payments to such organizations under this section.

(C) The requirement to accept enrollment of new enrollees during November 1998 under section 1851(e)(6).

(D) Payments under section 1857(e)(2).

LIMITATION ON CERTAIN PHYSICIAN REFERRALS[584]

SEC. 1877. [42 U.S.C. 1395] (a) PROHIBITION OF CERTAIN REFERRALS.—

(1) IN GENERAL.—Except as provided in subsection (b), if a physician (or an immediate family member of such physician) has a financial relationship with an entity specified in paragraph (2), then—

(A) the physician may not make a referral to the entity for the furnishing of designated health services for which payment otherwise may be made under this title, and

[583] P.L. 108–173, §736(d)(2)(B), struck out "this setion" and substituted "this section".

[584] See Vol. II, P.L. 108-173, §507(c), with respect to a MEDPAC study, an HHS study and reports on those studies.

(B) the entity may not present or cause to be presented a claim under this title or bill to any individual, third party payor, or other entity for designated health services furnished pursuant to a referral prohibited under subparagraph (A).

(2) FINANCIAL RELATIONSHIP SPECIFIED.—For purposes of this section, a financial relationship of a physician (or an immediate family member of such physician) with an entity specified in this paragraph is—

(A) except as provided in subsections (c) and (d), an ownership or investment interest in the entity, or

(B) except as provided in subsection (e), a compensation arrangement (as defined in subsection (h)(1)) between the physician (or an immediate family member of such physician) and the entity.

An ownership or investment interest described in subparagraph (A) may be through equity, debt, or other means and includes an interest in an entity that holds an ownership or investment interest in any entity providing the designated health service.

(b) GENERAL EXCEPTIONS TO BOTH OWNERSHIP AND COMPENSATION ARRANGEMENT PROHIBITIONS.—Subsection (a)(1) shall not apply in the following cases:

(1) PHYSICIANS' SERVICES.—In the case of physicians' services (as defined in section 1861(q)) provided personally by (or under the personal supervision of) another physician in the same group practice (as defined in subsection (h)(4)) as the referring physician.

(2) IN-OFFICE ANCILLARY SERVICES.—In the case of services (other than durable medical equipment (excluding infusion pumps) and parenteral and enteral nutrients, equipment, and supplies)—

(A) that are furnished—

(i) personally by the referring physician, personally by a physician who is a member of the same group practice as the referring physician, or personally by individuals who are directly supervised by the physician or by another physician in the group practice, and

(ii)(I) in a building in which the referring physician (or another physician who is a member of the same group practice) furnishes physicians' services unrelated to the furnishing of designated health services, or

(II) in the case of a referring physician who is a member of a group practice, in another building which is used by the group practice—

(aa) for the provision of some or all of the group's clinical laboratory services, or

(bb) for the centralized provision of the group's designated health services (other than clinical laboratory services),

unless the Secretary determines other terms and conditions under which the provision of such services does not present a risk of program or patient abuse, and

(B) that are billed by the physician performing or supervising the services, by a group practice of which such phy-

sician is a member under a billing number assigned to the group practice, or by an entity that is wholly owned by such physician or such group practice,

if the ownership or investment interest in such services meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(3) PREPAID PLANS.—In the case of services furnished by an organization—

(A) with a contract under section 1876 to an individual enrolled with the organization,

(B) described in section 1833(a)(1)(A) to an individual enrolled with the organization,

(C) receiving payments on a prepaid basis, under a demonstration project under section 402(a) of the Social Security Amendments of 1967 or under section 222(a) of the Social Security Amendments of 1972, to an individual enrolled with the organization,

(D) that is a qualified health maintenance organization (within the meaning of section 1310(d) of the Public Health Service Act) to an individiual enrolled with the organization, or

(E) that is a Medicare+Choice organization under part C that is offering a coordinated care plan described in section 1851(a)(2)(A) to an individual enrolled with the organization.

(4) OTHER PERMISSIBLE EXCEPTIONS.—In the case of any other financial relationship which the Secretary determines, and specifies in regulations, does not pose a risk of program or patient abuse.

(5)[585] ELECTRONIC PRESCRIBING.—An exception established by regulation under section 1860D-3(e)(6).

(c) GENERAL EXCEPTION RELATED ONLY TO OWNERSHIP OR INVESTMENT PROHIBITION FOR OWNERSHIP IN PUBLICLY TRADED SECURITIES AND MUTUAL FUNDS.—Ownership of the following shall not be considered to be an ownership or investment interest described in subsection (a)(2)(A):

(1) Ownership of investment securities (including shares or bonds, debentures, notes, or other debt instruments) which may be purchased on terms generally available to the public and which are—

(A)(i) securities listed on the New York Stock Exchange, the American Stock Exchange, or any regional exchange in which quotations are published on a daily basis, or foreign securities listed on a recognized foreign, national, or regional exchange in which quotations are published on a daily basis, or

(ii) traded under an automated interdealer quotation system operated by the National Association of Securities Dealers, and

(B) in a corporation that had, at the end of the corporation's most recent fiscal year, or on average during the previous 3 fiscal years, stockholder equity exceeding $75,000,000.

[585] P.L. 108–173, §101(e)(8)(B), added paragraph (5), effective December 8, 2003.

(2) Ownership of shares in a regulated investment company as defined in section 851(a) of the Internal Revenue Code of 1986, if such company had, at the end of the company's most recent fiscal year, or on average during the previous 3 fiscal years, total assets exceeding $75,000,000.

(d) ADDITIONAL EXCEPTIONS RELATED ONLY TO OWNERSHIP OR INVESTMENT PROHIBITION.—The following, if not otherwise excepted under subsection (b), shall not be considered to be an ownership or investment interest described in subsection (a)(2)(A):

(1) HOSPITALS IN PUERTO RICO.—In the case of designated health services provided by a hospital located in Puerto Rico.

(2)[586] RURAL PROVIDERS.—In the case of designated health services furnished in a rural area (as defined in section 1886(d)(2)(D)) by an entity, if—

(A) substantially all of the designated health services furnished by the entity are furnished to individuals residing in such a rural area; and

(B) effective for the 18-month period beginning on the date of the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the entity is not a specialty hospital (as defined in subsection (h)(7)).

(3) HOSPITAL OWNERSHIP.—In the case of designated health services provided by a hospital (other than a hospital described in paragraph (1)) if—

(A) the referring physician is authorized to perform services at the hospital;[587]

(B)[588] effective for the 18-month period beginning on the date of the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003[589], the hospital is not a specialty hospital (as defined in subsection (h)(7)); and

(C)[590] the ownership or investment interest is in the hospital itself (and not merely in a subdivision of the hospital).

(e) EXCEPTIONS RELATING TO OTHER COMPENSATION ARRANGEMENTS.—The following shall not be considered to be a compensation arrangement described in subsection (a)(2)(B):

(1) RENTAL OF OFFICE SPACE; RENTAL OF EQUIPMENT.—

(A) OFFICE SPACE.—Payments made by a lessee to a lessor for the use of premises if—

(i) the lease is set out in writing, signed by the parties, and specifies the premises covered by the lease,

(ii) the space rented or leased does not exceed that which is reasonable and necessary for the legitimate business purposes of the lease or rental and is used exclusively by the lessee when being used by the lessee, except that the lessee may make payments for the use of space consisting of common areas if such payments do not exceed the lessee's pro rata share of expenses for such space based upon the ratio of the

[586] P.L. 108–173, §507(a)(2), amended paragraph (2) in its entirety, effective December 8, 2003.

[587] P.L. 108–173, §507(a)(1)(A)(i), struck out ", and" and substituted a semicolon.

[588] P.L. 108–173, §507(a)(1)(A)(ii), added this subparagraph (B), effective December 8, 2003.

[589] December 8, 2003.

[590] P.L. 108–173, §507(a)(1)(A)(ii), redesignated the former subparagraph (B) as subparagraph (C).

space used exclusively by the lessee to the total amount of space (other than common areas) occupied by all persons using such common areas,

(iii) the lease provides for a term of rental or lease for at least 1 year,

(iv) the rental charges over the term of the lease are set in advance, are consistent with fair market value, and are not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties,

(v) the lease would be commercially reasonable even if no referrals were made between the parties, and

(vi) the lease meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(B) EQUIPMENT.—Payments made by a lessee of equipment to the lessor of the equipment for the use of the equipment if—

(i) the lease is set out in writing, signed by the parties, and specifies the equipment covered by the lease,

(ii) the equipment rented or leased does not exceed that which is reasonable and necessary for the legitimate business purposes of the lease or rental and is used exclusively by the lessee when being used by the lessee,

(iii) the lease provides for a term of rental or lease of at least 1 year,

(iv) the rental charges over the term of the lease are set in advance, are consistent with fair market value, and are not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties,

(v) the lease would be commercially reasonable even if no referrals were made between the parties, and

(vi) the lease meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(2) BONA FIDE EMPLOYMENT RELATIONSHIPS.—Any amount paid by an employer to a physician (or an immediate family member of such physician) who has a bona fide employment relationship with the employer for the provision of services if—

(A) the employment is for identifiable services,

(B) the amount of the remuneration under the employment—

(i) is consistent with the fair market value of the services, and

(ii) is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician,

(C) the remuneration is provided pursuant to an agreement which would be commercially reasonable even if no referrals were made to the employer, and

(D) the employment meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

Subparagraph (B)(ii) shall not prohibit the payment of remuneration in the form of a productivity bonus based on services performed personally by the physician (or an immediate family member of such physician).

(3) PERSONAL SERVICE ARRANGEMENTS.—

(A) IN GENERAL.—Remuneration from an entity under an arrangement (including remuneration for specific physicians' services furnished to a nonprofit blood center) if—

(i) the arrangement is set out in writing, signed by the parties, and specifies the services covered by the arrangement,

(ii) the arrangement covers all of the services to be provided by the physician (or an immediate family member of such physician) to the entity,

(iii) the aggregate services contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement,

(iv) the term of the arrangement is for at least 1 year,

(v) the compensation to be paid over the term of the arrangement is set in advance, does not exceed fair market value, and except in the case of a physician incentive plan described in subparagraph (B), is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties,

(vi) the services to be performed under the arrangement do not involve the counseling or promotion or a business arrangement or other activity that violates any State or Federal law, and

(vii) the arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(B) PHYSICIAN INCENTIVE PLAN EXCEPTION.—

(i) IN GENERAL.—In the case of a physician incentive plan (as defined in clause (ii)) between a physician and an entity, the compensation may be determined in a manner (through a withhold, capitation, bonus, or otherwise) that takes into account directly or indirectly the volume or value of any referrals or other business generated between the parties, if the plan meets the following requirements:

(I) No specific payment is made directly or indirectly under the plan to a physician or a physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the entity.

(II) In the case of a plan that places a physician or a physician group at substantial financial risk as determined by the Secretary pursuant to section 1876(i)(8)(A)(ii), the plan complies with any requirements the Secretary may impose pursuant to such section.

(III) Upon request by the Secretary, the entity provides the Secretary with access to descriptive

information regarding the plan, in order to permit the Secretary to determine whether the plan is in compliance with the requirements of this clause.

(ii) PHYSICIAN INCENTIVE PLAN DEFINED.—For purposes of this subparagraph, the term "physician incentive plan" means any compensation arrangement between an entity and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the entity.

(4) REMUNERATION UNRELATED TO THE PROVISION OF DESIGNATED HEALTH SERVICES.—In the case of remuneration which is provided by a hospital to a physician if such remuneration does not relate to the provision of designated health services.

(5) PHYSICIAN RECRUITMENT.—In the case of remuneration which is provided by a hospital to a physician to induce the physician to relocate to the geographic area served by the hospital in order to be a member of the medical staff of the hospital, if—

(A) the physician is not required to refer patients to the hospital,

(B) the amount of the remuneration under the arrangement is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician, and

(C) the arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(6) ISOLATED TRANSACTIONS.—In the case of an isolated financial transaction, such as a one-time sale of property or practice, if—

(A) the requirements described in subparagraphs (B) and (C) of paragraph (2) are met with respect to the entity in the same manner as they apply to an employer, and

(B) the transaction meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(7) CERTAIN GROUP PRACTICE ARRANGEMENTS WITH A HOSPITAL.—

(A) IN GENERAL.—An arrangement between a hospital and a group under which designated health services are provided by the group but are billed by the hospital if—

(i) with respect to services provided to an inpatient of the hospital, the arrangement is pursuant to the provision of inpatient hospital services under section 1861(b)(3),

(ii) the arrangement began before December 19, 1989, and has continued in effect without interruption since such date,

(iii) with respect to the designated health services covered under the arrangement, substantially all of such services furnished to patients of the hospital are furnished by the group under the arrangement,

(iv) the arrangement is pursuant to an agreement that is set out in writing and that specifies the serv-

ices to be provided by the parties and the compensation for services provided under the agreement,

(v) the compensation paid over the term of the agreement is consistent with fair market value and the compensation per unit of services is fixed in advance and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties,

(vi) the compensation is provided pursuant to an agreement which would be commercially reasonable even if no referrals were made to the entity, and

(vii) the arrangement between the parties meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(8) PAYMENTS BY A PHYSICIAN FOR ITEMS AND SERVICES.—Payments made by a physician—

(A) to a laboratory in exchange for the provision of clinical laboratory services, or

(B) to an entity as compensation for other items or services if the items or services are furnished at a price that is consistent with fair market value.

(f) REPORTING REQUIREMENTS.—Each entity providing covered items or services for which payment may be made under this title shall provide the Secretary with the information concerning the entity's ownership, investment, and compensation arrangements, including—

(1) the covered items and services provided by the entity, and

(2) the names and unique physician identification numbers of all physicians with an ownership or investment interest (as described in subsection (a)(2)(A)), or with a compensation arrangement (as described in subsection (a)(2)(B)), in the entity, or whose immediate relatives have such an ownership or investment interest or who have such a compensation relationship with the entity.

Such information shall be provided in such form, manner, and at such times as the Secretary shall specify. The requirement of this subsection shall not apply to designated health services provided outside the United States or to entities which the Secretary determines provides services for which payment may be made under this title very infrequently.

(g) SANCTIONS.—

(1) DENIAL OF PAYMENT.—No payment may be made under this title for a designated health service which is provided in violation of subsection (a)(1).

(2) REQUIRING REFUNDS FOR CERTAIN CLAIMS.—If a person collects any amounts that were billed in violation of subsection (a)(1), the person shall be liable to the individual for, and shall refund on a timely basis to the individual, any amounts so collected.

(3) CIVIL MONEY PENALTY AND EXCLUSION FOR IMPROPER CLAIMS.—Any person that presents or causes to be presented a bill or a claim for a service that such person knows or should know is for a service for which payment may not be made under paragraph (1) or for which a refund has not been made

under paragraph (2) shall be subject to a civil money penalty of not more than $15,000 for each such service. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(4) CIVIL MONEY PENALTY AND EXCLUSION FOR CIRCUMVENTION SCHEMES.—Any physician or other entity that enters into an arrangement or scheme (such as a cross-referral arrangement) which the physician or entity knows or should know has a principal purpose of assuring referrals by the physician to a particular entity which, if the physician directly made referrals to such entity, would be in violation of this section, shall be subject to a civil money penalty of not more than $100,000 for each such arrangement or scheme. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(5) FAILURE TO REPORT INFORMATION.—Any person who is required, but fails, to meet a reporting requirement of subsection (f) is subject to a civil money penalty of not more than $10,000 for each day for which reporting is required to have been made. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(6) ADVISORY OPINIONS.—

(A) IN GENERAL.—The Secretary shall issue written advisory opinions concerning whether a referral relating to designated health services (other than clinical laboratory services) is prohibited under this section. Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

(B) APPLICATION OF CERTAIN RULES.—The Secretary shall, to the extent practicable, apply the rules under subsections (b)(3) and (b)(4) and take into account the regulations promulgated under subsection (b)(5) of section 1128D in the issuance of advisory opinions under this paragraph.

(C) REGULATIONS.—In order to implement this paragraph in a timely manner, the Secretary may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

(D) APPLICABILITY.—This paragraph shall apply to requests for advisory opinions made after the date which is 90 days after the date of the enactment of this paragraph and before the close of the period described in section 1128D(b)(6).

(h) DEFINITIONS AND SPECIAL RULES.—For purposes of this section:

(1) COMPENSATION ARRANGEMENT; REMUNERATION.—(A) The term "compensation arrangement" means any arrangement involving any remuneration between a physician (or an immediate family member of such physician) and an entity other

than an arrangement involving only remuneration described in subparagraph (C).

(B) The term "remuneration" includes any remuneration, directly or indirectly, overtly or covertly, in cash or in kind.

(C) Remuneration described in this subparagraph is any remuneration consisting of any of the following:

(i) The forgiveness of amounts owed for inaccurate tests or procedures, mistakenly performed tests or procedures, or the correction of minor billing errors.

(ii) The provision of items, devices, or supplies that are used solely to—

(I) collect, transport, process, or store specimens for the entity providing the item, device, or supply, or

(II) order or communicate the results of tests or procedures for such entity.

(iii) A payment made by an insurer or a self-insured plan to a physician to satisfy a claim, submitted on a fee for service basis, for the furnishing of health services by that physician to an individual who is covered by a policy with the insurer or by the self-insured plan, if—

(I) the health services are not furnished, and the payment is not made, pursuant to a contract or other arrangement between the insurer or the plan and the physician,

(II) the payment is made to the physician on behalf of the covered individual and would otherwise be made directly to such individual,

(III) the amount of the payment is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account directly or indirectly the volume or value of any referrals, and

(IV) the payment meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(2) EMPLOYEE.—An individual is considered to be "employed by" or an "employee" of an entity if the individual would be considered to be an employee of the entity under the usual common law rules applicable in determining the employer-employee relationship (as applied for purposes of section 3121(d)(2) of the Internal Revenue Code of 1986).

(3) FAIR MARKET VALUE.—The term "fair market value" means the value in arms length transactions, consistent with the general market value, and, with respect to rentals or leases, the value of rental property for general commercial purposes (not taking into account its intended use) and, in the case of a lease of space, not adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor where the lessor is a potential source of patient referrals to the lessee.

(4) GROUP PRACTICE.—

(A) DEFINITION OF GROUP PRACTICE.—The term "group practice" means a group of 2 or more physicians legally organized as a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan, or similar association—

(i) in which each physician who is a member of the group provides substantially the full range of services which the physician routinely provides, including medical care, consultation, diagnosis, or treatment, through the joint use of shared office space, facilities, equipment and personnel,

(ii) for which substantially all of the services of the physicians who are members of the group are provided through the group and are billed under a billing number assigned to the group and amounts so received are treated as receipts of the group,

(iii) in which the overhead expenses of and the income from the practice are distributed in accordance with methods previously determined,

(iv) except as provided in subparagraph (B)(i), in which no physician who is a member of the group directly or indirectly receives compensation based on the volume or value of referrals by the physician,

(v) in which members of the group personally conduct no less than 75 percent of the physician-patient encounters of the group practice, and

(vi) which meets such other standards as the Secretary may impose by regulation.

(B) SPECIAL RULES.—

(i) PROFITS AND PRODUCTIVITY BONUSES.—A physician in a group practice may be paid a share of overall profits of the group, or a productivity bonus based on services personally performed or services incident to such personally performed services, so long as the share or bonus is not determined in any manner which is directly related to the volume or value of referrals by such physician.

(ii) FACULTY PRACTICE PLANS.—In the case of a faculty practice plan associated with a hospital, institution of higher education, or medical school with an approved medical residency training program in which physician members may provide a variety of different specialty services and provide professional services both within and outside the group, as well as perform other tasks such as research, subparagraph (A) shall be applied only with respect to the services provided within the faculty practice plan.

(5) REFERRAL; REFERRING PHYSICIAN.—

(A) PHYSICIANS' SERVICES.—Except as provided in subparagraph (C), in the case of an item or service for which payment may be made under part B, the request by a physician for the item or service, including the request by a physician for a consultation with another physician (and any test or procedure ordered by, or to be performed by (or under the supervision of) that other physician), constitutes a "referral" by a "referring physician".

(B) OTHER ITEMS.—Except as provided in subparagraph (C), the request or establishment of a plan of care by a physician which includes the provision of the designated health service constitutes a "referral" by a "referring physician".

(C) CLARIFICATION RESPECTING CERTAIN SERVICES INTEGRAL TO A CONSULTATION BY CERTAIN SPECIALISTS.—A request by a pathologist for clinical diagnostic laboratory tests and pathological examination services, a request by a radiologist for diagnostic radiology services, and a request by a radiation oncologist for radiation therapy, if such services are furnished by (or under the supervision of) such pathologist, radiologist, or radiation oncologist pursuant to a consultation requested by another physician does not constitute a "referral" by a "referring physician".

(6) DESIGNATED HEALTH SERVICES.—The term "designated health services" means any of the following items or services:

(A) Clinical laboratory services.

(B) Physical therapy services.

(C) Occupational therapy services.

(D) Radiology services, including magnetic resonance imaging, computerized axial tomography, and ultrasound services.

(E) Radiation therapy services and supplies.

(F) Durable medical equipment and supplies.

(G) Parenteral and enteral nutrients, equipment, and supplies.

(H) Prosthetics, orthotics, and prosthetic devices and supplies.

(I) Home health services.

(J) Outpatient prescription drugs.

(K) Inpatient and outpatient hospital services.

(7)[591] SPECIALTY HOSPITAL.—

(A) IN GENERAL.—For purposes of this section, except as provided in subparagraph (B), the term "specialty hospital" means a subsection (d) hospital (as defined in section 1886(d)(1)(B)) that is primarily or exclusively engaged in the care and treatment of one of the following categories:

(i) Patients with a cardiac condition.

(ii) Patients with an orthopedic condition.

(iii) Patients receiving a surgical procedure.

(iv) Any other specialized category of services that the Secretary designates as inconsistent with the purpose of permitting physician ownership and investment interests in a hospital under this section.

(B) EXCEPTION.—For purposes of this section, the term "specialty hospital" does not include any hospital—

(i) determined by the Secretary—

(I) to be in operation before November 18, 2003; or

(II) under development as of such date;[592]

[591] P.L. 108–173, §507(a)(1)(B), added paragraph (7), effective December 8, 2003.

[592] See Vol. II, P.L. 108-173, §507(b), with respect to the application of exception for hospitals under development.

(ii) for which the number of physician investors at any time on or after such date is no greater than the number of such investors as of such date;

(iii) for which the type of categories described in subparagraph (A) at any time on or after such date is no different than the type of such categories as of such date;

(iv) for which any increase in the number of beds occurs only in the facilities on the main campus of the hospital and does not exceed 50 percent of the number of beds in the hospital as of November 18, 2003, or 5 beds, whichever is greater; and

(v) that meets such other requirements as the Secretary may specify.

PROVIDER REIMBURSEMENT REVIEW BOARD

SEC. 1878. [42 U.S.C. 1395oo] (a) Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) and (except as provided in subsection (g)(2)) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1886 and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if—

(1) such provider—

(A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1816 as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this title for the period covered by such report, or

(ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1886,

(B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply,

(2) the amount in controversy is $10,000 or more, and

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i), or with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination, or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

(b) The provisions of subsection (a) shall apply to any group of providers of services if each provider of services in such group would, upon the filing of an appeal (but without regard to the $10,000 limitation), be entitled to such a hearing, but only if the matters in controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is, in the aggregate, $50,000 or more.

(c) At such hearing, the provider of services shall have the right to be represented by counsel, to introduce evidence, and to examine and cross-examine witnesses. Evidence may be received at any such hearing even though inadmissible under rules of evidence applicable to court procedure.

(d) A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

(e) The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this title or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this section. In the course of any hearing the Board may administer oaths and affirmations. The provisions of subsections (d) and (e) of section 205 with respect to subpenas shall apply to the Board to the same extent as they apply to the Secretary with respect to title II.

(f)(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. If a provider of services may obtain a hearing under subsection (a) and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision

and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5, United States Code, notwithstanding any other provisions in section 205. Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) must be brought by such providers as a group with respect to any matter involving an issue common to such providers.

(2) Where a provider seeks judicial review pursuant to paragraph (1), the amount in controversy shall be subject to annual interest beginning on the first day of the first month beginning after the 180-day period as determined pursuant to subsection (a)(3) and equal to the rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund for the month in which the civil action authorized under paragraph (1) is commenced, to be awarded by the reviewing court in favor of the prevailing party.

(3) No interest awarded pursuant to paragraph (2) shall be deemed income or cost for the purposes of determining reimbursement due providers under this Act.

(g)(1) The finding of a fiscal intermediary that no payment may be made under this title for any expenses incurred for items or services furnished to an individual because such items or services are listed in section 1862 shall not be reviewed by the Board, or by any court pursuant to an action brought under subsection (f).

(2) The determinations and other decisions described in section 1886(d)(7) shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) or otherwise.

(h) The Board shall be composed of five members appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive services. Two of such members shall be representative of providers of services. All of the members of the Board shall be persons knowledgeable in the field of payment of providers of services, and at least one of them shall be a certified public accountant. Members of the Board shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding the rate specified (at the time the service involved is rendered by such members) for grade GS-18 in section 5332 of title 5, United States Code. The term of office shall be three years, except that the Secretary shall appoint the initial members of the Board for shorter terms to the extent necessary to permit staggered terms of office.

(i) The Board is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Board such secretarial, clerical, and other assistance as the Board may require to carry out its functions.

(j) In this section, the term "provider of services" includes a rural health clinic and a Federally qualified health center.

LIMITATION ON LIABILITY OF BENEFICIARY WHERE MEDICARE CLAIMS ARE DISALLOWED[593]

SEC. 1879. [42 U.S.C. 1395pp] (a) Where—

(1) a determination is made that, by reason of section 1862(a)(1) or (9) or by reason of a coverage denial described in subsection (g), payment may not be made under part A or part B of this title for any expenses incurred for items or services furnished an individual by a provider of services or by another person pursuant to an assignment under section 1842(b)(3)(B)(ii), and

(2) both such individual and such provider of services or such other person, as the case may be, did not know, and could not reasonably have been expected to know, that payment would not be made for such items or services under such part A or part B,

then to the extent permitted by this title, payment shall, notwithstanding such determination, be made for such items or services (and for such period of time as the Secretary finds will carry out the objectives of this title), as though section 1862(a)(1) and section 1862(a)(9) did not apply and as though the coverage denial described in subsection (g) had not occurred. In each such case the Secretary shall notify both such individual and such provider of services or such other person, as the case may be, of the conditions under which payment for such items or services was made and in the case of comparable situations arising thereafter with respect to such individual or such provider or such other person, each shall, by reason of such notice (or similar notices provided before the enactment of this section[594]), be deemed to have knowledge that payment cannot be made for such items or services or reasonably comparable items or services. Any provider or other person furnishing items or services for which payment may not be made by reason of section 1862(a)(1) or (9) or by reason of a coverage denial described in subsection (g) shall be deemed to have knowledge that payment cannot be made for such items or services if the claim relating to such items or services involves a case, provider or other person furnishing services, procedure, or test, with respect to which such provider or other person has been notified by the Secretary (including notification by a utilization and quality control peer review organization) that a pattern of inappropriate utilization has occurred in the past, and such provider or other person has been allowed a reasonable time to correct such inappropriate utilization.

(b) In any case in which the provisions of paragraphs (1) and (2) of subsection (a) are met, except that such provider or such other person, as the case may be, knew, or could be expected to know, that payment for such services or items could not be made under such part A or part B, then the Secretary shall, upon proper application filed within such time as may be prescribed in regulations, indemnify the individual (referred to in such paragraphs) for any

[593] See Vol. II, P.L. 97–248, §119, with respect to private sector review initiative and restriction against recovery from beneficiaries.

See Vol. II, P.L. 108-173, §938(c), with respect to provisions relating to advance beneficiary notices and a report on prior deterimination process.

[594] October 30, 1972 [P.L. 92–603; 86 Stat. 1385].

payments received from such individual by such provider or such other person, as the case may be, for such items or services. Any payments made by the Secretary as indemnification shall be deemed to have been made to such provider or such other person, as the case may be, and shall be treated as overpayments, recoverable from such provider or such other person, as the case may be, under applicable provisions of law. In each such case the Secretary shall notify such individual of the conditions under which indemnification is made and in the case of comparable situations arising thereafter with respect to such individual, he shall, by reason of such notice (or similar notices provided before the enactment of this section[595]), be deemed to have knowledge that payment cannot be made for such items or services. No item or service for which an individual is indemnified under this subsection shall be taken into account in applying any limitation on the amount of items and services for which payment may be made to or on behalf of the individual under this title.

(c) No payments shall be made under this title in any cases in which the provisions of paragraph (1) of subsection (a) are met, but both the individual to whom the items or services were furnished and the provider of service or other person, as the case may be, who furnished the items or services knew, or could reasonably have been expected to know, that payment could not be made for items or services under part A or part B by reason of section 1862(a)(1) or (a)(9) or by reason of a coverage denial described in subsection (g).

(d) In any case arising under subsection (b) (but without regard to whether payments have been made by the individual to the provider or other person) or subsection (c), the provider or other person shall have the same rights that an individual has under sections 1869(b) and 1842(b)(3)(C) (as may be applicable) when the amount of benefit or payments is in controversy, except that such rights may, under prescribed regulations, be exercised by such provider or other person only after the Secretary determines that the individual will not exercise such rights under such sections.

(e) Where payment for inpatient hospital services or extended care services may not be made under part A of this title on behalf of an individual entitled to benefits under such part solely because of an unintentional, inadvertent, or erroneous action with respect to the transfer of such individual from a hospital or skilled nursing facility that meets the requirements of section 1861(e) or (j) by such a provider of services acting in good faith in accordance with the advice of a utilization review committee, quality control and peer review organization, or fiscal intermediary, or on the basis of a clearly erroneous administrative decision by a provider of services, the Secretary shall take such action with respect to the payment of such benefits as he determines may be necessary to correct the effects of such unintentional, inadvertent, or erroneous action.

(f)(1) A home health agency which meets the applicable requirements of paragraphs (3) and (4) shall be presumed to meet the requirement of subsection (a)(2).

(2) The presumption of paragraph (1) with respect to specific services may be rebutted by actual or imputed knowledge of

[595] October 30, 1972 [P.L. 92–603; 86 Stat. 1385].

the facts described in subsection (a)(2), including any of the following:

(A) Notice by the fiscal intermediary of the fact that payment may not be made under this title with respect to the services.

(B) It is clear and obvious that the provider should have known at the time the services were furnished that they were excluded from coverage.

(3) The requirements of this paragraph are as follows:

(A) The agency complies with requirements of the Secretary under this title respecting timely submittal of bills for payment and medical documentation.

(B) The agency program has reasonable procedures to notify promptly each patient (and the patient's physician) where it is determined that a patient is being or will be furnished items or services which are excluded from coverage under this title.

(4)(A) The requirement of this paragraph is that, on the basis of bills submitted by a home health agency during the previous quarter, the rate of denial of bills for the agency by reason of a coverage denial described in subsection (g) does not exceed 2.5 percent, computed based on visits for home health services billed.

(B) For purposes of determining the rate of denial of bills for a home health agency under subparagraph (A), a bill shall not be considered to be denied until the expiration of the 60-day period that begins on the date such bill is denied by the fiscal intermediary, or, with respect to such a denial for which the agency requests reconsideration, until the fiscal intermediary issues a decision denying payment for such bill.

(5) In this subsection, the term "fiscal intermediary" means, with respect to a home health agency, an agency or organization with an agreement under section 1816 with respect to the agency.

(6) The Secretary shall monitor the proportion of denied bills submitted by home health agencies for which reconsideration is requested, and shall notify Congress if the proportion of denials reversed upon reconsideration increases significantly.

(g) The coverage denial described in this subsection is—

(1) with respect to the provision of home health services to an individual, a failure to meet the requirements of section 1814(a)(2)(C) or section 1835(a)(2)(A) in that the individual—

(A) is or was not confined to his home, or

(B) does or did not need skilled nursing care on an intermittent basis; and

(2) with respect to the provision of hospice care to an individual, a determination that the individual is not terminally ill.

(h) If a supplier of medical equipment and supplies (as defined in section 1834(j)(5))—

(1) furnishes an item or service to a beneficiary for which no payment may be made by reason of section 1834(j)(1);

(2) furnishes an item or service to a beneficiary for which payment is denied in advance under section 1834(a)(15); or

(3) furnishes an item or service to a beneficiary for which no payment may be made by reason of section 1834(a)(17)(B),

any expenses incurred for items and services furnished to an individual by such a supplier on an assignment-related basis shall be the responsibility of such supplier. The individual shall have no financial responsibility for such expenses and the supplier shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts collected from the individual for such items or services. The provisions of section 1834(a)(18) shall apply to refunds required under the previous sentence in the same manner as such provisions apply to refunds under such section.

INDIAN HEALTH SERVICE FACILITIES[596]

SEC. 1880. [42 U.S.C. 1395qq] (a) A hospital or skilled nursing facility of the Indian Health Service, whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act[597]), shall be eligible for payments under this title, notwithstanding sections 1814(c) and 1835(d), if and for so long as it meets all of the conditions and requirements for such payments which are applicable generally to hospitals or skilled nursing facilities (as the case may be) under this title.

(b) Notwithstanding subsection (a), a hospital or skilled nursing facility of the Indian Health Service which does not meet all of the conditions and requirements of this title which are applicable generally to hospitals or skilled nursing facilities (as the case may be), but which submits to the Secretary within six months after the date of the enactment of this section[598] an acceptable plan for achieving compliance with such conditions and requirements, shall be deemed to meet such conditions and requirements (and to be eligible for payments under this title), without regard to the extent of its actual compliance with such conditions and requirements, during the first 12 months after the month in which such plan is submitted.

(c) Notwithstanding any other provision of this title, payments to which any hospital or skilled nursing facility of the Indian Health Service is entitled by reason of this section shall be placed in a special fund to be held by the Secretary and used by him (to such extent or in such amounts as are provided in appropriation Acts) exclusively for the purpose of making any improvements in the hospitals and skilled nursing facilities of such Service which may be necessary to achieve compliance with the applicable conditions and requirements of this title. The preceding sentence shall cease to apply when the Secretary determines and certifies that substantially all of the hospitals and skilled nursing facilities of such Service in the United States are in compliance with such conditions and requirements.

(d) The annual report of the Secretary which is required by section 701 of the Indian Health Care Improvement Act shall include (along with the matters specified in section 403 of such Act) a detailed statement of the status of the hospitals and skilled nursing facilities of the Service in terms of their compliance with the applicable conditions and requirements of this title and of the progress

[596] See P.L. 94–437, §401(c) with respect to appropriations, and §401(d) with respect to equality of right to coverage.
[597] P.L. 94–437.
[598] September 30, 1976 [P.L. 94–437; 90 Stat. 1400].

being made by such hospitals and facilities (under plans submitted under subsection (b) and otherwise) toward the achievement of such compliance.

(e)(1)(A) Notwithstanding section 1835(d), subject to subparagraph (B), the Secretary shall make payment under part B to a hospital or an ambulatory care clinic (whether provider-based or freestanding) that is operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined for purposes of subsection (a)) for services described in paragraph (2) (and for items and services furnished during the 5-year period beginning on January 1, 2005, all items and services for which payment may be made under part B)[599] furnished in or at the direction of the hospital or clinic under the same situations, terms, and conditions as would apply if the services were furnished in or at the direction of such a hospital or clinic that was not operated by such Service, tribe, or organization.

(B) Payment shall not be made for services under subparagraph (A) to the extent that payment is otherwise made for such services under this title

(2) The services described in this paragraph are the following:

(A) Services for which payment is made under section 1848.

(B) Services furnished by a practitioner described in section 1842(b)(18)(C) for which payment under part B is made under a fee schedule.

(C) Services furnished by a physical therapist or occupational therapist as described in section 1861(p) for which payment under part B is made under a fee schedule.

(3) Subsection (c) shall not apply to payments made under this subsection.

(f) For provisions relating to the authority of certain Indian tribes, tribal organizations, and Alaska Native health organizations to elect to directly bill for, and receive payment for, health care services provided by a hospital or clinic of such tribes or organizations and for which payment may be made under this title, see section 405 of the Indian Health Care Improvement Act[600] (25 U.S.C. 1645).

MEDICARE COVERAGE FOR END STAGE RENAL DISEASE PATIENTS[601]

SEC. 1881. [42 U.S.C. 1395rr] (a) The benefits provided by parts A and B of this title shall include benefits for individuals who have been determined to have end stage renal disease as provided in section 226A, and benefits for kidney donors as provided in subsection (d) of this section. Notwithstanding any other provision of this title, the type, duration, and scope of the benefit provided by parts A and B with respect to individuals who have been deter-

[599] P.L. 108–173, §630, added "(and for items and services furnished during the 5-year period beginning on January 1, 2005, all items and services for which payment may be made under part B)", effective December 8, 2003.

[600] See Vol. II, P.L. 99–660, §405.

[601] See Vol. II, P.L. 106–554, §1(a)(6)[422(a)(2)], with respect to prohibition on exceptions under §1881(b)(7); [422(b)], with respect to development of ESRO market, and [422(c)], with respect to inclusion of additional services in composite rate.

See Vol. II, P.L. 108-173, §623(c), with respect to Inspector General studies on ESRD drugs; §623(e), with respect to a demonstration of bundled case-mix adjusted payment system for ESRD services; and §623(f), with respect to a report on a bundled prospective payment system for end stage renal disease services.

mined to have end stage renal disease and who are entitled to such benefits without regard to section 226A shall in no case be less than the type, duration, and scope of the benefits so provided for individuals entitled to such benefits solely by reason of that section.

(b)(1) Payments under this title with respect to services, in addition to services for which payment would otherwise be made under this title, furnished to individuals who have been determined to have end stage renal disease shall include (A) payments on behalf of such individuals to providers of services and renal dialysis facilities which meet such requirements as the Secretary shall by regulation prescribe for institutional dialysis services and supplies (including self-dialysis services in a self-care dialysis unit maintained by the provider or facility), transplantation services, self-care home dialysis support services which are furnished by the provider or facility, and routine professional services performed by a physician during a maintenance dialysis episode if payments for his other professional services furnished to an individual who has end stage renal disease are made on the basis specified in paragraph (3)(A) of this subsection, (B) payments to or on behalf of such individuals for home dialysis supplies and equipment, and (C) payments to a supplier of home dialysis supplies and equipment that is not a provider of services, a renal dialysis facility, or a physician for self-administered erythropoietin as described in section 1861(s)(2)(P) if the Secretary finds that the patient receiving such drug from such a supplier can safely and effectively administer the drug (in accordance with the applicable methods and standards established by the Secretary pursuant to such section). The requirements prescribed by the Secretary under subparagraph (A) shall include requirements for a minimum utilization rate for transplantations.

(2)(A) With respect to payments for dialysis services furnished by providers of services and renal dialysis facilities to individuals determined to have end stage renal disease for which payments may be made under part B of this title, such payments (unless otherwise provided in this section) shall be equal to 80 percent of the amounts determined in accordance with subparagraph (B); and with respect to payments for services for which payments may be made under part A of this title, the amounts of such payments (which amounts shall not exceed, in respect to costs in procuring organs attributable to payments made to an organ procurement agency or histocompatibility laboratory, the costs incurred by that agency or laboratory) shall be determined in accordance with section 1861(v) or section 1886 (if applicable). Payments shall be made to a renal dialysis facility only if it agrees to accept such payments as payment in full for covered services, except for payment by the individual of 20 percent of the estimated amounts for such services calculated on the basis established by the Secretary under subparagraph (B) and the deductible amount imposed by section 1833(b).

(B) The Secretary shall prescribe in regulations any methods and procedures to (i) determine the costs incurred by providers of services and renal dialysis facilities in furnishing covered services to individuals determined to have end stage renal disease, and (ii) determine, on a cost-related basis or other economical and equitable basis (including

any basis authorized under section 1861(v)) and consistent with any regulations promulgated under paragraph (7), the amounts of payments to be made for part B services furnished by such providers and facilities to such individuals.

(C) Such regulations, in the case of services furnished by proprietary providers and facilities (other than hospital outpatient departments) may include, if the Secretary finds it feasible and appropriate, provision for recognition of a reasonable rate of return on equity capital, providing such rate of return does not exceed the rate of return stipulated in section 1861(v)(1)(B).

(D) For purposes of section 1878, a renal dialysis facility shall be treated as a provider of services.

(3) With respect to payments for physicians' services furnished to individuals determined to have end stage renal disease, the Secretary shall pay 80 percent of the amounts calculated for such services—

(A) on a reasonable charge basis (but may, in such case, make payment on the basis of the prevailing charges of other physicians for comparable services or, for services furnished on or after January 1, 1992, on the basis described in section 1848) except that payment may not be made under this subparagraph for routine services furnished during a maintenance dialysis episode, or

(B) on a comprehensive monthly fee or other basis (which effectively encourages the efficient delivery of dialysis services and provides incentives for the increased use of home dialysis) for an aggregate of services provided over a period of time (as defined in regulations).

(4)(A) Pursuant to agreements with approved providers of services and renal dialysis facilities, the Secretary may make payments to such providers and facilities for the cost of home dialysis supplies and equipment and self-care home dialysis support services furnished to patients whose self-care home dialysis is under the direct supervision of such provider or facility, on the basis of a target reimbursement rate (as defined in paragraph (6)) or on the basis of a method established under paragraph (7).

(B) The Secretary shall make payments to a supplier of home dialysis supplies and equipment furnished to a patient whose self-care home dialysis is not under the direct supervision of an approved provider of services or renal dialysis facility only in accordance with a written agreement under which—

(i) the patient certifies that the supplier is the sole provider of such supplies and equipment to the patient,

(ii) the supplier agrees to receive payment for the cost of such supplies and equipment only on an assignment-related basis, and

(iii) the supplier certifies that it has entered into a written agreement with an approved provider of services or renal dialysis facility under which such provider or facility agrees to furnish to such patient all self-care home dialysis support services and all other

necessary dialysis services and supplies, including institutional dialysis services and supplies and emergency services.

(5) An agreement under paragraph (4) shall require, in accordance with regulations prescribed by the Secretary, that the provider or facility will—

(A) assume full responsibility for directly obtaining or arranging for the provision of—

(i) such medically necessary dialysis equipment as is prescribed by the attending physician;

(ii) dialysis equipment maintenance and repair services;

(iii) the purchase and delivery of all necessary medical supplies; and

(iv) where necessary, the services of trained home dialysis aides;

(B) perform all such administrative functions and maintain such information and records as the Secretary may require to verify the transactions and arrangements described in subparagraph (A);

(C) submit such cost reports, data, and information as the Secretary may require with respect to the costs incurred for equipment, supplies, and services furnished to the facility's home dialysis patient population; and

(D) provide for full access for the Secretary to all such records, data, and information as he may require to perform his functions under this section.

(6) The Secretary shall establish, for each calendar year, commencing with January 1, 1979, a target reimbursement rate for home dialysis which shall be adjusted for regional variations in the cost of providing home dialysis. In establishing such a rate, the Secretary shall include—

(A) the Secretary's estimate of the cost of providing medically necessary home dialysis supplies and equipment;

(B) an allowance, in an amount determined by the Secretary, to cover the cost of providing personnel to aid in home dialysis; and

(C) an allowance, in an amount determined by the Secretary, to cover administrative costs and to provide an incentive for the efficient delivery of home dialysis;

but in no event (except as may be provided in regulations under paragraph (7)) shall such target rate exceed 75 percent of the national average payment, adjusted for regional variations, for maintenance dialysis services furnished in approved providers and facilities during the preceding fiscal year. Any such target rate so established shall be utilized, without renegotiation of the rate, throughout the calendar year for which it is established. During the last quarter of each calendar year, the Secretary shall establish a home dialysis target reimbursement rate for the next calendar year based on the most recent data available to the Secretary at the time. In establishing any rate under this paragraph, the Secretary may utilize a competitive-bid procedure, a prenegotiated rate procedure, or any other procedure (including methods established under paragraph (7)) which the Secretary determines is appropriate and feasible in order to carry out this paragraph in an effective and efficient manner.

(7) Subject to paragraph (12), the Secretary[602] shall provide by regulation for a method (or methods) for determining prospectively the amounts of payments to be made for dialysis services furnished by providers of services and renal dialysis facilities to individuals in a facility and to such individuals at home. Such method (or methods) shall provide for the prospective determination of a rate (or rates) for each mode of care based on a single composite weighted formula (which takes into account the mix of patients who receive dialysis services at a facility or at home and the relative costs of providing such services in such settings) for hospital-based facilities and such a single composite weighted formula for other renal dialysis facilities, or based on such other method or combination of methods which differentiate between hospital-based facilities and other renal dialysis facilities and which the Secretary determines, after detailed analysis, will more effectively encourage the more efficient delivery of dialysis services and will provide greater incentives for increased use of home dialysis than through the single composite weighted formulas. The amount of a payment made under any method other than a method based on a single composite weighted formula may not exceed the amount (or, in the case of continuous cycling peritoneal dialysis, 130 percent of the amount) of the median payment that would have been made under the formula for hospital-based facilities. Subject to section 422(a)(2) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the Secretary[603] shall provide for such exceptions to such methods as may be warranted by unusual circumstances (including the special circumstances of sole facilities located in isolated, rural areas and of pediatric facilities). Each application for such an exception shall be deemed to be approved unless the Secretary disapproves it by not later than 60 working days after the date the application is filed. The Secretary may provide that such method will serve in lieu of any target reimbursement rate that would otherwise be established under paragraph (6). The Secretary shall reduce the amount of each composite rate payment under this paragraph for each treatment by 50 cents (subject to such adjustments as may be required to reflect modes of dialysis other than hemodialysis) and provide for payment of such amount to the organizations (designated under subsection (c)(1)(A)) for such organizations' necessary and proper administrative costs incurred in carrying out the responsibilities described in subsection (c)(2). The Secretary shall provide that amounts paid under the previous sentence shall be distributed to the organizations described in subsection (c)(1)(A) to ensure equitable treatment of all such network organizations. The Secretary in distributing any such payments to network organizations shall take into account—

(A) the geographic size of the network area;

(B) the number of providers of end stage renal disease services in the network area;

[602] P.L. 108-173, §623(d)(2), struck out "The Secretary" and substituted "Subject to paragraph (12), the Secretary", effective December 8, 2003.

[603] P.L. 108–173, §623(b)(2), struck out "The Secretary" and substituted "Subject to section 422(a)(2) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the Secretary", effective December 8, 2003.

(C) the number of individuals who are entitled to end stage renal disease services in the network area; and

(D) the proportion of the aggregate administrative funds collected in the network area.

The Secretary shall increase the amount of each composite rate payment for dialysis services furnished during 2000 by 1.2 percent above such composite rate payment amounts for such services furnished on December 31, 1999,[604] for such services furnished on or after January 1, 2001, and before January 1, 2005,[605] by 2.4 percent above such composite rate payment amounts for such services furnished on December 31, 2000, and for such services furnished on or after January 1, 2005, by 1.6 percent above such composite rate payment amounts for such services furnished on December 31, 2004[606].

(8) For purposes of this title, the term "home dialysis supplies and equipment" means medically necessary supplies and equipment (including supportive equipment) required by an individual suffering from end stage renal disease in connection with renal dialysis carried out in his home (as defined in regulations), including obtaining, installing, and maintaining such equipment.

(9) For purposes of this title, the term "self-care home dialysis support services", to the extent permitted in regulation, means—

(A) periodic monitoring of the patient's home adaptation, including visits by qualified provider or facility personnel (as defined in regulations), so long as this is done in accordance with a plan prepared and periodically reviewed by a professional team (as defined in regulations) including the individual's physician;

(B) installation and maintenance of dialysis equipment;

(C) testing and appropriate treatment of the water; and

(D) such additional supportive services as the Secretary finds appropriate and desirable.

(10) For purposes of this title, the term "self-care dialysis unit" means a renal dialysis facility or a distinct part of such facility or of a provider of services, which has been approved by the Secretary to make self-dialysis services, as defined by the Secretary in regulations, available to individuals who have been trained for self-dialysis. A self-care dialysis unit must, at a minimum, furnish the services, equipment and supplies needed for self-care dialysis, have patient-staff ratios which are appropriate to self-dialysis (allowing for such appropriate lesser degree of ongoing medical supervision and assistance of ancillary personnel than is required for full care maintenance dialysis), and meet such other requirements as the Secretary may prescribe with respect to the quality and cost-effectiveness of services.

(11)(A) Hepatitis B vaccine and its administration, when provided to a patient determined to have end stage renal disease, shall not be included as dialysis services for purposes of pay-

[604] P.L. 108–173, §623(a)(1), struck out "and".

[605] P.L. 108–173, §623(a)(2), inserted "and before January 1, 2005,", effective December 8, 2003.

[606] P.L. 108–173, §623(a)(3), inserted ", and for such services furnished on or after January 1, 2005, by 1.6 percent above such composite rate payment amounts for such services furnished on December 31, 2004", effective December 8, 2003.

ment under any prospective payment amount or comprehensive fee established under this section. Payment for such vaccine and its administration shall be made separately in accordance with section 1833.

(B) Erythropoietin, when provided to a patient determined to have end stage renal disease, shall not be included as a dialysis service for purposes of payment under any prospective payment amount or comprehensive fee established under this section, and subject to paragraphs (12) and (13)[607] payment for such item shall be made separately—

(i) in the case of erythropoietin provided by a physician, in accordance with section 1833; and

(ii) in the case of erythropoietin provided by a provider of services, renal dialysis facility, or other supplier of home dialysis supplies and equipment—

(I) for erythropoietin provided during 1994, in an amount equal to $10 per thousand units (rounded to the nearest 100 units), and

(II) for erythropoietin provided during a subsequent year, in an amount determined to be appropriate by the Secretary, except that such amount may not exceed the amount determined under this clause for the previous year increased by the percentage increase (if any) in the implicit price deflator for gross national product (as published by the Department of Commerce) for the second quarter of the preceding year over the implicit price deflator for the second quarter of the second preceding year.

(C) The amount payable to a supplier of home dialysis supplies and equipment that is not a provider of services, a renal dialysis facility, or a physician for erythropoietin shall be determined in the same manner as the amount payable to a renal dialysis facility for such item.

(12)[608](A) In lieu of payment under paragraph (7) beginning with services furnished on January 1, 2005, the Secretary shall establish a basic case-mix adjusted prospective payment system for dialysis services furnished by providers of services and renal dialysis facilities in a year to individuals in a facility and to such individuals at home. The case-mix under such system shall be for a limited number of patient characteristics.

(B) The system described in subparagraph (A) shall include—

(i) the services comprising the composite rate established under paragraph (7); and

(ii) the difference between payment amounts under this title for separately billed drugs and biologicals (including erythropoietin) and acquisition costs of such drugs and biologicals, as determined by the Inspector General reports to the Secretary as required by section

[607] P.L. 108-173, §623(d)(3), inserted "subject to paragraphs (12) and (13)", effective December 8, 2003.

[608] P.L. 108–173, §623(d)(1), added paragraph (12), effective December 8, 2003.

623(c) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [609]—

(I) beginning with 2005, for such drugs and biologicals for which a billing code exists prior to January 1, 2004; and

(II) beginning with 2007, for such drugs and biologicals for which a billing code does not exist prior to January 1, 2004,

adjusted to 2005, or 2007, respectively, as determined to be appropriate by the Secretary.

(C)(i) In applying subparagraph (B)(ii) for 2005, such payment amounts under this title shall be determined using the methodology specified in paragraph (13)(A)(i).

(ii) For 2006, the Secretary shall provide for an adjustment to the payments under clause (i) to reflect the difference between the payment amounts using the methodology under paragraph (13)(A)(i) and the payment amount determined using the methodology applied by the Secretary under paragraph (13)(A)(iii) of such paragraph, as estimated by the Secretary.

(D) The Secretary shall adjust the payment rates under such system by a geographic index as the Secretary determines to be appropriate. If the Secretary applies a geographic index under this paragraph that differs from the index applied under paragraph (7) the Secretary shall phase-in the application of the index under this paragraph over a multiyear period.

(E)(i) Such system shall be designed to result in the same aggregate amount of expenditures for such services, as estimated by the Secretary, as would have been made for 2005 if this paragraph did not apply.

(ii) The adjustment made under subparagraph (B)(ii)(II) shall be done in a manner to result in the same aggregate amount of expenditures after such adjustment as would otherwise have been made for such services for 2006 or 2007, respectively, as estimated by the Secretary, if this paragraph did not apply.

(F) Beginning with 2006, the Secretary shall annually increase the basic case-mix adjusted payment amounts established under this paragraph, by an amount determined by—

(i) applying the estimated growth in expenditures for drugs and biologicals (including erythropoietin) that are separately billable to the component of the basic case-mix adjusted system described in subparagraph (B)(ii); and

(ii) converting the amount determined in clause (i) to an increase applicable to the basic case-mix adjusted payment amounts established under subparagraph (B).

Nothing in this paragraph shall be construed as providing for an update to the composite rate component of the basic case-mix adjusted system under subparagraph (B).

[609] See Vol. II, P.L. 108-173, §623(c).

(G) There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of the case-mix system, relative weights, payment amounts, the geographic adjustment factor, or the update for the system established under this paragraph, or the determination of the difference between medicare payment amounts and acquisition costs for separately billed drugs and biologicals including erythropoietin) under this paragraph and paragraph (13).

(13)[610](A) The payment amounts under this title for separately billed drugs and biologicals furnished in a year, beginning with 2004, are as follows:

(i) For such drugs and biologicals (other than erythropoietin) furnished in 2004, the amount determined under section 1842(o)(1)(A)(v) for the drug or biological.

(ii) For such drugs and biologicals (including erythropoietin) furnished in 2005, the acquisition cost of the drug or biological, as determined by the Inspector General reports to the Secretary as required by section 623(c) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003[611]. Insofar as the Inspector General has not determined the acquisition cost with respect to a drug or biological, the Secretary shall determine the payment amount for such drug or biological.

(iii) For such drugs and biologicals (including erythropoietin) furnished in 2006 and subsequent years, such acquisition cost or the amount determined under section 1847A for the drug or biological, as the Secretary may specify.

(B)(i) Drugs and biologicals (including erythropoietin) which were separately billed under this subsection on the day before the date of the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003[612] shall continue to be separately billed on and after such date.

(ii) Nothing in this paragraph, section 1842(o), section 1847A, or section 1847B shall be construed as requiring or authorizing the bundling of payment for drugs and biologicals into the basic case-mix adjusted payment system under this paragraph.

(c)(1)(A)(i) For the purpose of assuring effective and efficient administration of the benefits provided under this section, the Secretary shall, in accordance with such criteria as he finds necessary to assure the performance of the responsibilities and functions specified in paragraph (2)—

(I) establish at least 17 end stage renal disease network areas, and

(II) for each such area, designate a network administrative organization which, in accordance with regulations of the Secretary, shall establish (aa) a network council of renal dialysis and

[610] P.L. 108–173, §623(d)(1), added paragraph (13), effective December 8, 2003.
[611] See Vol. II, P.L. 108-173, §623(c).
[612] December 8, 2003.

transplant facilities located in the area and (bb) a medical review board, which has a membership including at least one patient representative and physicians, nurses, and social workers engaged in treatment relating to end stage renal disease.

The Secretary shall publish in the Federal Register a description of the geographic area that he determines, after consultation with appropriate professional and patient organizations, constitutes each network area and the criteria on the basis of which such determination is made.

(ii)(I) In order to determine whether the Secretary should enter into, continue, or terminate an agreement with a network administrative organization designated for an area established under clause (i), the Secretary shall develop and publish in the Federal Register standards, criteria, and procedures to evaluate an applicant organization's capabilities to perform (and, in the case of an organization with which such an agreement is in effect, actual performance of) the responsibilities described in paragraph (2). The Secretary shall evaluate each applicant based on quality and scope of services and may not accord more than 20 percent of the weight of the evaluation to the element of price.

(II) An agreement with a network administrative organization may be terminated by the Secretary only if he finds, after applying such standards and criteria, that the organization has failed to perform its prescribed responsibilities effectively and efficiently. If such an agreement is to be terminated, the Secretary shall select a successor to the agreement on the basis of competitive bidding and in a manner that provides an orderly transition.

(B) At least one patient representative shall serve as a member of each network council and each medical review board.

(C) The Secretary shall, in regulations, prescribe requirements with respect to membership in network organizations by individuals (and the relatives of such individuals) (i) who have an ownership or control interest in a facility or provider which furnishes services referred to in section 1861(s)(2)(F), or (ii) who have received remuneration from any such facility or provider in excess of such amounts as constitute reasonable compensation for services (including time and effort relative to the provision of professional medical services) or goods supplied to such facility or provider; and such requirements shall provide for the definition, disclosure, and, to the maximum extent consistent with effective administration, prevention of potential or actual financial or professional conflicts of interest with respect to decisions concerning the appropriateness, nature, or site of patient care.

(2) The network organizations of each network shall be responsible, in addition to such other duties and functions as may be prescribed by the Secretary, for—

(A) encouraging, consistent with sound medical practice, the use of those treatment settings most compatible with the successful rehabilitation of the patient and the participation of patients, providers of services, and renal disease facilities in vocational rehabilitation programs;

(B) developing criteria and standards relating to the quality and appropriateness of patient care and with respect to working with patients, facilities, and providers in encouraging participation in vocational rehabilitation programs; and network goals with respect to the placement of patients in self-care settings and undergoing or preparing for transplantation;

(C) evaluating the procedure by which facilities and providers in the network assess the appropriateness of patients for pro- posed treatment modalities;

(D) implementing a procedure for evaluating and resolving patient grievances;

(E) conducting on-site reviews of facilities and providers as necessary (as determined by a medical review board or the Secretary), utilizing standards of care established by the network organization to assure proper medical care;

(F) collecting, validating, and analyzing such data as are necessary to prepare the reports required by subparagraph (H) and to assure the maintenance of the registry established under paragraph (7);

(G) identifying facilities and providers that are not cooperating toward meeting network goals and assisting such facilities and providers in developing appropriate plans for correction and reporting to the Secretary on facilities and providers that are not providing appropriate medical care; and

(H) submitting an annual report to the Secretary on July 1 of each year which shall include a full statement of the network's goals, data on the network's performance in meeting its goals (including data on the comparative performance of facilities and providers with respect to the identification and placement of suitable candidates in self-care settings and transplantation and encouraging participation in vocational rehabilitation programs), identification of those facilities that have consistently failed to cooperate with network goals, and recommendations with respect to the need for additional or alternative services or facilities in the network in order to meet the network goals, including self-dialysis training, transplantation, and organ procurement facilities.

(3) Where the Secretary determines, on the basis of the data contained in the network's annual report and such other relevant data as may be available to him, that a facility or provider has consistently failed to cooperate with network plans and goals or to follow the recommendations of the medical review board, he may terminate or withhold certification of such facility or provider (for purposes of payment for services furnished to individuals with end stage renal disease) until he determines that such provider or facility is making reasonable and appropriate efforts to cooperate with the network's plans and goals. If the Secretary determines that the facility's or pro-

vider's failure to cooperate with network plans and goals does not jeopardize patient health or safety or justify termination of certification, he may instead, after reasonable notice to the provider or facility and to the public, impose such other sanctions as he determines to be appropriate, which sanctions may include denial of reimbursement with respect to some or all patients admitted to the facility after the date of notice to the facility or provider, and graduated reduction in reimbursement for all patients.

(4) The Secretary shall, in determining whether to certify additional facilities or expansion of existing facilities within a network, take into account the network's goals and performance as reflected in the network's annual report.

(5) The Secretary, after consultation with appropriate professional and planning organizations, shall provide such guidelines with respect to the planning and delivery of renal disease services as are necessary to assist network organizations in their development of their respective networks' goals to promote the optimum use of self-dialysis and transplantation by suitable candidates for such modalities.

(6) It is the intent of the Congress that the maximum practical number of patients who are medically, socially, and psychologically suitable candidates for home dialysis or transplantation should be so treated and that the maximum practical number of patients who are suitable candidates for vocational rehabilitation services be given access to such services and encouraged to return to gainful employment. The Secretary shall consult with appropriate professional and network organizations and consider available evidence relating to developments in research, treatment methods, and technology for home dialysis and transplantation.

(7) The Secretary shall establish a national end stage renal disease registry the purpose of which shall be to assemble and analyze the data reported by network organizations, transplant centers, and other sources on all end stage renal disease patients in a manner that will permit—

(A) the preparation of the annual report to the Congress required under subsection (g);

(B) an identification of the economic impact, cost-effectiveness, and medical efficacy of alternative modalities of treatment;

(C) an evaluation with respect to the most appropriate allocation of resources for the treatment and research into the cause of end stage renal disease;

(D) the determination of patient mortality and morbidity rates, and trends in such rates, and other indices of quality of care; and

(E) such other analyses relating to the treatment and management of end stage renal disease as will assist the Congress in evaluating the end stage renal disease program under this section.

The Secretary shall provide for such coordination of data collection activities, and such consolidation of existing end stage renal disease data systems, as is necessary to achieve the purpose of such registry, shall determine the appropriate location of the registry, and shall provide for the appointment of a professional advisory

group to assist the Secretary in the formulation of policies and procedures relevant to the management of such registry.

(8) The provisions of sections 1157 and 1160 shall apply with respect to network administrative organizations (including such organizations as medical review boards) with which the Secretary has entered into agreements under this subsection.

(d) Notwithstanding any provision to the contrary in section 226 any individual who donates a kidney for transplant surgery shall be entitled to benefits under parts A and B of this title with respect to such donation. Reimbursement for the reasonable expenses incurred by such an individual with respect to a kidney donation shall be made (without regard to the deductible, premium, and coinsurance provisions of this title), in such manner as may be prescribed by the Secretary in regulations, for all reasonable preparatory, operation, and postoperation recovery expenses associated with such donation, including but not limited to the expenses for which payment could be made if he were an eligible individual for purposes of parts A and B of this title without regard to this subsection. Payments for postoperation recovery expenses shall be limited to the actual period of recovery.

(e)(1) Notwithstanding any other provision of this title, the Secretary may, pursuant to agreements with approved providers of services, renal dialysis facilities, and nonprofit entities which the Secretary finds can furnish equipment economically and efficiently, reimburse such providers, facilities, and nonprofit entities (without regard to the deductible and coinsurance provisions of this title) for the reasonable cost of the purchase, installation, maintenance and reconditioning for subsequent use of artificial kidney and automated dialysis peritoneal machines (including supportive equipment) which are to be used exclusively by entitled individuals dialyzing at home.

(2) An agreement under this subsection shall require that the provider, facility, or other entity will—

(A) make the equipment available for use only by entitled individuals dialyzing at home;

(B) recondition the equipment, as needed, for reuse by such individuals throughout the useful life of the equipment, including modification of the equipment consistent with advances in research and technology;

(C) provide for full access for the Secretary to all records and information relating to the purchase, maintenance, and use of the equipment; and

(D) submit such reports, data, and information as the Secretary may require with respect to the cost, management, and use of the equipment.

(3) For purposes of this section, the term "supportive equipment" includes blood pumps, heparin pumps, bubble detectors, other alarm systems, and such other items as the Secretary may determine are medically necessary.

(f)(1) The Secretary shall initiate and carry out, at selected locations in the United States, pilot projects under which financial assistance in the purchase of new or used durable medical equipment for renal dialysis is provided to individuals suffering from end stage renal disease at the time home dialysis is begun, with provision for a trial period to assure successful adaptation to home dialysis before the actual purchase of such equipment.

(2) The Secretary shall conduct experiments to evaluate methods for reducing the costs of the end stage renal disease program. Such experiments shall include (without being limited to) reimbursement for nurses and dialysis technicians to assist with home dialysis, and reimbursement to family members assisting with home dialysis.

(3) The Secretary shall conduct experiments to evaluate methods of dietary control for reducing the costs of the end stage renal disease program, including (without being limited to) the use of protein-controlled products to delay the necessity for, or reduce the frequency of, dialysis in the treatment of end stage renal disease.

(4) The Secretary shall conduct a comprehensive study of methods for increasing public participation in kidney donation and other organ donation programs.

(5) The Secretary shall conduct a full and complete study of the reimbursement of physicians for services furnished to patients with end stage renal disease under this title, giving particular attention to the range of payments to physicians for such services, the average amounts of such payments, and the number of hours devoted to furnishing such services to patients at home, in renal disease facilities, in hospitals, and elsewhere.

(6) The Secretary shall conduct a study of the number of patients with end stage renal disease who are not eligible for benefits with respect to such disease under this title (by reason of this section or otherwise), and of the economic impact of such noneligibility of such individuals. Such study shall include consideration of mechanisms whereby governmental and other health plans might be instituted or modified to permit the purchase of actuarially sound coverage for the costs of end stage renal disease.

(7)(A) The Secretary shall establish protocols on standards and conditions for the reuse of dialyzer filters for those facilities and providers which voluntarily elect to reuse such filters.

(B) With respect to dialysis services furnished on or after January 1, 1988 (or July 1, 1988, with respect to protocols that relate to the reuse of bloodlines), no dialysis facility may reuse dialysis supplies (other than dialyzer filters) unless the Secretary has established a protocol with respect to the reuse of such supplies and the facility follows the protocol so established.

(C) The Secretary shall incorporate protocols established under this paragraph, and the requirement of subparagraph (B), into the requirements for facilities prescribed under subsection (b)(1)(A) and failure to follow such a protocol or requirement subjects such a facility to denial of participation in the program established under this section and to denial of payment for dialysis treatment not furnished in compliance with such a protocol or in violation of such requirement.

(8) The Secretary shall submit to the Congress no later than October 1, 1979, a full report on the experiments conducted under paragraphs (1), (2), (3), and (7), and the studies under paragraphs (4), (5), (6), and (7). Such report shall include any recommendations for legislative changes which the Secretary

finds necessary or desirable as a result of such experiments and studies.

(g)(1) In any case where the Secretary—

(A) finds that a renal dialysis facility is not in substantial compliance with requirements for such facilities prescribed under subsection (b)(1)(A),

(B) finds that the facility's deficiencies do not immediately jeopardize the health and safety of patients, and

(C) has given the facility a reasonable opportunity to correct its deficiencies,

the Secretary may, in lieu of terminating approval of the facility, determine that payment under this title shall be made to the facility only for services furnished to individuals who were patients of the facility before the effective date of the notice.

(2) The Secretary's decision to restrict payments under this subsection shall be made effective only after such notice to the public

and to the facility as may be prescribed in regulations, and shall remain in effect until (A) the Secretary finds that the facility is in substantial compliance with the requirements under subsection (b)(1)(A), or (B) the Secretary terminates the agreement under this title with the facility.

(3) A facility dissatisfied with a determination by the Secretary under paragraph (1) shall be entitled to a hearing thereon by the Secretary (after reasonable notice) to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g), except that, in so applying such sections and in applying section 205(l) thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES[613]

SEC. 1882. [42 U.S.C. 1395ss] (a)(1) The Secretary shall establish a procedure whereby medicare supplemental policies (as defined in subsection (g)(1)) may be certified by the Secretary as meeting minimum standards and requirements set forth in subsection (c). Such procedure shall provide an opportunity for any insurer to submit any such policy, and such additional data as the Secretary finds necessary, to the Secretary for his examination and for his certification thereof as meeting the standards and requirements set forth in subsection (c). Subject to subsections (k)(3), (m), and (n), such certification shall remain in effect if the insurer files a notarized statement with the Secretary no later than June 30 of each year stating that the policy continues to meet such standards and requirements and if the insurer submits such additional data as the Secretary finds necessary to independently verify the accuracy of such notarized statement. Where the Secretary determines such a policy meets (or continues to meet) such standards and requirements, he shall authorize the insurer to have printed on such policy (but only in accordance with such requirements and condi-

[613] The abbreviation "NAIC" as used in this section means National Association of Insurance Commissioners; see §1882(g)(2)(A).

tions as the Secretary may prescribe) an emblem which the Secretary shall cause to be designed for use as an indication that a policy has received the Secretary's certification. The Secretary shall provide each State commissioner or superintendent of insurance with a list of all the policies which have received his certification.

(2) No medicare supplemental policy may be issued in a State on or after the date specified in subsection (p)(1)(C) unless—

(A) the State's regulatory program under subsection (b)(1) provides for the application and enforcement of the standards and requirements set forth in such subsection (including the 1991 NAIC Model Regulation or 1991 Federal Regulation or the Federal standards (as the case may be)) by the date specified in subsection (p)(1)(C); or

(B) if the State's program does not provide for the application and enforcement of such standards and requirements, the policy has been certified by the Secretary under paragraph (1) as meeting the standards and requirements set forth in subsection (c) (including such applicable standards) by such date.

Any person who issues a medicare supplemental policy, on and after the effective date specified in subsection (p)(1)(C)), in violation of this paragraph is subject to a civil money penalty of not to exceed $25,000 for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(b)(1) Any medicare supplemental policy issued in any State which the Secretary determines has established under State law a regulatory program that—

(A) provides for the application and enforcement of standards with respect to such policies equal to or more stringent than the NAIC Model Standards (as defined in subsection (g)(2)(A)), except as otherwise provided by subparagraph (H);

(B) includes requirements equal to or more stringent than the requirements described in paragraphs (2) through (5) of subsection (c);

(C) provides that—

(i) information with respect to the actual ratio of benefits provided to premiums collected under such policies will be reported to the State on forms conforming to those developed by the National Association of Insurance Commissioners for such purpose, or

(ii) such ratios will be monitored under the program in an alternative manner approved by the Secretary, and that a copy of each such policy, the most recent premium for each such policy, and a listing of the ratio of benefits provided to premiums collected for the most recent 3–year period for each such policy issued or sold in the State is maintained and made available to interested persons;

(D) provides for application and enforcement of the standards and requirements described in subparagraphs

(A), (B), and (C) to all medicare supplemental policies (as defined in subsection (g)(1)) issued in such State,

(E) provides the Secretary periodically (but at least annually) with a list containing the name and address of the issuer of each such policy and the name and number of each such policy (including an indication of policies that have been previously approved, newly approved, or withdrawn from approval since the previous list was provided),

(F) reports to the Secretary on the implementation and enforcement of standards and requirements of this paragraph at intervals established by the Secretary,

(G) provides for a process for approving or disapproving proposed premium increases with respect to such policies, and establishes a policy for the holding of public hearings prior to approval of a premium increase,

(H) in the case of a policy that meets the standards under subparagraph (A) except that benefits under the policy are limited to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), provides for the application of requirements equal to or more stringent than the requirements under subsection (t),

shall be deemed (subject to subsections (k)(3), (m), and (n), for so long as the Secretary finds that such State regulatory program continues to meet the standards and requirements of this paragraph) to meet the standards and requirements set forth in subsection (c). Each report required under subparagraph (F) shall include information on loss ratios of policies sold in the State, frequency and types of instances in which policies approved by the State fail to meet the standards and requirements of this paragraph, actions taken by the State to bring such policies into compliance, information regarding State programs implementing consumer protection provisions, and such further information as the Secretary in consultation with the National Association of Insurance Commissioners may specify.

(2) The Secretary periodically shall review State regulatory programs to determine if they continue to meet the standards and requirements specified in paragraph (1). If the Secretary finds that a State regulatory program no longer meets the standards and requirements, before making a final determination, the Secretary shall provide the State an opportunity to adopt such a plan of correction as would permit the State regulatory program to continue to meet such standards and requirements. If the Secretary makes a final determination that the State regulatory program, after such an opportunity, fails to meet such standards and requirements, the program shall no longer be considered to have in operation a program meeting such standards and requirements.

(3) Notwithstanding paragraph (1), a medicare supplemental policy offered in a State shall not be deemed to meet the standards and requirements set forth in subsection (c), with respect to an advertisement (whether through written, radio, or television medium) used (or, at a State's option, to be used) for the policy in the State, unless the entity issuing the policy provides a copy of each advertisement to the Commissioner of Insurance (or comparable officer identified by the Secretary) of that State

for review or approval to the extent it may be required under State law.

(c) The Secretary shall certify under this section any medicare supplemental policy, or continue certification of such a policy, only if he finds that such policy (or, with respect to paragraph (3) or the requirement described in subsection (s), the issuer of the policy)—

(1) meets or exceeds (either in a single policy or, in the case of nonprofit hospital and medical service associations, in one or more policies issued in conjunction with one another) the NAIC Model Standards (except as otherwise provided by subsection (t));

(2) meets the requirements of subsection (r);

(3)(A) accepts a notice under section 1842(h)(3)(B) as a claim form for benefits under such policy in lieu of any claim form otherwise required and agrees to make a payment determination on the basis of the information contained in such notice;

(B) where such a notice is received—

(i) provides notice to such physician or supplier and the beneficiary of the payment determination under the policy, and

(ii) provides any payment covered by such policy directly to the participating physician or supplier involved;

(C) provides each enrollee at the time of enrollment a card listing the policy name and number and a single mailing address to which notices under section 1842(h)(3)(B) respecting the policy are to be sent;

(D) agrees to pay any user fees established under section 1842(h)(3)(B) with respect to information transmitted to the issuer of the policy; and

(E) provides to the Secretary at least annually, for transmittal to carriers, a single mailing address to which notices under section 1842(h)(3)(B) respecting the policy are to be sent;

(4) may, during a period of not less than 30 days after the policy is issued, be returned for a full refund of any premiums paid (without regard to the manner in which the purchase of the policy was solicited); and

(5) meets the applicable requirements of subsections (o) through (t).

(d)(1) Whoever knowingly and willfully makes or causes to be made or induces or seeks to induce the making of any false statement or representation of a material fact with respect to the compliance of any policy with the standards and requirements set forth in subsection (c) or in regulations promulgated pursuant to such subsection, or with respect to the use of the emblem designed by the Secretary under subsection (a), shall be fined under title 18, United States Code, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $5,000 for each such prohibited act.

(2) Whoever falsely assumes or pretends to be acting, or misrepresents in any way that he is acting, under the authority of or in association with, the program of health insurance established by this title, or any Federal agency, for the purpose of selling or attempting to sell insurance, or in such pretended

character demands, or obtains money, paper, documents, or anything of value, shall be fined under title 18, United States Code, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $5,000 for each such prohibited act.

(3)(A)(i) It is unlawful for a person to sell or issue to an individual entitled to benefits under part A or enrolled under part B of this title (including an individual electing a Medicare+Choice plan under section 1851)—

(I) a health insurance policy with knowledge tht the policy duplicates health benefits to which the individual is otherwise entitled under this title or title XIX,

(II) in the case of an individual not electing a Medicare+Choice plan, a medicare supplemental policy[614] with knowledge that the individual is entitled to benefits under another medicare supplemental policy or in the case of an individual electing a Medicare+Choice plan, a medicare supplemental policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under the Medicare+Choice plan or under another medicare supplemental policy, or

(III) a health insurance policy (other than a medicare supplemental policy) with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled, other than benefits to which the individual is entitled under a requirement of State or Federal law.

(ii) Whoever violates clause (i) shall be fined under title 18, United States Code, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $25,000 (or $15,000 in the case of a person other than the issuer of the policy) for each such prohibited act.

(iii) A seller (who is not the issuer of a health insurance policy) shall not be considered to violate clause (i) with II respect to the sale of a medicare supplemental policy if the policy is sold in compliance with subparagraph (B).

(iv) For purposes of this subparagraph, a health insurance policy (other than a Medicare supplemental policy) providing for benefits which are payable to or on behalf of an individual without regard to other health benefit coverage of such individual is not considered to "duplicate" any health benefits under this title, under title XIX, or under a health insurance policy, and subclauses (I) and (III) of clause (i) do not apply to such a policy.

[614] P.L. 108-173, §736(e)(1), struck out "plan a medicare supplemental policy" and substituted "plan, a medicare supplemental policy".

(v) For purposes of this subparagraph, a health insurance policy (or a rider to an insurance contract which is not a health insurance policy) is not considered to "duplicate" health benefits under this title or under another health insurance policy if it—

(I) provides health care benefits only for long–term care, nursing home care, home health care, or community–based care, or any combination thereof,

(II) coordinates against or excludes items and services available or paid for under this title or under another health insurance policy, and

(III) for policies sold or issued on or after the end of the 90–day period beginning on the date of enactment of the Health Insurance Portability and Accountability Act of 1996 discloses such coordination or exclusion in the policy's outline of coverage.

For purposes of this clause, the terms "coordinates" and "coordination" mean, with respect to a policy in relation to health benefits under this title or under another health insurance policy, that the policy under its terms is secondary to, or excludes from payment, items and services to the extent available or paid for under this title or under another health insurance policy.

(vi)(I) An individual entitled to benefits under part A or enrolled under part B of this title who is applying for a health insurance policy (other than a policy described in subclause (III)) shall be furnished a disclosure statement described in clause (vii) for the type of policy being applied for. Such statement shall be furnished as a part of (or together with) the application for such policy.

(II) Whoever issues or sells a health insurance policy (other than a policy described in subclause (III)) to an individual described in subclause (I) and fails to furnish the appropriate disclosure statement as required under such subclause shall be fined under title 18, United States Code, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $25,000 (or $15,000 in the case of a person other than the issuer of the policy) for each such violation.

(III) A policy described in this subclause to which subclauses (I) and (II) do not apply) is a Medicare supplemental policy, a policy described in clause (v), or a health insurance policy identified under 60 Federal Register 30880 (June 12, 1995) as a policy not required to have a disclosure statement.

(IV) Any reference in this section to the revised NAIC model regulation (referred to in subsection (M)(1)(A)) is deemed a reference to such regulation as revised by section 171(m)(2) of the Social Security Act Amendments of 1994 (Public

Law 103–432) and as modified by substituting, for the disclosure required under section 16D(2), disclosure under subclause (I) of an appropriate disclosure statement under clause (vii).

(vii) The disclosure statement described in this clause for a type of policy is the statement specified under subparagraph (D) of this paragraph (as in effect before the date of the enactment for that type of policy, as revised as follows:

(I) In each statement, amend the second line to read as follows:

"THIS IS NOT MEDICARE SUPPLEMENT INSURANCE"

(II) In each statement, strike the third line and insert the following: "**Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.**".

(III) In each statement not described in subclause (V), strike the boldface matter that begins "**This insurance**." and all that follows up to the next paragraph that begins "**Medicare**.".

(IV) In each statement not described in subclause (V), insert before the boxed matter (that states "**Before You Buy This Insurance**.") the following: "**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**".

(V) In a statement relating to policies providing both nursing home and non–institutional coverage, to policies providing nursing home benefits only, or policies providing home care benefits only, amend the sentence that begins "Federal law" to read as follows: "Federal law requires us to inform you that in certain situations this insurance may pay for some care also covered by Medicare.".

(viii)(I) Subject to subclause (II), nothing in this subparagraph shall restrict or preclude a State's ability to regulate health insurance policies, including any health insurance policy that is described in clause (iv), (v), or (vi)(III).

(II) A State may not declare or specify, in statute, regulation, or otherwise, that a health insurance policy (other than a Medicare supplemental policy) or rider to an insurance contract which is not a health insurance policy, that is described in clause (iv), (v), or (vi)(III) and that is sold, issued, or renewed to an individual entitled to benefits under part A or enrolled under part B "duplicates" health benefits under this title or under a Medicare supplemental policy.

(B)(i) It is unlawful for a person to issue or sell a medicare supplemental policy to an individual entitled to benefits under part A or enrolled under part B, whether directly, through the mail, or otherwise, unless—

(I) the person obtains from the individual, as part of the application for the issuance or purchase and on a form described in clause (II), a written statement signed by the individual stating, to the best of the individual's knowledge, what health insurance policies [including any Medicare+Choice plan] the individual has, from what source, and whether the individual is entitled to any medical assistance under title XIX, whether as a qualified medicare beneficiary or otherwise, and

(II) the written statement is accompanied by a written acknowledgment, signed by the seller of the policy, of the request for and receipt of such statement.

(ii) The statement required by clause (i) shall be made on a form that—

(I) states in substance that a medicare-eligible individual does not need more than one medicare supplemental policy,

(II) states in substance that individuals may be eligible for benefits under the State medicaid program under title XIX and that such individuals who are entitled to benefits under that program usually do not need a medicare supplemental policy and that benefits and premiums under any such policy shall be suspended upon request of the policyholder during the period (of not longer than 24 months) of entitlement to benefits under such title and may be reinstituted upon loss of such entitlement, and

(III) states that counseling services may be available in the State to provide advice concerning the purchase of medicare supplemental policies and enrollment under the medicaid program and may provide the telephone number for such services.

(iii)(I) Except as provided in subclauses (II) and (III), if the statement required by clause (i) is not obtained or indicates that the individual has a medicare supplemental policy or indicates that the individual is entitled to any medical assistance under title XIX, the sale of a medicare supplemental policy shall be considered to be a violation of subparagraph (A).

(II) Subclause (I) shall not apply in the case of an individual who has a medicare supplemental policy, if the individual indicates in writing, as part of the application for purchase, that the policy being purchased replaces such other policy and indicates an intent to terminate the policy being replaced when the new policy becomes effective and the issuer or seller certifies in writing that such policy will not, to the best of the

issuer's or seller's knowledge[615] , duplicate coverage (taking into account any such replacement).

(III) If the statement required by clause (i) is obtained and indicates that the individual is entitled to any medical assistance under title XIX, the sale of the policy is not in violation of clause (i) (insofar as such clause relates to such medical assistance), if (aa) a State medicaid plan under such title pays the premiums for the policy, (bb) in the case of a qualified medicare beneficiary described in section 1905(p)(1), the policy provides for coverage of outpatient prescription drugs, or (cc) the only medical assistance to which the individual is entitled under the State plan is medicare cost sharing described in section 1905(p)(3)(A)(ii).

(iv) Whoever issues or sells a medicare supplemental policy in violation of this subparagraph shall be fined under title 18, United States Code, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $25,000 (or $15,000 in the case of a seller who is not the issuer of a policy) for each such violation.

(C) Subparagraph (A) shall not apply with respect to the sale or issuance of a group policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or for members or former members (or combination thereof) of the labor organizations.

(4)(A) Whoever knowingly, directly or through his agent, mails or causes to be mailed any matter for a prohibited purpose (as determined under subparagraph (B)) shall be fined under title 18, United States Code, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $5,000 for each such prohibited act.

(B) For purposes of subparagraph (A), a prohibited purpose means the advertising, solicitation, or offer for sale of a medicare supplemental policy, or the delivery of such a policy, in or into any State in which such policy has not been approved by the State commissioner or superintendent of insurance.

(C) Subparagraph (A) shall not apply in the case of a person who mails or causes to be mailed a medicare supplemental policy into a State if such person has ascertained that the party insured under such policy to whom (or on whose behalf) such policy is mailed is located in such State on a temporary basis.

[615] P.L. 108-173, §736(e)(2), struck out "to the best of the issuer or seller's knowledge" and substituted "to the best of the issuer's or seller's knowledge".

(D) Subparagraph (A) shall not apply in the case of a person who mails or causes to be mailed a duplicate copy of a medicare supplemental policy previously issued to the party to whom (or on whose behalf) such duplicate copy is mailed.

(E) Subparagraph (A) shall not apply in the case of an issuer who mails or causes to be mailed a policy, certificate, or other matter solely to comply with the requirements of subsection (q).

(5) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under paragraphs (1), (2), (3)(A), and (4)(A) in the same manner as such provisions apply to penalties and proceedings under section 1128A(a).

(e)(1) The Secretary shall provide to all individuals entitled to benefits under this title (and, to the extent feasible, to individuals about to become so entitled) such information as will permit such individuals to evaluate the value of medicare supplemental policies to them and the relationship of any such policies to benefits provided under this title.

(2) The Secretary shall—

(A) inform all individuals entitled to benefits under this title (and, to the extent feasible, individuals about to become so entitled) of—

(i) the actions and practices that are subject to sanctions under subsection (d), and

(ii) the manner in which they may report any such action or practice to an appropriate official of the Department of Health and Human Services (or to an appropriate State official), and

(B) publish the toll-free telephone number for individuals to report suspected violations of the provisions of such subsection.

(3) The Secretary shall provide individuals entitled to benefits under this title (and, to the extent feasible, individuals about to become so entitled) with a listing of the addresses and telephone numbers of State and Federal agencies and offices that provide information and assistance to individuals with respect to the selection of medicare supplemental policies.

(f)(1)(A) The Secretary shall, in consultation with Federal and State regulatory agencies, the National Association of Insurance Commissioners, private insurers, and organizations representing consumers and the aged, conduct a comprehensive study and evaluation of the comparative effectiveness of various State approaches to the regulation of medicare supplemental policies in (i) limiting marketing and agent abuse, (ii) assuring the dissemination of such information to individuals entitled to benefits under this title (and to other consumers) as is necessary to permit informed choice, (iii) promoting policies which provide reasonable economic benefits for such individuals, (iv) reducing the purchase of unnecessary duplicative coverage, (v) improving price competition, and (vi) establishing effective approved State regulatory programs described in subsection (b).

(B) Such study shall also address the need for standards or certification of health insurance policies, other than

medicare supplemental policies, sold to individuals eligible for benefits under this title.

(C) The Secretary shall, no later than January 1, 1982, submit a report to the Congress on the results of such study and evaluation, accompanied by such recommendations as the Secretary finds warranted by such results with respect to the need for legislative or administrative changes to accomplish the objectives set forth in subparagraphs (A) and (B), including the need for a mandatory Federal regulatory program to assure the marketing of appropriate types of medicare supplemental policies, and such other means as he finds may be appropriate to enhance effective State regulation of such policies.

(2) The Secretary shall submit to the Congress no later than July 1, 1982, and periodically as may be appropriate thereafter (but not less often than once every 2 years), a report evaluating the effectiveness of the certification procedure and the criminal penalties established under this section, and shall include in such reports an analysis of—

(A) the impact of such procedure and penalties on the types, market share, value, and cost to individuals entitled to benefits under this title of medicare supplemental policies which have been certified by the Secretary;

(B) the need for any change in the certification procedure to improve its administration or effectiveness; and

(C) whether the certification program and criminal penalties should be continued.

(3) The Secretary shall provide information via a toll-free telephone number on medicare supplemental policies (including the relationship of State programs under title XIX to such policies).

(g)(1) For purposes of this section, a medicare supplemental policy is a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under this title, which provides reimbursement for expenses incurred for services and items for which payment may be made under this title but which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed pursuant to this title; but does not include a Medicare+Choice plan or any such policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or for members or former members (or combination thereof) of the labor organizations and does not include a policy or plan of an eligible organization (as defined in section 1876(b)) if the policy or plan provides benefits pursuant to a contract under section 1876 or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, or, during the period beginning on the date specified in subsection (p)(1)(C) and ending on December 31, 1995, a policy or plan of an organization if the policy or plan provides benefits pursuant to an agreement under section 1833(a)(1)(A) For purposes of this section, the term "policy" includes a certificate issued under such policy.

(2) For purposes of this section:

(A) The term "NAIC Model Standards" means the "NAIC Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act", adopted by the National Association of Insurance Commissioners on June 6, 1979, as it applies to medicare supplemental[616] policies.

(B) The term "State with an approved regulatory program" means a State for which the Secretary has made a determination under subsection (b)(1).

(C) The State in which a policy is issued means—

(i) in the case of an individual policy, the State in which the policyholder resides; and

(ii) in the case of a group policy, the State in which the holder of the master policy resides.

(h) The Secretary shall prescribe such regulations as may be necessary for the effective, efficient, and equitable administration of the certification procedure established under this section. The Secretary shall first issue final regulations to implement the certification procedure established under subsection (a) not later than March 1, 1981.

(i)(1) No medicare supplemental policy shall be certified and no such policy may be issued bearing the emblem authorized by the Secretary under subsection (a) until July 1, 1982. On and after such date policies certified by the Secretary may bear such emblem, including policies which were issued prior to such date and were subsequently certified, and insurers may notify holders of such certified policies issued prior to such date using such emblem in the notification.

(2)(A) The Secretary shall not implement the certification program established under subsection (a) with respect to policies issued in a State unless the Panel makes a finding that such State cannot be expected to have established, by July 1, 1982, an approved State regulatory program meeting the standards and requirements of subsection (b)(1). If the Panel makes such a finding, the Secretary shall implement such program under subsection (a) with respect to medicare supplemental policies issued in such State, until such time as the Panel determines that such State has a program that meets the standards and requirements of subsection (b)(1).

(B) Any finding by the Panel under subparagraph (A) shall be transmitted in writing, not later than January 1, 1982, to the Committee on Finance of the Senate and to the Committee on Interstate and Foreign Commerce and the Committee on Ways and Means of the House of Representatives and shall not become effective until 60 days after the date of its transmittal to the Committees of the Congress under this subparagraph. In counting such days, days on which either House is not in session because of an adjournment sine die or an adjournment of more than three days to a day certain are excluded in the computation.

[616] P.L. 108-173, §736(e)(3), struck out "medicare supplement policies" and substituted "medicare supplemental policies".

(j) Nothing in this section shall be construed so as to affect the right of any State to regulate medicare supplemental policies which, under the provisions of this section, are considered to be issued in another State.

(k)(1)(A) If, within the 90-day period beginning on the date of the enactment of this subsection[617], the National Association of Insurance Commissioners (in this subsection referred to as the "Association") amends the NAIC Model Regulation adopted on June 6, 1979 (as it relates to medicare supplemental policies), with respect to matters such as minimum benefit standards, loss ratios, disclosure requirements, and replacement requirements and provisions otherwise necessary to reflect the changes in law made by the Medicare Catastrophic Coverage Act of 1988[618], except as provided in subsection (m), subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the Model Regulation as amended by the Association in accordance with this paragraph (in this subsection and subsection (l) referred to as the "amended NAIC Model Regulation").

(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the amended NAIC Model Regulation or 1 year after the date the Association first adopts such amended Regulation.

(2)(A) If the Association does not amend the NAIC Model Regulation within the 90-day period specified in paragraph (1)(A), the Secretary shall promulgate, not later than 60 days after the end of such period, Federal model standards (in this subsection and subsection (l) referred to as "Federal model standards") for medicare supplemental policies to reflect the changes in law made by the Medicare Catastrophic Coverage Act of 1988, and subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to Federal model standards.

(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the Federal model standards or 1 year after the date the Secretary first promulgates such standards.

(3) Notwithstanding any other provision of this section (except as provided in subsections (l), (m), and (n))—

(A) no medicare supplemental policy may be certified by the Secretary pursuant to subsection (a),

(B) no certification made pursuant to subsection (a) shall remain in effect, and

(C) no State regulatory program shall be found to meet (or to continue to meet) the requirements of subsection (b)(1)(A),

unless such policy meets (or such program provides for the application of standards equal to or more stringent than) the standards set forth in the amended NAIC Model Regulation or the Federal

[617] July 1, 1988.
[618] P.L. 100–360.

model standards (as the case may be) by the date specified in paragraph (1)(B) or (2)(B) (as the case may be).

(l)(1) Until the date specified in paragraph (3), in the case of a qualifying medicare supplemental policy described in paragraph (2) issued—

(A) before January 1, 1989, the policy is deemed to remain in compliance with this section if the insurer issuing the policy complies with the NAIC Model Transition Regulation (including giving notices to subscribers and filing for premium adjustments with the State as described in section 5.B. of such Regulation) by January 1, 1989; or

(B) on or after January 1, 1989, the policy is deemed to be in compliance with this section if the insurer issuing the policy complies with the NAIC Model Transition Regulation before the date of the sale of the policy.

(2) In paragraph (1), the term "qualifying medicare supplemental policy" means a medicare supplemental policy—

(A) issued in a State which—

(i) has not adopted standards equal to or more stringent than the NAIC Model Transition Regulation by January 1, 1989, and

(ii) has not adopted standards equal to or more stringent than the amended NAIC Model Regulation (or Federal model standards) by January 1, 1989; and

(B) which has been issued in compliance with this section (as in effect on June 1, 1988).

(3)(A) The date specified in this paragraph is the earlier of—

(i) the first date a State adopts, after January 1, 1989, standards equal to or more stringent than the NAIC Model Transition Regulation or equal to or more stringent than the amended NAIC Model Regulation (or Federal model standards), as the case may be, or

(ii) the later of (I) the date specified in subsection (k)(1)(B) or (k)(2)(B) (as the case may be), or (II) the date specified in subparagraph (B).

(B) In the case of a State which the Secretary identifies as—

(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet standards described in subparagraph (A)(i), but

(ii) having a legislature which is not scheduled to meet in 1989 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1989, and in which legislation described in clause (i) may be considered. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(4) In the case of a medicare supplemental policy in effect on January 1, 1989, and offered in a State which, as of such date—

(A) has adopted standards equal to or more stringent than the amended NAIC Model Regulation (or Federal model standards), but

(B) does not have in effect standards equal to or more stringent than the NAIC Model Transition Regulation (or otherwise re- quiring notice substantially the same as the notice required in section 5.B. of such Regulation),

the policy shall not be deemed to meet the standards in subsection (c) unless each individual who is entitled to benefits under this title and is a policyholder under such policy on January 1, 1989, is sent such a notice in any appropriate form by not later than January 31, 1989, that explains—

(A) the improved benefits under this title contained in the Medicare Catastrophic Coverage Act of 1988, and

(B) how these improvements affect the benefits contained in the policies and the premium for the policy.

(5) In this subsection, the term "NAIC Model Transition Regulation" refers to the standards contained in the "Model Regulation to Implement Transitional Requirements for the Conversion of Medicare Supplement Insurance Benefits and Premiums to Conform to Medicare Program Revisions" (as adopted by the National Association of Insurance Commissioners in September 1987).

(m)(1)(A) If, within the 90-day period beginning on the date of the enactment of this subsection, the National Association of Insurance Commissioners (in this subsection and subsection (n) referred to as the "Association") revises the amended NAIC Model Regulation (referred to in subsection (k)(1)(A) and adopted on September 20, 1988) to improve such regulation and otherwise to reflect the changes in law made by the Medicare Catastrophic Coverage Repeal Act of 1989[619], subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the amended NAIC Model Regulation (referred to in subsection (k)(1)(A)) as revised by the Association in accordance with this paragraph (in this subsection and subsection (n) referred to as the "revised NAIC Model Regulation").

(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the revised NAIC Model Regulation or 1 year after the date the Association first adopts such revised Regulation.

(2)(A) If the Association does not revise the amended NAIC Model Regulation, within the 90-day period specified in paragraph (1)(A), the Secretary shall promulgate, not later than 60 days after the end of such period, revised Federal model standards (in this subsection and subsection (n) referred to as "revised Federal model standards") for medicare supplemental policies to improve such standards and otherwise to reflect the changes in law made by the Medicare Catastrophic Coverage Repeal Act of 1989, subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on

[619] P.L. 101–234.

June 6, 1979, were a reference to the revised Federal model standards.

(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the revised Federal model standards or 1 year after the date the Secretary first promulgates such standards.

(3) Notwithstanding any other provision of this section (except as provided in subsection (n))—

(A) no medicare supplemental policy may be certified by the Secretary pursuant to subsection (a),

(B) no certification made pursuant to subsection (a) shall remain in effect, and

(C) no State regulatory program shall be found to meet (or to continue to meet) the requirements of subsection (b)(1)(A),

unless such policy meets (or such program provides for the application of standards equal to or more stringent than) the standards set forth in the revised NAIC Model Regulation or the revised Federal model standards (as the case may be) by the date specified in paragraph (1)(B) or (2)(B) (as the case may be).

(n)(1) Until the date specified in paragraph (4), in the case of a qualifying medicare supplemental policy described in paragraph (3) issued in a State—

(A) before the transition deadline, the policy is deemed to remain in compliance with the standards described in subsection (b)(1)(A) only if the insurer issuing the policy complies with the transition provision described in paragraph (2), or

(B) on or after the transition deadline, the policy is deemed to be in compliance with the standards described in subsection (b)(1)(A) only if the insurer issuing the policy complies with the revised NAIC Model Regulation or the revised Federal model standards (as the case may be) before the date of the sale of the policy.

In this paragraph, the term "transition deadline" means 1 year after the date the Association adopts the revised NAIC Model Regulation or 1 year after the date the Secretary promulgates revised Federal model standards (as the case may be).

(2) The transition provision described in this paragraph is—

(A) such transition provision as the Association provides, by not later than December 15, 1989, so as to provide for an appropriate transition (i) to restore benefit provisions which are no longer duplicative as a result of the changes in benefits under this title made by the Medicare Catastrophic Coverage Repeal Act of 1989 and (ii) to eliminate the requirement of payment for the first 8 days of coinsurance for extended care services, or

(B) if the Association does not provide for a transition provision by the date described in subparagraph (A), such transition provision as the Secretary shall provide, by January 1, 1990, so as to provide for an appropriate transition described in subparagraph (A).

(3) In paragraph (1), the term "qualifying medicare supplemental policy" means a medicare supplemental policy which

has been issued in compliance with this section as in effect on the date before the date of the enactment of this subsection.

(4)(A) The date specified in this paragraph for a policy issued in a State is—

(i) the first date a State adopts, after the date of the enactment of this subsection, standards equal to or more stringent than the revised NAIC Model Regulation (or revised Federal model standards), as the case may be, or

(ii) the date specified in subparagraph (B),

whichever is earlier.

(B) In the case of a State which the Secretary identifies, in consultation with the Association, as—

(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet standards described in subparagraph (A)(i), but

(ii) having a legislature which is not scheduled to meet in 1990 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1990. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(5) In the case of a medicare supplemental policy in effect on January 1, 1990, the policy shall not be deemed to meet the standards in subsection (c) unless each individual who is entitled to benefits under this title and is a policyholder or certificate holder under such policy on such date is sent a notice in an appropriate form by not later than January 31, 1990, that explains—

(A) the changes in benefits under this title effected by the Medicare Catastrophic Coverage Repeal Act of 1989, and

(B) how these changes may affect the benefits contained in such policy and the premium for the policy.

(6)(A) Except as provided in subparagraph (B), in the case of an individual who had in effect, as of December 31, 1988, a medicare supplemental policy with an insurer (as a policyholder or, in the case of a group policy, as a certificate holder) and the individual terminated coverage under such policy before the date of the enactment of this subsection[620], no medicare supplemental policy of the insurer shall be deemed to meet the standards in subsection (c) unless the insurer—

(i) provides written notice, no earlier than December 15, 1989, and no later than January 30, 1990, to the policyholder or certificate holder (at the most recent available address) of the offer described in clause (ii), and

(ii) offers the individual, during a period of at least 60 days beginning not later than February 1, 1990, reinstitution of coverage (with coverage effective as of

[620] December 13, 1989.

January 1, 1990), under the terms which (I) do not provide for any waiting period with respect to treatment of pre-existing conditions, (II) provides for coverage which is substantially equivalent to coverage in effect before the date of such termination, and (III) provides for classification of premiums on which terms are at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage never terminated.

(B) An insurer is not required to make the offer under subparagraph (A)(ii) in the case of an individual who is a policyholder or certificate holder in another medicare supplemental policy as of the date of the enactment of this subsection, if (as of January 1, 1990) the individual is not subject to a waiting period with respect to treatment of a pre-existing condition under such other policy.

(o) The requirements of this subsection are as follows:

(1) Each medicare supplemental policy shall provide for coverage of a group of benefits consistent with subsection (p).

(2) If the medicare supplemental policy provides for coverage of a group of benefits other than the core group of basic benefits described in subsection (p)(2)(B), the issuer of the policy must make available to the individual a medicare supplemental policy with only such core group of basic benefits.

(3) The issuer of the policy has provided, before the sale of the policy, an outline of coverage that uses uniform language and format (including layout and print size) that facilitates comparison among medicare supplemental policies and comparison with medicare benefits.

(p)(1)(A) If, within 9 months after the date of the enactment of this subsection, the National Association of Insurance Commissioners (in this subsection referred to as the "Association") changes the revised NAIC Model Regulation (described in subsection (m)) to incorporate—

(i) limitations on the groups or packages of benefits that may be offered under a medicare supplemental policy consistent with paragraphs (2) and (3) of this subsection,

(ii) uniform language and definitions to be used with respect to such benefits,

(iii) uniform format to be used in the policy with respect to such benefits, and

(iv) other standards to meet the additional requirements imposed by the amendments made by the Omnibus Budget Reconciliation Act of 1990[621], subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policyholders on and after the date specified in subparagraph (C), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the revised NAIC Model Regulation as changed under this subparagraph (such changed regulation referred to in this section as the "1991 NAIC Model Regulation").

[621] P.L. 101-508.

(B) If the Association does not make the changes in the revised NAIC Model Regulation within the 9-month period specified in subparagraph (A), the Secretary shall promulgate, not later than 9 months after the end of such period, a regulation and subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policyholders on and after the date specified in subparagraph (C), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the revised NAIC Model Regulation as changed by the Secretary under this subparagraph (such changed regulation referred to in this section as the "1991 Federal Regulation".

(C)(i) Subject to clause (ii), the date specified in this subparagraph for a State is the date the State adopts the 1991 NAIC Model Regulation or 1991 Federal Regulation or 1 year after the date the Association or the Secretary first adopts such standards, whichever is earlier.

(ii) In the case of a State which the Secretary identifies, in consultation with the Association, as—

(I) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet the 1991 NAIC or Model Regulation or 1991 Federal Regulation but

(II) having a legislature which is not scheduled to meet in 1992 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1992. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(D) In promulgating standards under this paragraph, the Association or Secretary shall consult with a working group composed of representatives of issuers of medicare supplemental policies, consumer groups, medicare beneficiaries, and other qualified individuals. Such representatives shall be selected in a manner so as to assure balanced representation among the interested groups.

(E) If benefits (including deductibles and coinsurance) under this title are changed and the Secretary determines, in consultation with the Association, that changes in the 1991 NAIC Model Regulation or 1991 Federal Regulation are needed to reflect such changes, the preceding provisions of this paragraph shall apply to the modification of standards previously established in the same manner as they applied to the original establishment of such standards.

(2) The benefits under the 1991 NAIC Model Regulation or 1991 Federal Regulation shall provide—

(A) for such groups or packages of benefits as may be appropriate taking into account the considerations specified in paragraph (3) and the requirements of the succeeding subparagraphs;

(B) for identification of a core group of basic benefits common to all policies; and[622]

(C) that, subject to paragraph (4)(B), the total number of different benefit packages (counting the core group of basic benefits described in subparagraph (B) and each other combination of benefits that may be offered as a separate benefit package) that may be established in all the States and by all issuers shall not exceed 10 plus the 2 plans described in paragraph (11)(A).

(3) The benefits under paragraph (2) shall, to the extent possible—

(A) provide for benefits that offer consumers the ability to purchase the benefits that are available in the market as of the date of the enactment of this subsection; and

(B) balance the objectives of (i) simplifying the market to facilitate comparisons among policies, (ii) avoiding adverse selection, (iii) providing consumer choice, (iv) providing market stability, and (v) promoting competition.

(4)(A)(i) Except as provided in subparagraph (B) or paragraph (6), no State with a regulatory program approved under subsection (b)(1) may provide for or permit the grouping of benefits (or language or format with respect to such benefits) under a medicare supplemental policy unless such grouping meets the applicable 1991 NAIC Model Regulation or 1991 Federal Regulation.

(ii) Except as provided in subparagraph (B), the Secretary may not provide for or permit the grouping of benefits (or language or format with respect to such benefits) under a medicare supplemental policy seeking approval by the Secretary unless such grouping meets the applicable 1991 NAIC Model Regulation or 1991 Federal Regulation.

(B) With the approval of the State (in the case of a policy issued in a State with an approved regulatory program) or the Secretary (in the case of any other policy), the issuer of a medicare supplemental policy may offer new or innovative benefits in addition to the benefits provided in a policy that otherwise complies with the applicable 1991 NAIC Model Regulation or 1991 Federal Regulation. Any such new or innovative benefits may include benefits that are not otherwise available and are cost-effective and shall be offered in a manner which is consistent with the goal of simplification of medicare supplemental policies.

(5)(A) Except as provided in subparagraph (B), this subsection shall not be construed as preventing a State from restricting the groups of benefits that may be offered in medicare supplemental policies in the State.

(B) A State with a regulatory program approved under subsection (b)(1) may not restrict under subparagraph (A) the offering of a medicare supplemental policy consisting only of the core group of benefits described in paragraph (2)(B).

(6) The Secretary may waive the application of standards described in clauses (i) through (iii) of paragraph (1)(A) in those

[622] P.L. 108-173, §736(e)(4), struck out “, and ” and substituted “; and”.

States that on the date of enactment of this subsection had in place an alternative simplification program.

(7) This subsection shall not be construed as preventing an issuer of a medicare supplemental policy who otherwise meets the requirements of this section from providing, through an arrangement with a vendor, for discounts from that vendor to policyholders or certificateholders for the purchase of items or services not covered under its medicare supplemental policies.

(8) Any person who sells or issues a medicare supplemental policy, on and after the effective date specified in paragraph (1)(C) (but subject to paragraph (10), in violation of the applicable 1991 NAIC Model Regulation or 1991 Federal Regulation insofar as such regulation relates to the requirements of subsection (o) or (q) or clause (i), (ii), or (iii) of paragraph (1)(A) is subject to a civil money penalty of not to exceed $25,000 (or $15,000 in the case of a seller who is not an issuer of a policy) for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(9)(A) Anyone who sells a medicare supplemental policy to an individual shall make available for sale to the individual a medicare supplemental policy with only the core group of basic benefits (described in paragraph (2)(B)).

(B) Anyone who sells a medicare supplemental policy to an individual shall provide the individual, before the sale of the policy, an outline of coverage which describes the benefits under the policy. Such outline shall be on a standard form approved by the State regulatory program or the Secretary (as the case may be) consistent with the 1991 NAIC Model Regulation or 1991 Federal Regulation under this subsection.

(C) Whoever sells a medicare supplemental policy in violation of this paragraph is subject to a civil money penalty of not to exceed $25,000 (or $15,000 in the case of a seller who is not the issuer of the policy) for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(D) Subject to paragraph (10), this paragraph shall apply to sales of policies occurring on or after the effective date specified in paragraph (1)(C).

(10) No penalty may be imposed under paragraph (8) or (9) in the case of a seller who is not the issuer of a policy until the Secretary has published a list of the groups of benefit packages that may be sold or issued consistent with paragraph (1)(A)(i).

(11)(A) For purposes of paragraph (2), the benefit packages described in this subparagraph are as follows:

(i) The benefit package classified as "F" under the standards established by such paragraph, except that it has a high deductible feature.

(ii) The benefit package classified as "J" under the standards established by such paragraph, except that it has a high deductible feature.

(B) For purposes of subparagraph (A), a high deductible feature is one which—

(i) requires the beneficiary of the policy to pay annual out–of–pocket expenses (other than premiums) in the amount specified in subparagraph (C) before the policy begins payment of benefits, and

(ii) covers 100 percent of covered out–of–pocket expenses once such deductible has been satisfied in a year.

(C) The amount specified in this subparagraph—

(i) for 1998 and 1999 is $1,500, and

(ii) for a subsequent year, is the amount specified in this subparagraph for the previous year increased by the percentage increase in the Consumer Price Index for all urban consumers (all items; U.S. city average) for the 12–month period ending with August of the preceding year.

If any amount determined under clause (ii) is not a multiple of $10, it shall be rounded to the nearest multiple of $10.

(q) The requirements of this subsection are as follows:

(1) Each medicare supplemental policy shall be guaranteed renewable and—

(A) the issuer may not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(B) the issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(2) If the medicare supplemental policy is terminated by the group policyholder and is not replaced as provided under paragraph (4), the issuer shall offer certificateholders an individual medicare supplemental policy which (at the option of the certificateholder)—

(A) provides for continuation of the benefits contained in the group policy, or

(B) provides for such benefits as otherwise meets the requirements of this section.

(3) If an individual is a certificateholder in a group medicare supplemental policy and the individual terminates membership in the group, the issuer shall—

(A) offer the certificateholder the conversion opportunity described in paragraph (2), or

(B) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(4) If a group medicare supplemental policy is replaced by another group medicare supplemental policy purchased by the same policyholder, issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(5)(A) Each medicare supplemental policy shall provide that benefits and premiums under the policy shall be suspended at

the request of the policyholder for the period (not to exceed 24 months) in which the policyholder has applied for and is determined to be entitled to medical assistance under title XIX, but only if the policyholder notifies the issuer of such policy within 90 days after the date the individual becomes entitled to such assistance. If such suspension occurs and if the policyholder or certificate holder loses entitlement to such medical assistance, such policy shall be automatically reinstituted (effective as of the date of termination of such entitlement) under terms described in subsection (n)(6)(A)(ii) as of the termination of such entitlement if the policyholder provides notice of loss of such entitlement within 90 days after the date of such loss.

(B) Nothing in this section shall be construed as affecting the authority of a State, under title XIX, to purchase a medicare supplemental policy for an individual otherwise entitled to assistance under such title.

(C) Any person who issues a medicare supplemental policy and fails to comply with the requirements of this paragraph or paragraph (6) is subject to a civil money penalty of not to exceed $25,000 for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(6) Each medicare supplemental policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) and is covered under a group health plan (as defined in section 1862(b)(1)(A)(v)). If such suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, such policy shall be automatically reinstituted (effective as of the date of such loss of coverage) under terms described in subsection (n)(6)(A)(ii) as of the loss of such coverage if the policyholder provides notice of loss of such coverage within 90 days after the date of such loss.

(r)(1) A medicare supplemental policy may not be issued or renewed (or otherwise provide coverage after the date described in subsection (p)(1)(C)) in any State unless—

(A) the policy can be expected for periods after the effective date of these provisions (as estimated for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience and earned premiums for such periods and in accordance with a uniform methodology, including uniform reporting standards, developed by the National Association of Insurance Commissioners), to return to policyholders in the form of aggregate benefits provided under the policy, at least 75 percent of the aggregate amount of premiums collected in the case of group policies and at least 65 percent in the case of individual policies; and

(B) the issuer of the policy provides for the issuance of a proportional refund, or a credit against future premiums of a proportional amount, based on the premium paid and in accordance with paragraph (2), of the amount of pre-

miums received necessary to assure that the ratio of aggregate benefits provided to the aggregate premiums collected (net of such refunds or credits) complies with the expectation required under subparagraph (A), treating policies of the same type as a single policy for each standard package.

For purposes of applying subparagraph (A) only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies. For the purpose of calculating the refund or credit required under paragraph (1)(B) for a policy issued before the date specified in subsection (p)(1)(C), the refund or credit calculation shall be based on the aggregate benefits provided and premiums collected under all such policies issued by an insurer in a State (separated as to individual and group policies) and shall be based only on aggregate benefits provided and premiums collected under such policies after the date specified in section 171(m)(4) of the Social Security Act Amendments of 1994.

(2)(A) Paragraph (1)(B) shall be applied with respect to each type of policy by standard package. Paragraph (1)(B) shall not apply to a policy until 12 months following issue. The Comptroller General, in consultation with the National Association of Insurance Commissioners, shall submit to Congress a report containing recommendations on adjustments in the percentages under paragraph (1)(A) that may be appropriate. In the case of a policy issued before the date specified in subsection (p)(1)(C), paragraph (1)(B) shall not apply until 1 year after the date specified in section 171(m)(4) of the Social Security Act Amendments of 1994.

(B) A refund or credit required under paragraph (1)(B) shall be made to each policyholder insured under the applicable policy as of the last day of the year involved.

(C) Such a refund or credit shall include interest from the end of the calendar year involved until the date of the refund or credit at a rate as specified by the Secretary for this purpose from time to time which is not less than the average rate of interest for 13-week Treasury notes.

(D) For purposes of this paragraph and paragraph (1)(B), refunds or credits against premiums due shall be made, with respect to a calendar year, not later than the third quarter of the succeeding calendar year.

(3) The provisions of this subsection do not preempt a State from requiring a higher percentage than that specified in paragraph (1)(A).

(4) The Secretary shall submit in October of each year (beginning with 1993) a report to the Committees on Energy and Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate on loss ratios under medicare supplemental policies and the use of sanctions, such as a required rebate or credit or the disallowance of premium increases, for policies that fail to meet the requirements of this subsection (relating to loss ratios). Such report shall include a list of the policies that failed to comply with such loss ratio.

(5)(A) The Comptroller General shall periodically, not less often than once every 3 years, perform audits with respect to the compliance of medicare supplemental policies with the loss

ratio requirements of this subsection and shall report the results of such audits to the State involved and to the Secretary.

(B) The Secretary may independently perform such compliance audits.

(6)(A) A person who fails to provide refunds or credits as required in paragraph (1)(B) is subject to a civil money penalty of not to exceed $25,000 for each policy issued for which such failure occurred. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(B) Each issuer of a policy subject to the requirements of paragraph (1)(B) shall be liable to the policyholder or, in the case of a group policy, to the certificate holder for credits required under such paragraph.

(s)(1) If a medicare supplemental policy replaces another medicare supplemental policy, the issuer of the replacing policy shall waive any time periods applicable to preexisting conditions, waiting period, elimination periods and probationary periods in the new medicare supplemental policy for similar benefits to the extent such time was spent under the original policy.

(2)(A) The issuer of a medicare supplemental policy may not deny or condition the issuance or effectiveness of a medicare supplemental policy, or discriminate in the pricing of the policy, because of health status, claims experience, receipt of health care, or medical condition in the case of an individual for whom an application is submitted prior to or during the 6 month period beginning with the first month as of the first day on which the individual is 65 years of age or older and is enrolled for benefits under part B.

(B) Subject to subparagraphs (C) and (D), subparagraph (A) shall not be construed as preventing the exclusion of benefits under a policy, during its first 6 months, based on a pre-existing condition for which the policyholder received treatment or was otherwise diagnosed during the 6 months before the policy became effective.

(C) If a medicare supplemental policy or certificate replaces another such policy or certificate which has been in effect for 6 months or longer, the replacing policy may not provide any time period applicable to pre-existing conditions, waiting periods, elimination periods, and probationary periods in the new policy or certificate for similar benefits.

(D) In the case of a policy issued during the 6–month period described in subparagraph (A) to an individual who is 65 years of age or older as of the date of issuance and who as of the date of the application for enrollment has a continuous period of creditable coverage (as defined in section 2701(c) of the Public Health Service Act) of—

(i) at least 6 months, the policy may not exclude benefits based on a pre–existing condition; or

(ii) less than 6 months, if the policy excludes benefits based on a preexisting condition, the policy shall reduce the period of any preexisting condition exclusion by the aggregate of the periods of creditable cov-

erage (if any, as so defined) applicable to the individual as of the enrollment date.

The Secretary shall specify the manner of the reduction under clause (ii), based upon the rules used by the Secretary in carrying out section 2701(a)(3) of such Act.

(3)(A) The issuer of a medicare supplemental policy—

(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy described in subparagraph (C) that is offered and is available for issuance to new enrollees by such issuer;

(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

(iii) may not impose an exclusion of benefits based on a preexisting[623] condition under such policy,

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy during the period specified in subparagraph (E) and who submits evidence of the date of termination or disenrollment along with the application for such medicare supplemental policy.

(B) An individual described in this subparagraph is an individual described in any of the following clauses:

(i) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under this title and the plan terminates or ceases to provide all such supplemental health benefits to the individual.

(ii) The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under part C, and there are circumstances permitting discontinuance of the individual's election of the plan under the first sentence of section 1851(e)(4) or the individual is 65 years of age or older and is enrolled with a PACE provider under section 1894, and there are circumstances that would permit the discontinuance of the individual's enrollment with such provider under circumstances that are similar to the circumstances that would permit discontinuance of the individual's election under the first sentence of such section if such individual were enrolled in a Medicare+Choice plan, applicable to terminations or discontinuances made on or after November 29, 1999.

(iii) The individual is enrolled with an eligible organization under a contract under section 1876, a similar organization operating under demonstration project authority, effective for periods before April 1, 1999, with an organization under an agreement under section 1833(a)(1)(A), or with an organization under a policy described in subsection (t), and such enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under the first sentence of section 1851(e)(4) and, in the case of a policy described in subsection (t),

[623] P.L. 108-173, §736(e)(5), struck out "pre-existing " and substituted "preexisting".

there is no provision under applicable State law for the continuation or conversion of coverage under such policy.

(iv) The individual is enrolled under a medicare supplemental policy under this section and such enrollment ceases because—

(I) of the bankruptcy or insolvency of the issuer or because of other involuntary termination of coverage or enrollment under such policy and there is no provision under applicable State law for the continuation or conversion of such coverage;

(II) the issuer of the policy substantially violated a material provision of the policy; or

(III) the issuer (or an agent or other entity acting on the issuer's behalf) materially misrepresented the policy's provisions in marketing the policy to the individual.

(v) The individual—

(I) was enrolled under a medicare supplemental policy under this section,

(II) subsequently terminates such enrollment and enrolls, for the first time, with any Medicare+Choice organization under a Medicare+Choice plan under part C, any eligible organization under a contract under section 1876, any similar organization operating under demonstration project authority any PACE provider under section 1894, or any policy described in subsection (t), and

(III) the subsequent enrollment under subclause (II) is terminated by the enrollee during any period within the first 12 months of such enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e)).

(vi) The individual, upon first becoming eligible for benefits under part A at age 65, enrolls in a Medicare+Choice plan under part C or in a PACE program under section 1894, and disenrolls from such plan or such program by not later than 12 months after the effective date of such enrollment.

(C)(i) Subject to clauses (ii) and (iii), a medicare supplemental policy described in this subparagraph is a medicare supplemental policy which has a benefit package classified as "A", "B", "C", or "F" under the standards established under subsection (p)(2).

(ii) Only for purposes of an individual described in subparagraph (B)(v), a medicare supplemental policy described in this subparagraph is the same medicare supplemental policy referred to in such subparagraph in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in clause (i).

(iii) Only for purposes of an individual described in subparagraph (B)(vi), a medicare supplemental policy

described in this subparagraph shall include any medicare supplemental policy.

(iv) For purposes of applying this paragraph in the case of a State that provides for offering of benefit packages other than under the classification referred to in clause (i), the references to benefit packages in such clause are deemed references to comparable benefit packages offered in such State.

(D) At the time of an event described in subparagraph (B) because of which an individual ceases enrollment or loses coverage or benefits under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, the insurer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the rights of the individual under this paragraph, and obligations of issuers of medicare supplemental policies, under subparagraph (A).

(E) For purposes of subparagraph (A), the time period specified in this subparagraph is—

(i) in the case of an individual described in subparagraph (B)(i), the period beginning on the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if no such notice is received, notice that a claim has been denied because of such a termination or cessation) and ending on the date that is 63 days after the applicable notice;

(ii) in the case of an individual described in clause (ii), (iii), (v), or (vi) of subparagraph (B) whose enrollment is terminated involuntarily, the period beginning on the date that the individual receives a notice of termination and ending on the date that is 63 days after the date the applicable coverage is terminated;

(iii) in the case of an individual described in subparagraph (B)(iv)(I), the period beginning on the earlier of (I) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice, if any, and (II) the date that the applicable coverage is terminated, and ending on the date that is 63 days after the date the coverage is terminated;

(iv) in the case of an individual described in clause (ii), (iii), (iv)(II), (iv)(III), (v), or (vi) of subparagraph (B) who disenrolls voluntarily, the period beginning on the date that is 60 days before the effective date of the disenrollment and ending on the date that is 63 days after such effective date; and

(v) in the case of an individual described in subparagraph (B) but not described in the preceding provisions of this subparagraph, the period beginning on the effective date of the disenrollment and ending on the date that is 63 days after such effective date.

(F)(i) Subject to clause (ii), for purposes of this paragraph—

(I) in the case of an individual described in subparagraph (B)(v) (or deemed to be so described, pursuant to this subparagraph) whose enrollment

with an organization or provider described in subclause (II) of such subparagraph is involuntarily terminated within the first 12 months of such enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, such subsequent enrollment shall be deemed to be an initial enrollment described in such subparagraph; and

(II) in the case of an individual described in clause (vi) of subparagraph (B) (or deemed to be so described, pursuant to this subparagraph) whose enrollment with a plan or in a program described in such clause is involuntarily terminated within the first 12 months of such enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, such subsequent enrollment shall be deemed to be an initial enrollment described in such clause.

(ii) For purposes of clauses (v) and (vi) of subparagraph (B), no enrollment of an individual with an organization or provider described in clause (v)(II), or with a plan or in a program described in clause (vi), may be deemed to be an initial enrollment under this clause after the 2-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan, or program.

(4) Any issuer of a medicare supplemental policy that fails to meet the requirements of this subsection is subject to a civil money penalty of not to exceed $5,000 for each such failure. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(t)(1) If a medicare supplemental policy meets the 1991 NAIC Model Regulation or 1991 Federal Regulation complies with the requirements of this section except that benefits under the policy are restricted to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), the policy shall nevertheless be treated as meeting those standards if—

(A) full benefits are provided for items and services furnished through a network of entities which have entered into contracts or agreements with the issuer of the policy;

(B) full benefits are provided for items and services furnished by other entities if the services are medically necessary and immediately required because of an unforeseen illness, injury, or condition and it is not reasonable given the circumstances to obtain the services through the network;

(C) the network offers sufficient access;

(D) the issuer of the policy has arrangements for an ongoing quality assurance program for items and services furnished through the network;

(E)(i) the issuer of the policy provides to each enrollee at the time of enrollment an explanation of (I) the restrictions on payment under the policy for services furnished other than by or through the network, (II) out of area coverage under the policy, (III) the policy's coverage of emergency services and urgently needed care, and (IV) the availability of a policy through the entity that meets the standards in the 1991 NAIC Model Regulations or 1991 Federal Regulation without reference to this subsection and the premium charged for such policy, and

(ii) each enrollee prior to enrollment acknowledges receipt of the explanation provided under clause (i); and

(F) the issuer of the policy makes available to individuals, in addition to the policy described in this subsection, any policy (otherwise offered by the issuer to individuals in the State) that meets the standards in the 1991 NAIC Model Regulation or 1991 Federal Regulation and other requirements of this section without reference to this subsection.

(2) If the Secretary determines that an issuer of a policy approved under paragraph (1)—

(A) fails substantially to provide medically necessary items and services to enrollees seeking such items and services through the issuer's network, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual,

(B) imposes premiums on enrollees in excess of the premiums approved by the State,

(C) acts to expel an enrollee for reasons other than nonpayment of premiums, or

(D) does not provide the explanation required under paragraph (1)(E)(i) or does not obtain the acknowledgment required under paragraph (1)(E)(ii),

the issuer is subject to a civil money penalty in an amount not to exceed $25,000 for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(3) The Secretary may enter into a contract with an entity whose policy has been certified under paragraph (1) or has been approved by a State under subsection (b)(1)(H) to determine whether items and services (furnished to individuals entitled to benefits under this title and under that policy) are not allowable under section 1862(a)(1). Payments to the entity shall be in such amounts as the Secretary may determine, taking into account estimated savings under contracts with carriers and fiscal intermediaries and other factors that the Secretary finds appropriate. Paragraph (1), the first sentence of paragraph (2)(A), paragraph (2)(B), paragraph (3)(C), paragraph (3)(D), and paragraph (3)(E) of section 1842(b) shall apply to the entity.

(u)(1) It is unlawful for a person to sell or issue a policy described in paragraph (2) to an individual with knowledge that the

individual has in effect under section 1851 an election of an MSA plan or a Medicare+Choice private fee–for–service plan.

(2)(A) A policy described in this subparagraph is a health insurance policy (other than a policy described in subparagraph (B)) that provides for coverage of expenses that are otherwise required to be counted toward meeting the annual deductible amount provided under the MSA plan.

(B) A policy described in this subparagraph is any of the following:

(i) A policy that provides coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long–term care.

(ii) A policy of insurance to which substantially all of the coverage relates to—

(I) liabilities incurred under workers' compensation laws,

(II) tort liabilities,

(III) liabilities relating to ownership or use of property, or

(IV) such other similar liabilities as the Secretary may specify by regulations.

(iii) A policy of insurance that provides coverage for a specified disease or illness.

(iv) A policy of insurance that pays a fixed amount per day (or other period) of hospitalization.

(v)[624] RULES RELATING TO MEDIGAP POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE.—

(1) PROHIBITION ON SALE, ISSUANCE, AND RENEWAL OF NEW POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE.—

(A) IN GENERAL.—Notwithstanding any other provision of law, on or after January 1, 2006, a medigap Rx policy (as defined in paragraph (6)(A)) may not be sold, issued, or renewed under this section—

(i) to an individual who is a part D enrollee (as defined in paragraph (6)(B)); or

(ii) except as provided in subparagraph (B), to an individual who is not a part D enrollee.

(B) CONTINUATION PERMITTED FOR NON-PART D ENROLLEES.—Subparagraph (A)(ii) shall not apply to the renewal of a medigap Rx policy that was issued before January 1, 2006.

(C) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the offering on and after January 1, 2006, of "H", "I", and "J" policies described in paragraph (2)(D)(i) if the benefit packages are modified in accordance with paragraph (2)(C).

(2) ELIMINATION OF DUPLICATIVE COVERAGE UPON PART D ENROLLMENT.—

(A) IN GENERAL.—In the case of an individual who is covered under a medigap Rx policy and enrolls under a part D plan—

(i) before the end of the initial part D enrollment period, the individual may—

[624] P.L. 108-173, §104(a)(1), added subsection (v), effective December 8, 2003.

(I) enroll in a medicare supplemental policy without prescription drug coverage under paragraph (3); or

(II) continue the policy in effect subject to the modification described in subparagraph (C)(i); or

(ii) after the end of such period, the individual may continue the policy in effect subject to such modification.

(B) NOTICE REQUIRED TO BE PROVIDED TO CURRENT POLICYHOLDERS WITH MEDIGAP RX POLICY.—No medicare supplemental policy of an issuer shall be deemed to meet the standards in subsection (c) unless the issuer provides written notice (in accordance with standards of the Secretary established in consultation with the National Association of Insurance Commissioners) during the 60-day period immediately preceding the initial part D enrollment period, to each individual who is a policyholder or certificate holder of a medigap Rx policy (at the most recent available address of that individual) of the following:

(i) If the individual enrolls in a plan under part D during the initial enrollment period under section 1860D-1(b)(2)(A), the individual has the option of—

(I) continuing enrollment in the individual's current plan, but the plan's coverage of prescription drugs will be modified under subparagraph (C)(i); or

(II) enrolling in another medicare supplemental policy pursuant to paragraph (3).

(ii) If the individual does not enroll in a plan under part D during such period, the individual may continue enrollment in the individual's current plan without change, but—

(I) the individual will not be guaranteed the option of enrollment in another medicare supplemental policy pursuant to paragraph (3); and

(II) if the current plan does not provide creditable prescription drug coverage (as defined in section 1860D- 13(b)(4)), notice of such fact and that there are limitations on the periods in a year in which the individual may enroll under a part D plan and any such enrollment is subject to a late enrollment penalty.

(iii) Such other information as the Secretary may specify (in consultation with the National Association of Insurance Commissioners), including the potential impact of such election on premiums for medicare supplemental policies.

(C) MODIFICATION.—

(i) IN GENERAL.—The policy modification described in this subparagraph is the elimination of prescription coverage for expenses of prescription drugs incurred after the effective date of the individual's coverage under a part D plan and the appropriate adjustment of premiums to reflect such elimination of coverage.

(ii) CONTINUATION OF RENEWABILITY AND APPLICATION OF MODIFICATION.—No medicare supplemental policy of an issuer shall be deemed to meet the standards in subsection (c) unless the issuer—

(I) continues renewability of medigap Rx policies that it has issued, subject to subclause (II); and

(II) applies the policy modification described in clause (i) in the cases described in clauses (i)(II) and (ii) of subparagraph (A).

(D) REFERENCES TO RX POLICIES.—

(i) H, I, AND J POLICIES.—Any reference to a benefit package classified as "H", "I", or "J" (including the benefit package classified as 'J' with a high deductible feature, as described in subsection (p)(11)) under the standards established under subsection (p)(2) shall be construed as including a reference to such a package as modified under subparagraph (C) and such packages as modified shall not be counted as a separate benefit package under such subsection.

(ii) APPLICATION IN WAIVERED STATES.—Except for the modification provided under subparagraph (C), the waivers previously in effect under subsection (p)(2) shall continue in effect.

(3) AVAILABILITY OF SUBSTITUTE POLICIES WITH GUARANTEED ISSUE.—

(A) IN GENERAL.—The issuer of a medicare supplemental policy—

(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy that has a benefit package classified as "A", "B", "C", or "F" (including the benefit package classified as "F" with a high deductible feature, as described in subsection (p)(11)), under the standards established under subsection (p)(2), or a benefit package described in subparagraph (A) or (B) of subsection (w)(2) and that is offered and is available for issuance to new enrollees by such issuer;

(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

(iii) may not impose an exclusion of benefits based on a pre-existing condition under such policy, in the case of an individual described in subparagraph (B) who seeks to enroll under the policy not later than 63 days after the effective date of the individual's coverage under a part D plan.

(B) INDIVIDUAL COVERED.—An individual described in this subparagraph with respect to the issuer of a medicare supplemental policy is an individual who—

(i) enrolls in a part D plan during the initial part D enrollment period;

(ii) at the time of such enrollment was enrolled in a medigap Rx policy issued by such issuer; and

(iii) terminates enrollment in such policy and submits evidence of such termination along with the application for the policy under subparagraph (A).

(C) SPECIAL RULE FOR WAIVERED STATES.—For purposes of applying this paragraph in the case of a State that provides for offering of benefit packages other than under the classification referred to in subparagraph (A)(i), the references to benefit packages in such subparagraph are deemed references to comparable benefit packages offered in such State.

(4) ENFORCEMENT.—

(A) PENALTIES FOR DUPLICATION.—The penalties described in subsection (d)(3)(A)(ii) shall apply with respect to a violation of paragraph (1)(A).

(B) GUARANTEED ISSUE.—The provisions of paragraph (4) of subsection (s) shall apply with respect to the requirements of paragraph (3) in the same manner as they apply to the requirements of such subsection.

(5) CONSTRUCTION.—Any provision in this section or in a medicare supplemental policy relating to guaranteed renewability of coverage shall be deemed to have been met with respect to a part D enrollee through the continuation of the policy subject to modification under paragraph (2)(C) or the offering of a substitute policy under paragraph (3). The previous sentence shall not be construed to affect the guaranteed renewability of such a modified or substitute policy.

(6) DEFINITIONS.—For purposes of this subsection:

(A) MEDIGAP RX POLICY.—The term "medigap Rx policy" means a medicare supplemental policy—

(i) which has a benefit package classified as "H", "I", or "J" (including the benefit package classified as "J" with a high deductible feature, as described in subsection (p)(11)) under the standards established under subsection (p)(2), without regard to this subsection; and

(ii) to which such standards do not apply (or to which such standards have been waived under subsection (p)(6)) but which provides benefits for prescription drugs. Such term does not include a policy with a benefit package as classified under clause (i) which has been modified under paragraph (2)(C)(i).Rx policy (as defined in paragraph (6)(A)) may not be sold, issued, or renewed under this section—

(B) PART D ENROLLEE.—The term "part D enrollee" means an individual who is enrolled in a part D plan.

(C) PART D PLAN.—The term "part D plan" means a prescription drug plan or an MA-PD plan (as defined for purposes of part D).

(D) INITIAL PART D ENROLLMENT PERIOD.—The term "initial part D enrollment period" means the initial enrollment period described in section 1860D-1(b)(2)(A).

(w)[625] DEVELOPMENT OF NEW STANDARDS FOR MEDICARE SUPPLEMENTAL POLICIES.—

(1) IN GENERAL.—The Secretary shall request the National Association of Insurance Commissioners to review and revise the standards for benefit packages under subsection (p)(1), taking into account the changes in benefits resulting from enact-

[625] P.L. 108-173, §104(b)(1), added subsection (w), effective December 8, 2003.

ment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and to otherwise update standards to reflect other changes in law included in such Act. Such revision shall incorporate the inclusion of the 2 benefit packages described in paragraph (2). Such revisions shall be made consistent with the rules applicable under subsection (p)(1)(E) with the reference to the "1991 NAIC Model Regulation" deemed a reference to the NAIC Model Regulation as published in the Federal Register on December 4, 1998, and as subsequently updated by the National Association of Insurance Commissioners to reflect previous changes in law (and subsection (v)) and the reference to "date of enactment of this subsection" deemed a reference to the date of enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. To the extent practicable, such revision shall provide for the implementation of revised standards for benefit packages as of January 1, 2006.

(2) NEW BENEFIT PACKAGES.—The benefit packages described in this paragraph are the following (notwithstanding any other provision of this section relating to a core benefit package):

(A) FIRST NEW BENEFIT PACKAGE.—A benefit package consisting of the following:

(i) Subject to clause (ii), coverage of 50 percent of the cost-sharing otherwise applicable under parts A and B, except there shall be no coverage of the part B deductible and coverage of 100 percent of any cost-sharing otherwise applicable for preventive benefits.

(ii) Coverage for all hospital inpatient coinsurance and 365 extra lifetime days of coverage of inpatient hospital services (as in the current core benefit package).

(iii) A limitation on annual out-of-pocket expenditures under parts A and B to $4,000 in 2006 (or, in a subsequent year, to such limitation for the previous year increased by an appropriate inflation adjustment specified by the Secretary).

(B) SECOND NEW BENEFIT PACKAGE.—A benefit package consisting of the benefit package described in subparagraph (A), except as follows:

(i) Substitute "75 percent" for "50 percent" in clause (i) of such subparagraph.

(ii) Substitute "$2,000" for "$4,000" in clause (iii) of such subparagraph.

HOSPITAL PROVIDERS OF EXTENDED CARE SERVICES[626]

SEC. 1883. [42 U.S.C. 1395tt] (a)(1) Any hospital which has an agreement under section 1866 may (subject to subsection (b)) enter into an agreement with the Secretary under which its inpatient hospital facilities may be used for the furnishing of services of the type which, if furnished by a skilled nursing facility, would constitute extended care services.

(2)(A) Notwithstanding any other provision of this title, payment to any hospital (other than a critical access hospital) for

[626] See Vol. II, P.L. 101–508, §4008(j)(2), with respect to the reasonable cost of routine services.

services furnished under an agreement entered into under this section shall be based upon the reasonable cost of the services as determined under subparagraph (B).

(B)(i) The reasonable cost of the services consists of the reasonable cost of routine services (determined under clause (ii)) and the reasonable cost of ancillary services (determined under clause (iii)).

(ii) The reasonable cost of routine services furnished during any calendar year by a hospital under an agreement under this section is equal to the product of—

(I) the number of patient-days during the year for which the services were furnished, and

(II) the average reasonable cost per patient-day, such average reasonable cost per patient-day being the average rate per patient-day paid for routine services during the most recent year for which cost reporting data are available with respect to such services (increased in a compounded manner by the applicable increase for payments for routine service costs of skilled nursing facilities under subsections (a) through (d) of section 1888 for subsequent cost reporting periods and up to and including such calendar year) under this title to freestanding skilled nursing facilities in the region (as defined in section 1886(d)(2)(D)) in which the facility is located.

(iii) The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

(3) Notwithstanding any other provision of this title, a critical access hospital shall be paid for covered skilled nursing facility services furnished under an agreement entered into under this section on the basis of equal to 101 percent of[627] the reasonable costs of such services (as determined under section 1861(v)).

(b) The Secretary may not enter into an agreement under this section with any hospital unless, except as provided under subsection (g), the hospital is located in a rural area and has less than 100 beds.

(c) An agreement with a hospital under this section shall, except as otherwise provided under regulations of the Secretary, be of the same duration and subject to termination on the same conditions as are agreements with skilled nursing facilities under section 1866 and shall, where not inconsistent with any provision of this section, impose the same duties, responsibilities, conditions, and limitations, as those imposed under such agreements entered into under section 1866; except that no such agreement with any hospital shall be in effect for any period during which the hospital does not have in effect an agreement under section 1866. A hospital with respect to which an agreement under this section has been termi-

[627] P.L. 108–173, §405(a)(1), inserted "equal to 101 percent of", applicable to payments for services furnished during cost reporting periods beginning on or after January 1, 2004.

nated shall not be eligible to enter into a new agreement until a two-year period has elapsed from the termination date.

(d) Any agreement with a hospital under this section shall provide that payment for services will be made only for services for which payment would be made as post-hospital extended care services if those services had been furnished by a skilled nursing facility under an agreement entered into under section 1866; and any individual who is furnished services, for which payment may be made under an agreement under this section, shall, for purposes of this title (other than this section), be deemed to have received post-hospital extended care services in like manner and to the same extent as if the services furnished to him had been post-hospital extended care services furnished by a skilled nursing facility under an agreement under section 1866.

(e) During a period for which a hospital has in effect an agreement under this section, in order to allocate routine costs between hospital and long-term care services for purposes of determining payment for inpatient hospital services, the total reimbursement due for routine services from all classes of long-term care patients (including title XVIII, title XIX, and private pay patients) shall be subtracted from the hospital's total routine costs before calculations are made to determine title XVIII reimbursement for routine hospital services.

(f) A hospital which enters into an agreement with the Secretary under this section shall be required to meet those conditions applicable to skilled nursing facilities relating to discharge planning and the social services function (and staffing requirements to satisfy it) which are promulgated by the Secretary under section 1819. Services furnished by such a hospital which would otherwise constitute post-hospital extended care services if furnished by a skilled nursing facility shall be subject to the same requirements applicable to such services when furnished by a skilled nursing facility except for those requirements the Secretary determines are inappropriate in the case of these services being furnished by a hospital under this section.

(g) The Secretary may enter into an agreement under this section on a demonstration basis with any hospital which does not meet the requirement of subsection (b)(1), if the hospital otherwise meets the requirements of this section.

PAYMENTS TO PROMOTE CLOSING AND CONVERSION OF UNDERUTILIZED HOSPITAL FACILITIES

SEC. 1884. [42 U.S.C. 1395uu] (a) Any hospital may file an application with the Secretary (in such form and including such data and information as the Secretary may require) for establishment of a transitional allowance under this title with respect to the closing or conversion of an underutilized hospital facility. The Secretary also may establish procedures, consistent with this section, by which a hospital, before undergoing an actual closure or conversion of a hospital facility, can have a determination made as to whether or not it will be eligible for a transitional allowance under this section with respect to such closure or conversion.

(b) If the Secretary finds, after consideration of an application under subsection (a), that—

(1) the hospital's closure or conversion—

(A) is formally initiated after September 30, 1981,

(B) is expected to benefit the program under this title by (i) eliminating excess bed capacity, (ii) discontinuing an underutilized service for which there are adequate alternative sources, or (iii) substituting for the underutilized service some other service which is needed in the area, and

(C) is consistent with the findings of an appropriate health planning agency and with any applicable State program for reduction in the number of hospital beds in the State, and

(2) in the case of a complete closure of a hospital—

(A) the hospital is a private nonprofit hospital or a local governmental hospital, and

(B) the closure is not for replacement of the hospital,

the Secretary may include as an allowable cost in the hospital's reasonable cost (for the purpose of making payments to the hospital under this title) an amount (in this section referred to as a "transitional allowance"), as provided in subsection (c).

(c)(1) Each transitional allowance established shall be reasonably related to the prior or prospective use of the facility involved under this title and shall recognize—

(A) in the case of a facility conversion or closure (other than a complete closure of a hospital)—

(i) in the case of a private nonprofit or local governmental hospital, that portion of the hospital's costs attributable to capital assets of the facility which have been taken into account in determining reasonable cost for purposes of determining the amount of payment to the hospital under this title, and

(ii) in the case of any hospital, transitional operating cost increases related to the conversion or closure to the extent that such operating costs exceed amounts ordinarily reimbursable under this title; and

(B) in the case of complete closure of a hospital, the outstanding portion of actual debt obligations previously recognized as reasonable for purposes of reimbursement under this title, less any salvage value of the hospital.

(2) A transitional allowance shall be for a period (not to exceed 20 years) specified by the Secretary, except that, in the case of a complete closure described in paragraph (1)(B), the Secretary may provide for a lump-sum allowance where the Secretary determines that such a one-time allowance is more efficient and economical.

(3) A transitional allowance shall take effect on a date established by the Secretary, but not earlier than the date of completion of the closure or conversion concerned.

(4) A transitional allowance shall not be considered in applying the limits to costs recognized as reasonable pursuant to the third sentence of subparagraph (A) and subparagraph (L)(i) of section 1861(v)(1) of this Act, or in determining whether the reasonable cost exceeds the customary charges for a service for purposes of determining the amount to be paid to a provider pursuant to sections 1814(b) and 1833(a)(2) of this Act.

(d) A hospital dissatisfied with a determination of the Secretary on its application under this section may obtain an informal or formal hearing, at the discretion of the Secretary, by filing (in such form and within such time period as the Secretary establishes) a

request for such a hearing. The Secretary shall make a final determination on such application within 30 days after the last day of such hearing.

WITHHOLDING OF PAYMENTS FOR CERTAIN MEDICAID PROVIDERS

SEC. 1885. [42 U.S.C. 1395vv] (a) The Secretary may adjust, in accordance with this section, payments under parts A and B to any institution which has in effect an agreement with the Secretary under section 1866, and any person who has accepted payment on the basis of an assignment under section 1842(b)(3)(B)(ii), where such institution or person—

(1) has (or previously had) in effect an agreement with a State agency to furnish medical care and services under a State plan approved under title XIX, and

(2) from which (or from whom) such State agency (A) has been unable to recover overpayments made under the State plan, or (B) has been unable to collect the information necessary to enable it to determine the amount (if any) of the overpayments made to such institution or person under the State plan.

(b) The Secretary shall by regulation provide procedures for implementation of this section, which procedures shall—

(1) assure that the authority under this section is exercised only on behalf of a State agency which demonstrates to the Secretary's satisfaction that it has provided adequate notice of a determination or of a need for information, and an opportunity to appeal such determination or to provide such information,

(2) determine the amount of the payment to which the institution or person would otherwise be entitled under this title which shall be treated as a setoff against overpayments under title XIX, and

(3) assure the restoration to the institution or person of amounts withheld under this section which are ultimately determined to be in excess of overpayments under title XIX and to which the institution or person would otherwise be entitled under this title.

(c) Notwithstanding any other provision of this Act, from the trust funds established under sections 1817 and 1841, as appropriate, the Secretary shall pay to the appropriate State agency amounts recovered under this section to offset the State agency's overpayment under title XIX. Such payments shall be accounted for by the State agency as recoveries of overpayments under the State plan.

PAYMENT TO HOSPITALS FOR INPATIENT HOSPITAL SERVICES [628]

SEC. 1886. [42 U.S.C. 1395ww] (a)(1)(A)(i) The Secretary, in determining the amount of the payments that may be made under

[628] See Vol. II, P.L. 103–66, §13563(d), with respect to adjustment in GME base–year costs of Federal Insurance Contributions Act.

See Vol. II, P.L. 106–113, §1000(a)(6) [123], with respect to per discharge prospective payment system for long–term care hospitals; [124], with respect to per diem prospective payment system for psychiatric hospitals; [407(d)], with respect to not counting against numerical limitation certain interns and residents transferred from a VA residency program that loses accreditation.

Continued

this title with respect to operating costs of inpatient hospital services (as defined in paragraph (4)) shall not recognize as reasonable (in the efficient delivery of health services) costs for the provision of such services by a hospital for a cost reporting period to the extent such costs exceed the applicable percentage (as determined under clause (ii)) of the average of such costs for all hospitals in the same grouping as such hospital for comparable time periods.

(ii) For purposes of clause (i), the applicable percentage for hospital cost reporting periods beginning—

(I) on or after October 1, 1982, and before October 1, 1983, is 120 percent;

(II) on or after October 1, 1983, and before October 1, 1984, is 115 percent; and

(III) on or after October 1, 1984, is 110 percent.

(B)(i) For purposes of subparagraph (A) the Secretary shall establish case mix indexes for all short-term hospitals, and shall set limits for each hospital based upon the general mix of types of medical cases with respect to which such hospital provides services for which payment may be made under this title.

(ii) The Secretary shall set such limits for a cost reporting period of a hospital—

(I) by updating available data for a previous period to the immediate preceding cost reporting period by the estimated average rate of change of hospital costs industry-wide, and

(II) by projecting for the cost reporting period by the applicable percentage increase (as defined in subsection (b)(3)(B)).

(C) The limitation established under subparagraph (A) for any hospital shall in no event be lower than the allowable operating costs of inpatient hospital services (as defined in paragraph (4)) recognized under this title for such hospital for such hospital's last cost reporting period prior to the hospital's first cost reporting period for which this section is in effect.

(D) Subparagraph (A) shall not apply to cost reporting periods beginning on or after October 1, 1983.

(2) The Secretary shall provide for such exemptions from, and exceptions and adjustments to, the limitation established under paragraph (1)(A) as he deems appropriate, including those which he deems necessary to take into account—

(A) the special needs of sole community hospitals, of new hospitals, of risk based health maintenance organizations, and of hospitals which provide atypical services or essential community services, and to take into account extraordinary circumstances beyond the hospital's control, medical and paramedical education costs, significantly fluctuat-

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See Vol. II, P.L. 108-173, §404, with respect to more frequent update in weights used in hospital market basket; §410A, with respect to a rural community hospital demonstration program; §422(c), with respect to a report on extension of applications under redistribution program; §433, with respect to a MEDPAC study on rural hospital payment adjustments; §501(c), with respect to a GAO study and report on appropriateness of payments under the prospective payment system for inpatient hospital services; §508, with respect to a one-time appeals process for hospital wage index classification; §712, with respect to an exception to initial residency period for geriatric residency or fellowship programs; §713, with respect to treatment of volunteer supervision; and §951, with respect to furnishing hospitals with information to compute DSH formula.

ing population in the service area of the hospital, and unusual labor costs,

(B) the special needs of psychiatric hospitals and of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of this title, and

(C) a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals which results in a significant distortion in the operating costs of inpatient hospital services.

(3) The limitation established under paragraph (1)(A) shall not apply with respect to any hospital which—

(A) is located outside of a standard metropolitan statistical area, and

(B)(i) has less than 50 beds, and

(ii) was in operation and had less than 50 beds on the date of the enactment of this section[629].

(4) For purposes of this section, the term "operating costs of inpatient hospital services" includes all routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient hospital services as such costs are determined on an average per admission or per discharge basis (as determined by the Secretary), and includes the costs of all services for which payment may be made under this title that are provided by the hospital (or by an entity wholly owned or operated by the hospital) to the patient during the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1 day) immediately preceding the date of the patient's admission if such services are diagnostic services (including clinical diagnostic laboratory tests) or are other services related to the admission (as defined by the Secretary). Such term does not include costs of approved educational activities, a return on equity capital, other capital-related costs (as defined by the Secretary for periods before October 1, 1987), or costs with respect to administering blood clotting factors to individuals with hemophilia.

(b)(1)[630] Notwithstanding section 1814(b) but subject to the provisions of section 1813, if the operating costs of inpatient hospital services (as defined in subsection (a)(4)) of a hospital (other than a subsection (d) hospital, as defined in subsection (d)(1)(B) and other than a rehabilitation facility described in subsection (j)(1)) for a cost reporting period subject to this paragraph—

(A) are less than or equal to the target amount (as defined in paragraph (3)) for that hospital for that period, the amount of the payment with respect to such operating costs payable under part A on a per discharge or per admission basis (as the case may be) shall be equal to the amount of such operating costs, plus—

(i) 15 percent of the amount by which the target amount exceeds the amount of the operating costs, or

(ii) 2 percent of the target amount, whichever is less;

[629] September 3, 1982 [P.L. 97–248; 96 Stat. 324].

[630] See Vol. II, P.L. 105–33, §4415(d), with respect to a report that describes the effect of the amendments to this section on psychiatric hospitals that have approved medical residency training programs under title XVIII.

(B) are greater than the target amount but do not exceed 110 percent of the target amount, the amount of the payment with respect to those operating costs payable under part A on a per discharge basis shall equal the target amount; or

whichever is less; or

(C) are greater than 110 percent of the target amount, the amount of the payment with respect to such operating costs payable under part A on a per discharge or per admission basis (as the case may be) shall be equal to (i) the target amount, plus (ii) in the case of cost reporting periods beginning on or after October 1, 1991, an additional amount equal to 50 percent of the amount by which the operating costs exceed 110 percent of the target amount (except that such additional amount may not exceed 10 percent of the target amount) after any exceptions or adjustments are made to such target amount for the cost reporting period;

plus the amount, if any, provided under paragraph (2), except that in no case may the amount payable under this title (other than on the basis of a DRG prospective payment rate determined under subsection (d)) with respect to operating costs of inpatient hospital services exceed the maximum amount payable with respect to such costs pursuant to subsection (a).

(2)(A) Except as provided in subparagraph (E), in addition to the payment computed under paragraph (1), in the case of an eligible hospital (described in subparagraph (B)) for a cost reporting period beginning on or after October 1, 1997, the amount of payment on a per discharge basis under paragraph (1) shall be increased by the lesser of—

(i) 50 percent of the amount by which the operating costs are less than the expected costs (as defined in subparagraph (D)) for the period; or

(ii) 1 percent of the target amount for the period.

(B) For purposes of this paragraph, an "eligible hospital" means with respect to a cost reporting period, a hospital—

(i) that has received payments under this subsection for at least 3 full cost reporting periods before that cost reporting period, and

(ii) whose operating costs for the period are less than the least of its target amount, its trended costs (as defined in subparagraph (C)), or its expected costs (as defined in subparagraph (D)) for the period.

(C) For purposes of subparagraph (B)(ii), the term "trended costs" means for a hospital cost reporting period ending in a fiscal year—

(i) in the case of a hospital for which its cost reporting period ending in fiscal year 1996 was its third or subsequent full cost reporting period for which it receives payments under this subsection, the lesser of the operating costs or target amount for that hospital for its cost reporting period ending in fiscal year 1996, or

(ii) in the case of any other hospital, the operating costs for that hospital for its third full cost reporting period for which it receives payments under this sub-

section, increased (in a compounded manner) for each succeeding fiscal year (through the fiscal year involved) by the market basket percentage increase for the fiscal year.

(D) For purposes of this paragraph, the term "expected costs", with respect to the cost reporting period ending in a fiscal year, means the lesser of the operating costs of inpatient hospital services or target amount per discharge for the previous cost reporting period updated by the market basket percentage increase (as defined in paragraph (3)(B)(iii)) for the fiscal year.

(E)(i) In the case of an eligible hospital that is a hospital or unit that is within a class of hospital described in clause (ii) with a 12–month cost reporting period beginning before the enactment of this subparagraph, in determining the amount of the increase under subparagraph (A), the Secretary shall substitute for the percentage of the target amount applicable under subparagraph (A)(ii)—

(I) for a cost reporting period beginning on or after October 1, 2000, and before September 30, 2001, 1.5 percent; and

(II) for a cost reporting period beginning on or after October 1, 2001, and before September 30, 2002, 2 percent.

(ii) For purposes of clause (i), each of the following shall be treated as a separate class of hospital:

(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

(II) Hospitals described in clause (iv) of such subsection.

(3)(A) Except as provided in subparagraph (C) and succeeding subparagraphs and in paragraph (7)(A)(ii), for purposes of this subsection, the term "target amount" means, with respect to a hospital for a particular 12-month cost reporting period—

(i) in the case of the first such reporting period for which this subsection is in effect, the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for such hospital for the preceding 12-month cost reporting period, and

(ii) in the case of a later reporting period, the target amount for the preceding 12-month cost reporting period,

increased by the applicable percentage increase under subparagraph (B) for that particular cost reporting period.

(B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—

(I) for fiscal year 1986, ½ percent,

(II) for fiscal year 1987, 1.15 percent,

(III) for fiscal year 1988, 3.0 percent for hospitals located in a rural area, 1.5 percent for hospitals located in a large urban area (as defined in subsection (d)(2)(D)), and 1.0 percent for hospitals located in other urban areas,

(IV) for fiscal year 1989, the market basket percentage increase minus 1.5 percentage points for hospitals located in a rural area, the market basket percentage increase minus 2.0 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 2.5 percentage points for hospitals located in other urban areas,

(V) for fiscal year 1990, the market basket percentage increase plus 4.22 percentage points for hospitals located in a rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas,

(VI) for fiscal year 1991, the market basket percentage increase minus 2.0 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,

(VII) for fiscal year 1992, the market basket percentage increase minus 1.6 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area,

(VIII) for fiscal year 1993, the market basket percentage increase minus 1.55 percentage point for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.55 for hospitals located in a rural area,

(IX) for fiscal year 1994, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and the market basket percentage increase minus 1.0 percentage point for hospitals located in a rural area,

(X) for fiscal year 1995, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and such percentage increase for hospitals located in a rural area as will provide for the average standardized amount determined under subsection (d)(3)(A) for hospitals located in a rural area being equal to such average standardized amount for hospitals located in an urban area (other than a large urban area),

(XI) for fiscal year 1996, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas,

(XII) for fiscal year 1997, the market basket percentage increase minus 0.5 percentage point for hospitals in all areas,

(XIII) for fiscal year 1998, 0 percent,

(XIV) for fiscal year 1999, the market basket percentage increase minus 1.9 percentage points for hospitals in all areas,

(XV) for fiscal year 2000, the market basket percentage increase minus 1.8 percentage points for hospitals in all areas,

(XVI) for fiscal year 2001, the market basket percentage increase for hospitals in all areas,

(XVII) for fiscal year 2002, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,

(XVIII) for fiscal year 2003, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,[631]

(XIX)[632] for each of fiscal years 2004 through 2007, subject to clause (vii), the market basket percentage increase for hospitals in all areas; and

(XX)[633] for fiscal year 2008 and each subsequent fiscal year, the market basket percentage increase for hospitals in all areas.

(ii) For purposes of subparagraphs (A) and (E), the "applicable percentage increase" for 12-month cost reporting periods beginning during—

(I) fiscal year 1986, is 0.5 percent,

(II) fiscal year 1987, is 1.15 percent,

(III) fiscal year 1988, is the market basket percentage increase minus 2.0 percentage points,

(IV) a subsequent fiscal year ending on or before September 30, 1993, is the market basket percentage increase,

(V) fiscal years 1994 thorugh 1997, is the market basket percentage increase minus the applicable reduction (as defined in clause (v)(II)), or in the case of a hospital for a fiscal year for which the hospital's update adjustment percentage (as defined in clause (v)(I)) is at least 10 percent, the market basket percentage increase,

(VI) for fiscal year 1998, is 0 percent,

(VII) for fiscal years 1999 through 2002, is the applicable update factor specified under clause (vi) for the fiscal year, and

(VIII) subsequent fiscal years is the market basket percentage increase.

(iii) For purposes of this subparagraph, the term "market basket percentage increase" means, with respect to cost reporting periods and discharges occurring in a fiscal year, the percentage, estimated by the Secretary before the beginning of the period or fiscal year, by which the cost of the mix of goods and services (including personnel costs but excluding non-

[631] P.L. 108-173, §501(a)(1), struck out "and".

[632] P.L. 108-173, §501(a)(2), struck out the former subclause (XIX), effective December 8, 2003; §501(a)(3), added this subclause (XIX), effective December 8, 2003. For subclause (XIX) as it formerly read, see Vol. II, Appendix I, Superseded Provisions, P.L. 108-173.

[633] P.L. 108-173, §501(a)(3), added subclause (XX), effective December 8, 2003.

operating costs) comprising routine, ancillary, and special care unit inpatient hospital services, based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such inpatient hospital services, for the period or fiscal year will exceed the cost of such mix of goods and services for the preceding 12–month cost reporting period or fiscal year.

(iv) For purposes of subparagraphs (C) and (D), the "applicable percentage increase" is—

(I) for 12–month cost reporting periods beginning during fiscal years 1986 through 1993, the applicable percentage increase specified in clause (ii),

(II) for fiscal year 1994, the market basket percentage increase minus 2.3 percentage points (adjusted to exclude any portion of a cost reporting period beginning during fiscal year 1993 for which the applicable percentage increase is determined under subparagraph (I)),

(III) for fiscal year 1995, the market basket percentage increase minus 2.2 percentage points, and

(IV) for fiscal year 1996 and each subsequent fiscal year, the applicable percentage increase under clause (i).

(v) For purposes of clause (ii)(V)—

(I) a hospital's "update adjustment percentage" for a fiscal year is the percentage by which the hospital's allowable operating costs of inpatient hospital services recognized under this title for the cost reporting period beginning in fiscal year 1990 exceeds the hospital's target amount (as determined under subparagraph (A)) for such cost reporting period, increased for each fiscal year (beginning with fiscal year 1994) by the sum of any of the hospital's applicable reductions under subclause (V) for previous fiscal years; and

(II) the "applicable reduction" with respect to a hospital for a fiscal year is the lesser of 1 percentage point or the percentage point difference between 10 percent and the hospital's update adjustment percentage for the fiscal year.

(vi) For purposes of clause (ii)(VII) for a fiscal year, if a hospital's allowable operating costs of inpatient hospital services recognized under this title for the most recent cost reporting period for which information is available—

(I) is equal to, or exceeds, 110 percent of the hospital's target amount (as determined under subparagraph (A)) for such cost reporting period, the applicable update factor specified under this clause is the market basket percentage;

(II) exceeds 100 percent, but is less than 110 percent, of such target amount for the hospital,

the applicable update factor specified under this clause is 0 percent or, if greater, the market basket percentage minus 0.25 percentage points for each percentage point by which such allowable operating costs (expressed as a percentage of such target amount) is less than 110 percent of such target amount;

(III) is equal to, or less than 100 percent, but exceeds ⅔ of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent or, if greater, the market basket percentage minus 2.5 percentage points; or

(IV) does not exceed ⅔ of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent.

(vii)[634](I) For purposes of clause (i)(XIX) for each of fiscal years 2005 through 2007, in a case of a subsection (d) hospital that does not submit data to the Secretary in accordance with subclause (II) with respect to such a fiscal year, the applicable percentage increase under such clause for such fiscal year shall be reduced by 0.4 percentage points. Such reduction shall apply only with respect to the fiscal year involved, and the Secretary shall not take into account such reduction in computing the applicable percentage increase under clause (i)(XIX) for a subsequent fiscal year.

(II) Each subsection (d) hospital shall submit to the Secretary quality data (for a set of 10 indicators established by the Secretary as of November 1, 2003) that relate to the quality of care furnished by the hospital in inpatient settings in a form and manner, and at a time, specified by the Secretary for purposes of this clause, but with respect to fiscal year 2005, the Secretary shall provide for a 30-day grace period for the submission of data by a hospital.

(C) In the case of a hospital that is a sole community hospital (as defined in subsection (d)(5)(D)(iii)), subject to subparagraph (I) the term "target amount" means—

(i) with respect to the first 12–month cost reporting period in which this subparagraph is applied to the hospital—

(I) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12–month cost reporting period (in this subparagraph referred to as the "base cost reporting period") preceding the first cost reporting period for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by—

(II) the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods after the base cost reporting

[634] P.L. 108-173, §501(b), added clause (vii), effective December 8, 2003.

period and up to and including such first 12–month cost reporting period,

(ii) with respect to a later cost reporting period beginning before fiscal year 1994, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B)(iv) for discharges occurring in the fiscal year in which that later cost reporting period begins,

(iii) with respect to discharges occurring in fiscal year 1994, the target amount for the cost reporting period beginning in fiscal year 1993 increased by the applicable percentage increase under subparagraph (B)(iv), or

(iv) with respect to discharges occurring in fiscal year 1995 and each subsequent fiscal year, the target amount for the preceding year increased by the applicable percentage increase under subparagraph (B)(iv).

There shall be substituted for the base cost reporting period described in clause (i) a hospital's cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.

(D) For cost reporting periods ending on or before September 30, 1994 and for cost reporting periods beginning on or after October 1, 1997, and before October 1, 2006, in the case of a hospital that is a medicare-dependent, small rural hospital (as defined in subsection (d)(5)(G)), the term "target amount" means—

(i) with respect to the first 12–month cost reporting period in which this subparagraph is applied to the hospital—

(I) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12–month cost reporting period (in this subparagraph referred to as the "base cost reporting period") preceding the first cost reporting period for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by—

(II) the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12–month cost reporting period, or

(ii) with respect to a later cost reporting period beginning before fiscal year 1994, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B)(iv) for discharges occurring in the fiscal year in which that later cost reporting period begins,

(iii) with respect to discharges occurring in fiscal year 1994, the target amount for the cost reporting period beginning in fiscal year 1993 increased by the ap-

plicable percentage increase under subparagraph (B)(iv), and

(iv) with respect to discharges occurring during fiscal year 1998 through fiscal year 2005, the target amount for the preceding year increased by the applicable percentage increase under subparagraph (B)(iv).

There shall be substituted for the base cost reporting period described in clause (i) a hospital's cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.

(E) In the case of a hospital described in clause (v) of subsection (d)(1)(B), the term "target amount" means—

(i) with respect to the first 12–month cost reporting period in which this subparagraph is applied to the hospital—

(I) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12–month cost reporting period (in this subparagraph referred to as the "base cost reporting period") preceding the first cost reporting period for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by—

(II) the sum of the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12–month cost reporting period, or

(ii) with respect to a later cost reporting period, the target amount for the preceding 12–month cost reporting period, increased by the applicable percentage increase under subparagraph (B)(ii) for that later cost reporting period.

There shall be substituted for the base cost reporting period described in clause (i) a hospital's cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.

(F)(i) In the case of a hospital (or unit described in the matter following clause (v) of subsection (d)(1)(B)) that received payment under this subsection for inpatient hospital services furnished during cost reporting periods beginning before October 1, 1990, that is within a class of hospital described in clause (iii), and that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital, the target amount for the hospital's 12–month cost reporting period beginning during fiscal year 1998 is equal to the average described in clause (ii).

(ii) The average described in this clause for a hospital or unit shall be determined by the Secretary as follows:

(I) The Secretary shall determine the allowable operating costs for inpatient hospital services for the hospital or unit for each of the 5 cost reporting periods for which the Secretary has the most

recent settled cost reports as of the date of the enactment of this subparagraph.

(II) The Secretary shall increase the amount determined under subclause (I) for each cost reporting period by the applicable percentage increase under subparagraph (B)(ii) for each subsequent cost reporting period up to the cost reporting period described in clause (i).

(III) The Secretary shall identify among such 5 cost reporting periods the cost reporting periods for which the amount determined under subclause (II) is the highest, and the lowest.

(IV) The Secretary shall compute the averages of the amounts determined under subclause (II) for the 3 cost reporting periods not identified under subclause (III).

(iii) For purposes of this subparagraph, each of the following shall be treated as a separate class of hospital:

(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

(II) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

(III) Hospitals described in clause (iii) of such subsection.

(IV) Hospitals described in clause (iv) of such subsection.

(V) Hospitals described in clause (v) of such subsection.

(G)(i) In the case of a qualified long–term care hospital (as defined in clause (ii)) that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital, the target amount for the hospital's 12–month cost reporting period beginning during fiscal year 1998 is equal to the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12–month cost reporting period beginning during fiscal year 1996, increased by the applicable percentage increase for the cost reporting period beginning during fiscal year 1997.

(ii) In clause (i), a "qualified long–term care hospital" means, with respect to a cost reporting period, a hospital described in clause (iv) of subsection (d)(1)(B) during each of the 2 cost reporting periods for which the Secretary has the most recent settled cost reports as of the date of the enactment of this subparagraph for each of which—

(I) the hospital's allowable operating costs of inpatient hospital services recognized under this title exceeded 115 percent of the hospital's target amount, and

(II) the hospital would have a disproportionate patient percentage of at least 70 percent (as determined by the Secretary under subsection

(d)(5)(F)(vi)) if the hospital were a subsection (d) hospital.

(H)(i) In the case of a hospital or unit that is within a class of hospital described in clause (iv), for a cost reporting period beginning during fiscal years 1998 through 2002, the target amount for such a hospital or unit may not exceed the amount as updated up to or for such cost reporting period under clause (ii).

(ii)(I) In the case of a hospital or unit that is within a class of hospital described in clause (iv), the Secretary shall estimate the 75th percentile of the target amounts for such hospitals within such class for cost reporting periods ending during fiscal year 1996, as adjusted under clause (iii).

(II) The Secretary shall update the amount determined under subclause (I), for each cost reporting period after the cost reporting period described in such subclause and up to the first cost reporting period beginning on or after October 1, 1997, by a factor equal to the market basket percentage increase.

(III) For cost reporting periods beginning during each of fiscal years 1999 through 2002, subject to subparagraph (J), the Secretary shall update such amount by a factor equal to the market basket percentage increase.

(iii) In applying clause (ii)(I) in the case of a hospital or unit, the Secretary shall provide for an appropriate adjustment to the labor–related portion of the amount determined under such subparagraph to take into account differences between average wage–related costs in the area of the hospital and the national average of such costs within the same class of hospital.

(iv) For purposes of this subparagraph, each of the following shall be treated as a separate class of hospital:

(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

(II) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

(III) Hospitals described in clause (iv) of such subsection.

(I)(i) For cost reporting periods beginning on or after October 1, 2000, in the case of a sole community hospital there shall be substituted for the amount otherwise determined under subsection (d)(5)(D)(i), if such substitution results in a greater amount of payment under this section for the hospital—

(I) with respect to discharges occurring in fiscal year 2001, 75 percent of the[635] amount otherwise applicable to the hospital under subsection (d)(5)(D)(i) (referred to in this clause as the

[635] P.L. 108-173, §736(a)(9), struck out "the the" and substituted "the".

"subsection (d)(5)(D)(i) amount") (as defined in clause (ii));

(II) with respect to discharges occurring in fiscal year 2002, 50 percent of the subsection (d)(5)(D)(i) amount and 50 percent of the rebased target amount;

(III) with respect to discharges occurring in fiscal year 2003, 25 percent of the subsection (d)(5)(D)(i) amount and 75 percent of the rebased target amount; and

(IV) with respect to discharges occurring after fiscal year 2003, 100 percent of the rebased target amount.

(ii) For purposes of this subparagraph, the "rebased target amount" has the meaning given the term "target amount" in subparagraph (C) except that—

(I) there shall be substituted for the base cost reporting period the 12–month cost reporting period beginning during fiscal year 1996;

(II) any reference in subparagraph (C)(i) to the "first cost reporting period" described in such subparagraph is deemed a reference to the first cost reporting period beginning on or after October 1, 2000; and

(III) applicable increase percentage shall only be applied under subparagraph (C)(iv) for discharges occurring in fiscal years beginning with fiscal year 2002.

(iii)[636] In no case shall a hospital be denied treatment as a sole community hospital or payment (on the basis of a target rate as such as a hospital) because data are unavailable for any cost reporting period due to changes in ownership, changes in fiscal intermediaries, or other extraordinary circumstances, so long as data for at least one applicable base cost reporting period is available.

(J) For cost reporting periods beginning during fiscal year 2001, for a hospital described in subsection (d)(1)(B)(iv)—

(i) the limiting or cap amount otherwise determined under subparagraph (H) shall be increased by 2 percent; and

(ii) the target amount otherwise determined under subparagraph (A) shall be increased by 25 percent (subject to the limiting or cap amount determined under subparagraph (H), as increased by clause (i)).

(4)(A)(i) The Secretary shall provide for an exemption (and in the case of a hospital described in subsection (d)(1)(B)(iii), may provide an exemption from) and adjustment to, the method under this subsection for determining the amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for

[636] P.L. 108-173, §407(a), added clause (iii), applicable to cost reporting periods beginning on or after January 1, 2004.

a cost reporting period (including any distortion in the costs for the base period against which such increase is measured). The Secretary may provide for such other exemptions from, and exceptions and adjustments to, such method as the Secretary deems appropriate, including the assignment of a new base period which is more representative, as determined by the Secretary, of the reasonable and necessary cost of inpatient services and including those which he deems necessary to take into account a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals which results in a significant distortion in the operating costs of inpatient hospital services. The Secretary shall announce a decision on any request for an exemption, exception, or adjustment under this paragraph not later than 180 days after receiving a completed application from the intermediary for such exemption, exception, or adjustment, and shall include in such decision a detailed explanation of the grounds on which such request was approved or denied.

(ii) The payment reductions under paragraph (3)(B)(ii)(V) shall not be considered by the Secretary in making adjustments pursuant to clause (i). In making such reductions, the Secretary shall treat the applicable update factor described in paragraph (3)(B)(vi) for a fiscal year as being equal to the market basket percentage for that year.

(B) In determining under subparagraph (A) whether to assign a new base period which is more representative of the reasonable and necessary cost to a hospital of providing inpatient services, the Secretary shall take into consideration—

(i) changes in applicable technologies and medical practices, or differences in the severity of illness among patients, that increase the hospital's costs;

(ii) whether increases in wages and wage-related costs for hospitals located in the geographic area in which the hospital is located exceed the average of the increases in such costs paid by hospitals in the United States; and

(iii) such other factors as the Secretary considers appropriate in determining increases in the hospital's costs of providing inpatient services.

(C) Paragraph (1) shall not apply to payment of hospitals which is otherwise determined under paragraph (3) of section 1814(b).

(5) In the case of any hospital having any cost reporting period of other than a 12-month period, the Secretary shall determine the 12-month period which shall be used for purposes of this section.

(6) In the case of any hospital which becomes subject to the taxes under section 3111 of the Internal Revenue Code of 1954[637], with respect to any or all of its employees, for part or all of a cost reporting period, and was not subject to such taxes with respect to any or all of its employees for all or part of the 12–month base cost reporting period referred to in subsection

[637] See P.L. 83–591, §3111 (this volume).

(b)(3)(A)(i), the Secretary shall provide for an adjustment by increasing the base period amount described in such subsection for such hospital by an amount equal to the amount of such taxes which would have been paid or accrued by such hospital for such base period if such hospital had been subject to such taxes for all of such base period with respect to all its employees, minus the amount of any such taxes actually paid or accrued for such base period.

(7)(A) Notwithstanding paragraph (1), in the case of a hospital or unit that is within a class of hospital described in subparagraph (B) which first receives payments under this section on or after October 1, 1997—

(i) for each of the first 2 cost reporting periods for which the hospital has a settled cost report, the amount of the payment with respect to operating costs described in paragraph (1) under part A on a per discharge or per admission basis (as the case may be) is equal to the lesser of—

(I) the amount of operating costs for such respective period, or

(II) 110 percent of the national median (as estimated by the Secretary) of the target amount for hospitals in the same class as the hospital for cost reporting periods ending during fiscal year 1996, updated by the hospital market basket increase percentage to the fiscal year in which the hospital first received payments under this section, as adjusted under subparagraph (C); and

(ii) for purposes of computing the target amount for the subsequent cost reporting period, the target amount for the preceding cost reporting period is equal to the amount determined under clause (i) for such preceding period.

(B) For purposes of this paragraph, each of the following shall be treated as a separate class of hospital:

(i) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

(ii) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

(iii) Hospitals described in clause (iv) of such subsection.

(C) In applying subparagraph (A)(i)(II) in the case of a hospital or unit, the Secretary shall provide for an appropriate adjustment to the labor–related portion of the amount determined under such subparagraph to take into account differences between average wage–related costs in the area of the hospital and the national average of such costs within the same class of hospital.

(c)(1) The Secretary may provide, in his discretion, that payment with respect to services provided by a hospital in a State may be made in accordance with a hospital reimbursement control system in a State, rather than in accordance with the other provisions of this title, if the chief executive officer of the State requests such treatment and if—

(A) the Secretary determines that the system, if approved under this subsection, will apply (i) to substantially all non-Federal acute care hospitals (as defined by the Secretary) in the State and (ii) to the review of at least 75 percent of all revenues or expenses in the State for inpatient hospital services and of revenues or expenses for inpatient hospital services provided under the State's plan approved under title XIX;

(B) the Secretary has been provided satisfactory assurances as to the equitable treatment under the system of all entities (including Federal and State programs) that pay hospitals for inpatient hospital services, of hospital employees, and of hospital patients;

(C) the Secretary has been provided satisfactory assurances that under the system, over 36-month periods (the first such period beginning with the first month in which this subsection applies to that system in the State), the amount of payments made under this title under such system will not exceed the amount of payments which would otherwise have been made under this title not using such system;

(D) the Secretary determines that the system will not preclude an eligible organization (as defined in section 1876(b)) from negotiating directly with hospitals with respect to the organization's rate of payment for inpatient hospital services; and

(E) the Secretary determines that the system requires hospitals to meet the requirement of section 1866(a)(1)(G) and the system provides for the exclusion of certain costs in accordance with section 1862(a)(14) (except for such waivers thereof as the Secretary provides by regulation).

The Secretary cannot deny the application of a State under this subsection on the ground that the State's hospital reimbursement control system is based on a payment methodology other than on the basis of a diagnosis-related group or on the ground that the amount of payments made under this title under such system must be less than the amount of payments which would otherwise have been made under this title not using such system. If the Secretary determines that the conditions described in subparagraph (C) are based on maintaining payment amounts at no more than a specified percentage increase above the payment amounts in a base period, the State has the option of applying such test (for inpatient hospital services under part A) on an aggregate payment basis or on the basis of the amount of payment per inpatient discharge or admission. If the Secretary determines that the conditions described in subparagraph (C) are based on maintaining aggregate payment amounts below a national average percentage increase in total payments under part A for inpatient hospital services, the Secretary cannot deny the application of a State under this subsection on the ground that the State's rate of increase in such payments for such services must be less than such national average rate of increase.

(2) In determining under paragraph (1)(C) the amount of payment which would otherwise have been made under this title for a State, the Secretary may provide for appropriate adjustment of such amount to take into account previous reduc-

tions effected in the amount of payments made under this title in the State due to the operation of the hospital reimbursement control system in the State if the system has resulted in an aggregate rate of increase in operating costs of inpatient hospital services (as defined in subsection (a)(4)) under this title for hospitals in the State which is less than the aggregate rate of increase in such costs under this title for hospitals in the United States.

(3) The Secretary shall discontinue payments under a system described in paragraph (1) if the Secretary—

(A) determines that the system no longer meets the requirements of subparagraphs (A), (D), and (E) of paragraph (1) and, if applicable, the requirements of paragraph (5), or

(B) has reason to believe that the assurances described in subparagraph (B) or (C) of paragraph (1) (or, if applicable, in paragraph (5)) are not being (or will not be) met.

(4) The Secretary shall approve the request of a State under paragraph (1) with respect to a hospital reimbursement control system if—

(A) the requirements of subparagraphs (A), (B), (C), (D), and (E) of paragraph (1) have been met with respect to the system, and

(B) with respect to that system a waiver of certain requirements of title XVIII of the Social Security Act has been approved on or before (and which is in effect as of) the date of the enactment of the Social Security Amendments of 1983[638], pursuant to section 402(a) of the Social Security Amendments of 1967[639] or section 222(a) of the Social Security Amendments of 1972[640].

With respect to a State system described in this paragraph, the Secretary shall judge the effectiveness of such system on the basis of its rate of increase or inflation in inpatient hospital payments for individuals under this title, as compared to the national rate of increase or inflation for such payments, with the State retaining the option to have the test applied on the basis of the aggregate payments under the State system as compared to aggregate payments which would have been made under the national system since October 1, 1984, to the most recent date for which annual data are available.

(5) The Secretary shall approve the request of a State under paragraph (1) with respect to a hospital reimbursement control system if—

(A) the requirements of subparagraphs (A), (B), (C), (D), and (E) of paragraph (1) have been met with respect to the system;

(B) the Secretary determines that the system—

(i) is operated directly by the State or by an entity designated pursuant to State law,

(ii) provides for payment of hospitals covered under the system under a methodology (which sets forth exceptions and adjustments, as well as any method for changes in the methodology) by which rates or

[638] April 20, 1983 [P.L. 98–21; 97 Stat. 65].
[639] See Vol. II, P.L. 90–248.
[640] See Vol. II, P.L. 92–603.

amounts to be paid for hospital services during a specified period are established under the system prior to the defined rate period, and

(iii) hospitals covered under the system will make such reports (in lieu of cost and other reports, identified by the Secretary, otherwise required under this title) as the Secretary may require in order to properly monitor assurances provided under this subsection;

(C) the State has provided the Secretary with satisfactory assurances that operation of the system will not result in any change in hospital admission practices which result in—

(i) a significant reduction in the proportion of patients (receiving hospital services covered under the system) who have no third-party coverage and who are unable to pay for hospital services,

(ii) a significant reduction in the proportion of individuals admitted to hospitals for inpatient hospital services for which payment is (or is likely to be) less than the anticipated charges for or costs of such services,

(iii) the refusal to admit patients who would be expected to require unusually costly or prolonged treatment for reasons other than those related to the appropriateness of the care available at the hospital, or

(iv) the refusal to provide emergency services to any person who is in need of emergency services if the hospital provides such services;

(D) any change by the State in the system which has the effect of materially reducing payments to hospitals can only take effect upon 60 days notice to the Secretary and to the hospitals the payment to which is likely to be materially affected by the change; and

(E) the State has provided the Secretary with satisfactory assurances that in the development of the system the State has consulted with local governmental officials concerning the impact of the system on public hospitals.

The Secretary shall respond to requests of States under this paragraph within 60 days of the date the request is submitted to the Secretary.

(6) If the Secretary determines that the assurances described in paragraph (1)(C) have not been met with respect to any 36-month period, the Secretary may reduce payments under this title to hospitals under the system in an amount equal to the amount by which the payment under this title under such system for such period exceeded the amount of payments which would otherwise have been made under this title not using such system.

(7) In the case of a State which made a request under paragraph (5) before December 31, 1984, for the approval of a State hospital reimbursement control system and which request was approved—

(A) in applying paragraphs (1)(C) and (6), a reference to a "36–month period" is deemed a reference to a "48–month period", and

(B) in order to allow the State the opportunity to provide the assurances described in paragraph (1)(C) for a 48-month period, the Secretary may not discontinue payments under the system, under the authority of paragraph (3)(A) because the Secretary has reason to believe that such assurances are not being (or will not be) met, before July 1, 1986.

(d) (1)(A) Notwithstanding section 1814(b) but subject to the provisions of section 1813, the amount of the payment with respect to the operating costs of inpatient hospital services (as defined in subsection (a)(4)) of a subsection (d) hospital (as defined in subparagraph (B)) for inpatient hospital discharges in a cost reporting period or in a fiscal year—

(i) beginning on or after October 1, 1983, and before October 1, 1984, is equal to the sum of—

(I) the target percentage (as defined in subparagraph (C)) of the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(A), but determined without the application of subsection (a)), and

(II) the DRG percentage (as defined in subparagraph (C)) of the regional adjusted DRG prospective payment rate determined under paragraph (2) for such discharges;

(ii) beginning on or after October 1, 1984, and before October 1, 1987, is equal to the sum of—

(I) the target percentage (as defined in subparagraph (C)) of the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(A), but determined without the application of subsection (a)), and

(II) the DRG percentage (as defined in subparagraph (C)) of the applicable combined adjusted DRG prospective payment rate determined under subparagraph (D) for such discharges; or

(iii) beginning on or after April 1, 1988, is equal to

(I) the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges, or

(II) for discharges occurring during a fiscal year ending on or before September 30, 1996, the sum of 85 percent of the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges and 15 percent of the regional adjusted DRG prospective payment rate determined under such paragraph, but only if the average standardized amount (described in clause (i)(I) or clause (ii)(I) of paragraph(3)(D)) for hospitals within the region of, and in the same large urban or other area (or, for discharges occurring during a fiscal year ending on or before September 30, 1994, the same rural, large urban, or other urban area) as, the hospital is greater than the average standardized amount (described in the respective clause) for hospitals within the

United States in that type of area for discharges occurring during such fiscal year.

(B) As used in this section, the term "subsection (d) hospital" means a hospital located in one of the fifty States or the District of Columbia other than—

(i) a psychiatric hospital (as defined in section 1861(f)),

(ii) a rehabilitation hospital (as defined by the Secretary),

(iii) a hospital whose inpatients are predominantly individuals under 18 years of age,

(iv)(I) a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days, or

(II) a hospital that first received payment under this subsection in 1986 which has an average inpatient length of stay (as determined by the Secretary) of greater than 20 days and that has 80 percent or more of its annual medicare inpatient discharges with a principal diagnosis that reflects a finding of neoplastic disease in the 12–month cost reporting period ending in fiscal year 1997, or

(v)(I) a hospital that the Secretary has classified, at any time on or before December 31, 1990, (or, in the case of a hospital that, as of the date of the enactment of this clause[641], is located in a State operating a demonstration project under section 1814(b), on or before December 31, 1991) for purposes of applying exceptions and adjustments to payment amounts under this subsection, as a hospital involved extensively in treatment for or research on cancer,

(II) a hospital that was recognized as a comprehensive cancer center or clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983, that is located in a State which, as of December 19, 1989, was not operating a demonstration project under section 1814(b), that applied and was denied, on or before December 31, 1990, for classification as a hospital involved extensively in treatment for or research on cancer under this clause (as in effect on the day before the date of the enactment of this subclause), that as of the date of the enactment of this subclause, is licensed for less than 50 acute care beds, and that demonstrates for the 4–year period ending on December 31, 1996, that at least 50 percent of its total discharges have a principal finding of neoplastic disease, as defined in subparagraph (E), or

(III) a hospital that was recognized as a clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of February 18, 1998, that has never been

[641] December 19, 1989.

reimbursed for inpatient hospital services pursuant to a reimbursement system under a demonstration project under section 1814(b), that is a freestanding facility organized primarily for treatment of and research on cancer and is not a unit of another hospital, that as of the date of the enactment of this subclause, is licensed for 162 acute care beds, and that demonstrates for the 4–year period ending on June 30, 1999, that at least 50 percent of its total discharges have a principal finding of neoplastic disease, as defined in subparagraph (E);

and, in accordance with regulations of the Secretary, does not include a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital (as defined by the Secretary). A hospital that was classified by the Secretary on or before September 30, 1995, as a hospital described in clause (iv) shall continue to be so classified notwithstanding that it is located in the same building as, or on the same campus as, another hospital.

(C) For purposes of this subsection, for cost reporting periods beginning—

(i) on or after October 1, 1983, and before October 1, 1984, the "target percentage" is 75 percent and the "DRG percentage" is 25 percent;

(ii) on or after October 1, 1984, and before October 1, 1985, the "target percentage" is 50 percent and the "DRG percentage" is 50 percent;

(iii) on or after October 1, 1985, and before October 1, 1986, the "target percentage" is 45 percent and the "DRG percentage" is 55 percent; and

(iv) on or after October 1, 1986, and before October 1, 1987, the "target percentage" is 25 percent and the "DRG percentage" is 75 percent.

(D) For purposes of subparagraph (A)(ii)(II), the "applicable combined adjusted DRG prospective payment rate" for discharges occurring—

(i) on or after October 1, 1984, and before October 1, 1986, is a combined rate consisting of 25 percent of the national adjusted DRG prospective payment rate, and 75 percent of the regional adjusted DRG prospective payment rate, determined under paragraph (3) for such discharges; and

(ii) on or after October 1, 1986, and before October 1, 1987, is a combined rate consisting of 50 percent of the national adjusted DRG prospective payment rate, and 50 percent of the regional adjusted DRG prospective payment rate, determined under paragraph (3) for such discharges.

(E) For purposes of subclauses (II) and (III) of subparagraph (B)(v) only, the term "principal finding of neoplastic disease" means the condition established after study to be chiefly responsible for occasioning the admission of a patient to a hospital, except that only discharges with ICD–9–CM principal diagnosis codes of 140 through 239, V58.0, V58.1, V66.1, V66.2, or 990 will be considered to reflect such a principal diagnosis.

(2) The Secretary shall determine a national adjusted DRG prospective payment rate, for each inpatient hospital discharge in fiscal year 1984 involving inpatient hospital services of a subsection (d) hospital in the United States, and shall determine a regional adjusted DRG prospective payment rate for such discharges in each region, for which payment may be made under part A of this title. Each such rate shall be determined for hospitals located in urban or rural areas within the United States or within each such region, respectively, as follows:

(A) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COSTS FOR BASE PERIOD.—The Secretary shall determine the allowable operating costs per discharge of inpatient hospital services for the hospital for the most recent cost reporting period for which data are available.

(B) UPDATING FOR FISCAL YEAR 1984.—The Secretary shall update each amount determined under subparagraph (A) for fiscal year 1984 by—

(i) updating for fiscal year 1983 by the estimated average rate of change of hospital costs industry-wide between the cost reporting period used under such subparagraph and fiscal year 1983 and the most recent case-mix data available, and

(ii) projecting for fiscal year 1984 by the applicable percentage increase (as defined in subsection (b)(3)(B)) for fiscal year 1984.

(C) STANDARDIZING AMOUNTS.—The Secretary shall standardize the amount updated under subparagraph (B) for each hospital by—

(i) excluding an estimate of indirect medical education costs (taking into account, for discharges occurring after September 30, 1986, the amendments made by section 9104(a) of the Medicare and Medicaid Budget Reconciliation Amendments of 1985[642]), except that the Secretary shall not take into account any reduction in the amount of additional payments under paragraph (5)(B)(ii) resulting from the amendment made by section 4621(a)(1) of the Balanced Budget Act of 1997 or any additional payments under such paragraph resulting from the application of section 111 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999[643], of section 302 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, or the Medicare Prescription Drug, Improvement, and Modernization Act of 2003[644],

(ii) adjusting for variations among hospitals by area in the average hospital wage level,

(iii) adjusting for variations in case mix among hospitals, or

(iv) for discharges occurring on or after October 1, 1986, excluding an estimate of the additional pay-

[642] P.L. 99–272.

[643] P.L. 108-173, §502(b)(1), struck out "1999 or" and substituted "1999".

[644] P.L. 108-173, §502(b)(2), inserted ", or the Medicare Prescription Drug, Improvement, and Modernization Act of 2003,", applicable to discharges occurring on or after April 1, 2004.

ments to certain hospitals to be made under paragraph (5)(F), except that the Secretary shall not exclude additional payments under such paragraph made as a result of the enactment of section 6003(c) of the Omnibus Budget Reconciliation Act of 1989, the enactment of section 4002(b) of the Omnibus Budget Reconciliation Act of 1990,[645] the enactment of section 303 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, or the enactment of section 402(a)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003[646].

(D) COMPUTING URBAN AND RURAL AVERAGES.—The Secretary shall compute an average of the standardized amounts determined under subparagraph (C) for the United States and for each region—

(i) for all subsection (d) hospitals located in an urban area within the United States or that region, respectively, and

(ii) for all subsection (d) hospitals located in a rural area within the United States or that region, respectively.

For purposes of this subsection, the term "region" means one of the nine census divisions, comprising the fifty States and the District of Columbia, established by the Bureau of the Census for statistical and reporting purposes; the term "urban area" means an area within a Metropolitan Statistical Area (as defined by the Office of Management and Budget) or within such similar area as the Secretary has recognized under subsection (a) by regulation; the term "large urban area" means, with respect to a fiscal year, such an urban area which the Secretary determines (in the publications described in subsection (e)(5) before the fiscal year) has a population of more than 1,000,000 (as determined by the Secretary based on the most recent available population data published by the Bureau of the Census); and the term "rural area" means any area outside such an area or similar area. A hospital located in a Metropolitan Statistical Area shall be deemed to be located in the region in which the largest number of the hospitals in the same Metropolitan Statistical Area are located, or, at the option of the Secretary, the region in which the majority of the inpatient discharges (with respect to which payments are made under this title) from hospitals in the same Metropolitan Statistical Area are made.

(E) REDUCING FOR VALUE OF OUTLIER PAYMENTS.—The Secretary shall reduce each of the average standardized amounts determined under subparagraph (D) by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this subsection based on DRG prospective payment rates which are additional payments described in paragraph (5)(A) (relating to outlier payments).

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[645] P.L. 108-173, §402(b)(2)(A), struck out "or".

[646] P.L. 108-173, §402(b)(2)(B), added ", or the enactment of section 402(a)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003", effective December 8, 2003.

(F) MAINTAINING BUDGET NEUTRALITY.—The Secretary shall adjust each of such average standardized amounts as may be required under subsection (e)(1)(B) for that fiscal year.

(G) COMPUTING DRG–SPECIFIC RATES FOR URBAN AND RURAL HOSPITALS IN THE UNITED STATES AND IN EACH REGION.—For each discharge classified within a diagnosis–related group, the Secretary shall establish a national DRG prospective payment rate and shall establish a regional DRG prospective payment rate for each region, each of which is equal—

(i) for hospitals located in an urban area in the United States or that region (respectively), to the product of—

(I) the average standardized amount (computed under subparagraph (D), reduced under subparagraph (E), and adjusted under subparagraph (F)) for hospitals located in an urban area in the United States or that region, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis–related group; and

(ii) for hospitals located in a rural area in the United States or that region (respectively), to the product of—

(I) the average standardized amount (computed under subparagraph (D), reduced under subparagraph (E), and adjusted under subparagraph (F)) for hospitals located in a rural area in the United States or that region, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis–related group.

(H) ADJUSTING FOR DIFFERENT AREA WAGE LEVELS.—The Secretary shall adjust the proportion, (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage–related costs, of the national and regional DRG prospective payment rates computed under subparagraph (G) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.

(3) The Secretary shall determine a national adjusted DRG prospective payment rate, for each inpatient hospital discharge in a fiscal year after fiscal year 1984 involving inpatient hospital services of a subsection (d) hospital in the United States, and shall determine a regional adjusted DRG prospective payment rate for such discharges in each region for which payment may be made under part A of this title. Each such rate shall be determined for hospitals located in large urban, other urban, or rural areas within the United States and within each such region, respectively, as follows:

(A) UPDATING PREVIOUS STANDARDIZED AMOUNTS.—

(i) For discharges occurring in a fiscal year beginning before October 1, 1987, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a

rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, equal to the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph, increased for the fiscal year involved by the applicable percentage increase under subsection (b)(3)(B). With respect to discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital weighting, making appropriate adjustments to ensure that computation on such basis does not result in total payments under this section that are greater or less than the total payments that would have been made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (C)(ii).

(ii) For discharges occurring in a fiscal year beginning on or after October 1, 1987, and ending on or before September 30, 1994, the Secretary shall compute an average standardized amount for hospitals located in a large urban area, for hospitals located in a rural area, and for hospitals located in other urban areas, within the United States and within each region, equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.

(iii) For discharges occurring in the fiscal year beginning on October 1, 1994, the average standardized amount for hospitals located in a rural area shall be equal to the average standardized amount for hospitals located in an other[647] urban area. For discharges occurring on or after October 1, 1994, the Secretary shall adjust the ratio of the labor portion to non-labor portion of each average standardized amount to equal such ration for the national average of all standardized amounts.

(iv)(I) Subject to subclause (II), for discharges[648] occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals

[647] As in original.

[648] P.L. 108-173, §401(a)(1), struck out "(iv) For discharges" and substituted "(iv)(I) Subject to subclause (II), for discharges", effective December 8, 2003.

located in the respective areas for the fiscal year involved.

(II)[649] For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.

(v) Average standardized amounts computed under this paragraph shall be adjusted to reflect the most recent case-mix data available.

(vi) Insofar as the Secretary determines that the adjustments under paragraph (4)(C)(i) for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under this subsection during the fiscal year that are a result of changes in the coding or classification of discharges that do not reflect real changes in case mix, the Secretary may adjust the average standardized amounts computed under this paragraph for subsequent fiscal years so as to eliminate the effect of such coding or classification changes.

(B) REDUCING FOR VALUE OF OUTLIER PAYMENTS.—The Secretary shall reduce each of the average standardized amounts determined under subparagraph (A) by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary) based on DRG prospective payment amounts which are additional payments described in paragraph (5)(A) (relating to outlier payments).

(C)(i) MAINTAINING BUDGET NEUTRALITY FOR FISCAL YEAR 1985.—For discharges occurring in fiscal year 1985, the Secretary shall adjust each of such average standardized amounts as may be required under subsection (e)(1)(B) for that fiscal year.

(ii) REDUCING FOR SAVINGS FROM AMENDMENT TO INDIRECT TEACHING ADJUSTMENT FOR DISCHARGES AFTER SEPTEMBER 30, 1986.—For discharges occurring after September 30, 1986, the Secretary shall further reduce each of the average standardized amounts (in a proportion which takes into account the differing effects of the standardization effected under paragraph (2)(C)(i)) so as to provide for a reduction in the total of the payments (attributable to this paragraph) made for discharges occurring on or after October 1, 1986, of an amount equal to the estimated reduction in the payment amounts under paragraph (5)(B) that would have resulted from the enactment of the amendments

[649] P.L. 108-173, §401(a)(2), added subclause (II), effective December 8, 2003.

made by section 9104 of the Medicare and Medicaid Budget Reconciliation Amendments of 1985[650] and by section 4003(a)(1) of the Omnibus Budget Reconciliation Act of 1987[651] if the factor described in clause (ii)(II) of paragraph (5)(B) (determined without regard to amendments made by the Omnibus Budget Reconciliation Act of 1990[652]) were applied for discharges occurring on or after such date instead of the factor described in clause (ii) of that paragraph.

(D) COMPUTING DRG–SPECIFIC RATES FOR HOSPITALS[653].—For each discharge classified within a diagnosis–related group, the Secretary shall establish for the fiscal year a national DRG prospective payment rate and shall establish a regional DRG prospective payment rate for each region[654] which is equal—

(i) for fiscal years before fiscal year 2004,[655] for hospitals located in a large urban area in the United States or that region (respectively), to the product of—

(I) the average standardized amount (computed under subparagraph (A), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C)) for the fiscal year for hospitals located in such a large urban area in the United States or that region, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis–related group;[656]

(ii) for fiscal years before fiscal year 2004,[657] for hospitals located in other areas in the United States or that region (respectively), to the product of—

(I) the average standardized amount (computed under subparagraph (A), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C)) for the fiscal year for hospitals located in other areas in the United States or that region, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group; and[658]

(iii)[659] for a fiscal year beginning after fiscal year 2003, for hospitals located in all areas, to the product of-

(I) the applicable standardized amount (computed under subparagraph (A)), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C) for the fiscal year; and

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[650] P.L. 99–272.
[651] P.L. 100–203.
[652] P.L. 101–508.
[653] P.L. 108-173, §401(b)(1)(A), struck out "IN DIFFERENT AREAS", effective December 8, 2003.
[654] P.L. 108-173, §401(b)(1)(B), struck out ", each of", effective December 8, 2003.
[655] P.L. 108-173, §401(b)(1)(C)(i), added "for fiscal years before fiscal year 2004," effective December 8, 2003.
[656] P.L. 108-173, §401(b)(1)(C)(ii), struck out "and".
[657] P.L. 108-173, §401(b)(1)(D)(i), added "for fiscal years before fiscal year 2004," effective December 8, 2003.
[658] P.L. 108-173, §401(b)(1)(D)(ii), struck out period, added "; and", effective December 8, 2003.
[659] P.L. 108-173, §401(b)(1)(E), added subclause (iii), effective December 8, 2003.

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

(E)[660] ADJUSTING FOR DIFFERENT AREA WAGE LEVELS.—

(i) IN GENERAL.—Except as provided in clause (ii), the Secretary[661] shall adjust the proportion, (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the DRG prospective payment rates computed under subparagraph (D) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level. Not later than October 1, 1990, and October 1, 1993 (and at least every 12 months thereafter), the Secretary shall update the factor under the preceding sentence on the basis of a survey conducted by the Secretary (and updated as appropriate) of the wages and wage–related costs of subsection (d) hospitals in the United States. Not less often than once every 3 years the Secretary (through such survey or otherwise) shall measure the earnings and paid hours of employment by occupational category and shall exclude data with respect to the wages and wage–related costs incurred in furnishing skilled nursing facility services. Any adjustments or updates made under this subparagraph for a fiscal year (beginning with fiscal year 1991) shall be made in a manner that assures that the aggregate payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment. The Secretary shall apply the previous sentence for any period as if the amendments made by section 403(a)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 had not been enacted.[662]

(ii)[663] ALTERNATIVE PROPORTION TO BE ADJUSTED BEGINNING IN FISCAL YEAR 2005.—For discharges occurring on or after October 1, 2004, the Secretary shall substitute "62 percent" for the proportion described in the first sentence of clause (i), unless the application of this clause would result in lower payments to a hospital than would otherwise be made.

(4)(A) The Secretary shall establish a classification of inpatient hospital discharges by diagnosis-related groups and a methodology for classifying specific hospital discharges within these groups.

(B) For each such diagnosis–related group the Secretary shall assign an appropriate weighting factor which reflects the relative hospital resources used with respect to dis-

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[660] See Vol. II, P.L. 105–33, §4410, with respect to the floor on area wage index.

[661] P.L. 108-173, §403(a)(1)(A), struck out "WAGE LEVELS.—The Secretary" and substituted "WAGE LEVELS.—

"(i) IN GENERAL.— Except as provided in clause (ii), the Secretary", effective December 8, 2003.

[662] P.L. 108-173, §403(a)(2), added this last sentence to clause (ii), effective December 8, 2003.

[663] P.L. 108-173, §403(a)(1)(B), added clause (ii), effective December 8, 2003.

charges classified within that group compared to discharges classified within other groups.

(C)(i) The Secretary shall adjust the classifications and weighting factors established under subparagraphs (A) and (B), for discharges in fiscal year 1988 and at least annually thereafter, to reflect changes in treatment patterns, technology (including a new medical service or technology under paragraph (5)(K)), and other factors which may change the relative use of hospital resources.

(ii) For discharges in fiscal year 1990, the Secretary shall reduce the weighting factor for each diagnosis–related group by 1.22 percent.

(iii) Any such adjustment under clause (i) for discharges in a fiscal year (beginning with fiscal year 1991) shall be made in a manner that assures that the aggregate payments under this subsection for discharges in the fiscal year are not greater or less than those that would have been made for discharges in the year without such adjustment.

(iv) The Secretary shall include recommendations with respect to adjustments to weighting factors under clause (i) in the annual report to Congress required under subsection (e)(3)(B).

(5)(A)(i) For discharges occurring during fiscal years ending on or before September 30, 1997, the Secretary shall provide for an additional payment for a subsection (d) hospital for any discharge in a diagnosis–related group, the length of stay of which exceeds the mean length of stay for discharges within that group by a fixed number of days, or exceeds such mean length of stay by some fixed number of standard deviations, whichever is the fewer number of days.

(ii) For cases which are not included in clause (i), a subsection (d) hospital may request additional payments in any case where charges, adjusted to cost, exceed a fixed multiple of the applicable DRG prospective payment rate, or exceed such other fixed dollar amount, whichever is greater, or for discharges in fiscal years beginning on or after October 1, 1994, exceed the sum of the applicable DRG prospective payment rate plus any amounts payable under subparagraphs (B) and (F) plus a fixed dollar amount determined by the Secretary.

(iii) The amount of such additional payment under clauses (i) and (ii) shall be determined by the Secretary and shall (except as payments under clause (i) are required to be reduced to take into account the requirements of clause (v)) approximate the marginal cost of care beyond the cutoff point applicable under clause (i) or (ii).

(iv) The total amount of the additional payments made under this subparagraph for discharges in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year.

(v) The Secretary shall provide that—

(I) the day outlier percentage for fiscal year 1995 shall be 75 percent of the day outlier percentage for fiscal year 1994;

(II) the day outlier percentage for fiscal year 1996 shall be 50 percent of the day outlier percentage for fiscal year 1994; and

(III) the day outlier percentage for fiscal year 1997 shall be 25 percent of the day outlier percentage for fiscal year 1994.

(vi) For purposes of this subparagraph the term "day outlier percentage" means, for a fiscal year, the percentage of the total additional payments made by the Secretary under this subparagraph for discharges in that fiscal year which are additional payments under clause (i).

(B) The Secretary shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education, in an amount computed in the same manner as the adjustment for such costs under regulations (in effect as of January 1, 1983) under subsection (a)(2), except as follows:

(i) The amount of such additional payment shall be determined by multiplying (I) the sum of the amount determined under paragraph (1)(A)(ii)(II) (or, if applicable, the amount determined under paragraph (1)(A)(iii)), for cases qualifying for additional payment under subparagraph (A)(i), and the amount paid to the hospital under subparagraph (A), by (II) the indirect teaching adjustment factor described in clause (ii).

(ii) For purposes of clause (i)(II), the indirect teaching adjustment factor is equal to c –0A (((1+r) to the nth power) – 1), where "r" is the ratio of the hospital's full–time equivalent interns and residents to beds and "n" equals .405. Subject to clause (ix), for discharges[664] occurring—

(I) on or after October 1, 1988, and before October 1, 1997, "c" is equal to 1.89;

(II) during fiscal year 1998, "c" is equal to 1.72;

(III) during fiscal year 1999, "c" is equal to 1.6;

(IV) during fiscal year 2000, "c" is equal to 1.47;

(V) during fiscal year 2001, "c" is equal to 1.54; and

(VI) during fiscal year 2002, "c" is equal to 1.6;[665]

(VII) on or after October 1, 2002, and before April 1, 2004,[666] "c" is equal to 1.35;[667]

(VIII)[668] on or after April 1, 2004, and before October 1, 2004, "c" is equal to 1.47;

(IX) during fiscal year 2005, "c" is equal to 1.42;

(X) during fiscal year 2006, "c" is equal to 1.37;

[664] P.L. 108-173, §422(b)(A), struck out "For discharges" and substituted "Subject to clause (ix), for discharges, effective December 8, 2003.

[665] P.L. 108-173, §502(a)(1), struck out "and", effective December 8, 2003.

[666] P.L. 108-173, §502(a)(2)(A), inserted "and before April 1, 2004," effective December 8, 2003.

[667] P.L. 108-173, §502(a)(2)(B), struck out "period" and substituted a semicolon, effective December 8, 2003.

[668] P.L. 108-173, §502(a)(3), added subclauses (VIII) through (XII), effective December 8, 2003.

(XI) during fiscal year 2007, "c" is equal to 1.32; and

(XII) on or after October 1, 2007, "c" is equal to 1.35.

(iii) In determining such adjustment the Secretary shall not distinguish between those interns and residents who are employees of a hospital and those interns and residents who furnish services to a hospital but are not employees of such hospital.

(iv) Effective for discharges occurring on or after October 1, 1997, all the time spent by an intern or resident in patient care activities under an approved medical residency training program at an entity in a nonhospital setting shall be counted towards the determination of full–time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

(v) In determining the adjustment with respect to a hospital for discharges occurring on or after October 1, 1997, the total number of full–time equivalent interns and residents in the fields of allopathic and osteopathic medicine in either a hospital or nonhospital setting may not exceed the number (or, 130 percent of such number in the case of a hospital located in a rural area) of such full–time equivalent interns and residents in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996. The provisions of subsection (h)(7) shall apply with respect to the first sentence of this clause in the same manner as it applies with respect to subsection (h)(4)(F)(i).[669]

(vi) For purposes of clause (ii)—

(I) "r" may not exceed the ratio of the number of interns and residents, subject to the limit under clause (v), with respect to the hospital for its most recent cost reporting period to the hospital's available beds (as defined by the Secretary) during that cost reporting period, and

(II) for the hospital's cost reporting periods beginning on or after October 1, 1997, subject to the limits described in clauses (iv) and (v), the total number of full–time equivalent residents for payment purposes shall equal the average of the actual full–time equivalent resident count for the cost reporting period and the preceding two cost reporting periods.

In the case of the first cost reporting period beginning on or after October 1, 1997, subclause (II) shall be applied by using the average for such period and the preceding cost reporting period.

(vii) If any cost reporting period beginning on or after October 1, 1997, is not equal to twelve months, the Secretary shall make appropriate modifications to ensure that the average full–time equivalent residency

[669] P.L. 108-173, §422(b)(B), added "The provisions of subsection (h)(7) shall apply with respect to the first sentence of this clause in the same manner as it applies with respect to subsection (h)(4)(F)(i).", effective December 8, 2003.

count pursuant to subclause (II) of clause (vi) is based on the equivalent of full twelve–month cost reporting periods.

(viii) Rules similar to the rules of subsection (h)(4)(H) shall apply for purposes of clauses (v) and (vi).

(ix)[670] For discharges occurring on or after July 1, 2005, insofar as an additional payment amount under this subparagraph is attributable to resident positions redistributed to a hospital under subsection (h)(7)(B), in computing the indirect teaching adjustment factor under clause (ii) the adjustment shall be computed in a manner as if "c" were equal to 0.66 with respect to such resident positions.

(C)(i) The Secretary shall provide for such exceptions and adjustments to the payment amounts established under this subsection (other than under paragraph (9)) as the Secretary deems appropriate to take into account the special needs of regional and national referral centers (including those hospitals of 275 or more beds located in rural areas). A hospital which is classified as a rural hospital may appeal to the Secretary to be classified as a rural referral center under this clause on the basis of criteria (established by the Secretary) which shall allow the hospital to demonstrate that it should be so reclassified by reason of certain of its operating characteristics being similar to those of a typical urban hospital located in the same census region and which shall not require a rural osteopathic hospital to have more than 3,000 discharges in a year in order to be classified as a rural referral center. Such characteristics may include wages, scope of services, service area, and the mix of medical specialties. The Secretary shall publish the criteria not later than August 17, 1984, for implementation by October 1, 1984. An appeal allowed under this clause must be submitted to the Secretary (in such form and manner as the Secretary may prescribe) during the quarter before the first quarter of the hospital's cost reporting period (or, in the case of a cost reporting period beginning during October 1984, during the first quarter of that period), and the Secretary must make a final determination with respect to such appeal within 60 days after the date the appeal was submitted. Any payment adjustments necessitated by a reclassification based upon the appeal shall be effective at the beginning of such cost reporting period.

(ii) The Secretary shall provide, under clause (i), for the classification of a rural hospital as a regional referral center if the hospital has a case mix index equal to or greater than the median case mix index for hospitals (other than hospitals with approved teaching programs) located in an urban area in the same region (as defined in paragraph (2)(D)), has at least 5,000 discharges a year or, if less, the median number of discharges in urban hospitals in the region in which the

[670] P.L. 108-173, §422(b)(C), added clause (ix), effective December 8, 2003.

hospital is located (or, in the case of a rural osteopathic hospital, meets the criterion established by the Secretary under clause (i) with respect to the annual number of discharges for such hospitals), and meets any other criteria established by the Secretary under clause (i).[671]

(D)(i) For any cost reporting period beginning on or after April 1, 1990, with respect to a subsection (d) hospital which is a sole community hospital, payment under paragraph (1)(A) shall be—

(I) an amount based on 100 percent of the hospital's target amount for the cost reporting period, as defined in subsection (b)(3)(C), or

(II) the amount determined under paragraph (1)(A)(iii),

whichever results in greater payment to the hospital.

(ii) In the case of a sole community hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

(iii) For purposes of this title, the term "sole community hospital" means any hospital—

(I) that the Secretary determines is located more than 35 road miles from another hospital,

(II) that, by reason of factors such as the time required for an individual to travel to the nearest alternative source of appropriate inpatient care (in accordance with standards promulgated by the Secretary), location, weather conditions, travel conditions, or absence of other like hospitals (as determined by the Secretary), is the sole source of inpatient hospital services reasonably available to individuals in a geographic area who are entitled to benefits under part A, or

(III) that is located in a rural area and designated by the Secretary as an essential access community hospital under section 1820(i)(1) as in effect on September 30, 1997.

(iv) The Secretary shall promulgate a standard for determining whether a hospital meets the criteria for classification as a sole community hospital under clause (iii)(II) because of the time required for an individual to travel to the nearest alternative source of appropriate inpatient care.

(v) If the Secretary determines that, in the case of a hospital located in a rural area and designated by

[671] For extension for regional referral centers, see Vol. II, P.L. 103–66, §13501(d).
See Vol. II, P.L. 105–33, §4202(b), with respect to continuing treatment of previously designated rural referral centers.

the Secretary as an essential access community hospital under section 1820(i)(1) as in effect on September 30, 1997, the hospital has incurred increases in reasonable costs during a cost reporting period as a result of becoming a member of a rural health network (as defined in section 1820(d)) in the State in which it is located, and in incurring such increases, the hospital will increase its costs for subsequent cost reporting periods, the Secretary shall increase the hospital's target amount under subsection (b)(3)(C) to account for such incurred increases.

(E)(i) The Secretary shall estimate the amount of reimbursement made for services described in section 1862(a)(14) with respect to which payment was made under part B in the base reporting periods referred to in paragraph (2)(A) and with respect to which payment is no longer being made.

(ii) The Secretary shall provide for an adjustment to the payment for subsection (d) hospitals in each fiscal year so as appropriately to reflect the net amount described in clause (i).

(F)(i) For discharges occurring on or after May 1, 1986, the Secretary shall provide, in accordance with this subparagraph, for an additional payment amount for each subsection (d) hospital which—

(I) serves a significantly disproportionate number of low-income patients (as defined in clause (v)), or

(II) is located in an urban area, has 100 or more beds, and can demonstrate that its net inpatient care revenues (excluding any of such revenues attributable to this title or State plans approved under title XIX), during the cost reporting period in which the discharges occur, for indigent care from State and local government sources exceed 30 percent of its total of such net inpatient care revenues during the period.

(ii) Subject to clause (ix), the amount of such payment for each discharge shall be determined by multiplying (I) the sum of the amount determined under paragraph (1)(A)(ii)(II) (or, if applicable, the amount determined under paragraph (1)(A)(iii)) and, for cases qualifying for additional payment under subparagraph (A)(i), the amount paid to the hospital under subparagraph (A) for that discharge, by (II) the disproportionate share adjustment percentage established under clause (iii) or (iv) for the cost reporting period in which the discharge occurs.

(iii) The disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (i)(II) is equal to 35 percent.

(iv) The disproportionate share adjustment percentage for a cost reporting period for a hospital that is not described in clause (i)(II) and that—

(I) is located in an urban area and has 100 or more beds or is described in the second sentence

of clause (v), is equal to the percent determined in accordance with the applicable formula described in clause (vii);

(II) is located in an urban area and has less than 100 beds, is equal to 5 percent or, subject to clause (xiv) and [672] for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xiii);

(III) is located in a rural area and is not described in subclause (IV) or (V) or in the second sentence of clause (v), is equal to 4 percent or, subject to clause (xiv) and [673] for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xii);

(IV) is located in a rural area, is classified as a rural referral center under subparagraph (C), and is classified as a sole community hospital under subparagraph (D), is equal to 10 percent or, if greater, the percent determined in accordance with the applicable formula described in clause (viii) or, subject to clause (xiv) and [674] for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (x) or (xi);

(V) is located in a rural area, is classified as a rural referral center under subparagraph (C), and is not classified as a sole community hospital under subparagraph (D), is equal to the percent determined in accordance with the applicable formula described in clause (viii) or, subject to clause (xiv) and [675] for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xi); or

(VI) is located in a rural area, is classified as a sole community hospital under subparagraph (D), and is not classified as a rural referral center under subparagraph (C), is 10 percent or, subject to clause (xiv) and [676] for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (x).

(v) In this subparagraph, a hospital "serves a significantly disproportionate number of low income patients" for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that period which equals, or exceeds—

(I) 15 percent, if the hospital is located in an urban area and has 100 or more beds,

(II) 30 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in a rural area and has more than 100

[672] P.L. 108-173, §402(b)(1)(A), added "subject to clause (xiv) and", effective December 8, 2003.
[673] P.L. 108-173, §402(b)(1)(A), added "subject to clause (xiv) and", effective December 8, 2003.
[674] P.L. 108-173, §402(b)(1)(A), added "subject to clause (xiv) and", effective December 8, 2003.
[675] P.L. 108-173, §402(b)(1)(A), added "subject to clause (xiv) and", effective December 8, 2003.
[676] P.L. 108-173, §402(b)(1)(A), added "subject to clause (xiv) and", effective December 8, 2003.

beds, or is located in a rural area and is classified as a sole community hospital under subparagraph (D),

(III) 40 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in an urban area and has less than 100 beds, or

(IV) 45 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in a rural area and is not described in subclause (II).

A hospital located in a rural area and with 500 or more beds also "serves a significantly disproportionate number of low income patients" for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that period which equals or exceeds a percentage specified by the Secretary.

(vi) In this subparagraph, the term "disproportionate patient percentage" means, with respect to a cost reporting period of a hospital, the sum of—

(I) the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this title and were entitled to supplementary security income benefits (excluding any State supplementation) under title XVI of this Act, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of this title, and

(II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under title XIX, but who were not entitled to benefits under part A of this title, and the denominator of which is the total number of the hospital's patient days for such period.

(vii) The formula used to determine the disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (iv)(I) is—

(I) in the case of such a hospital with a disproportionate patient percentage (as defined in clause (vi)) greater than 20.2—

(a) for discharges occurring on or after April 1, 1990, and on or before December 31, 1990, (P–20.2)(.65) + 5.62,

(b) for discharges occurring on or after January 1, 1991, and on or before September 30, 1993, (P–20.2)(.7) + 5.62,

(c) for discharges occurring on or after October 1, 1993, and on or before September 30, 1994, (P–20.2)(.8) + 5.88, and

(d) for discharges occurring on or after October 1, 1994, (P–20.2)(.825) + 5.88; or

(II) in the case of any other such hospital—

(a) for discharges occurring on or after April 1, 1990, and on or before December 31, 1990, (P–15)(.6) + 2.5,

(b) for discharges occurring on or after January 1, 1991, and on or before September 30, 1993, (P–15)(.6) + 2.5,

(c) for discharges occurring on or after October 1, 1993, (P–15)(.65) + 2.5,

where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(viii) Subject to clause (xiv), the formula[677] used to determine the disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (iv)(IV) or (iv)(V) is the percentage determined in accordance with the following formula: (P–30)(.6) + 4.0, where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).[678]

(ix) In the case of discharges occurring—

(I) during fiscal year 1998, the additional payment amount otherwise determined under clause (ii) shall be reduced by 1 percent;

(II) during fiscal year 1999, such additional payment amount shall be reduced by 2 percent;

(III) during fiscal years 2000 and 2001, such additional payment amount shall be reduced by 3 percent and 2 percent, respectively;

(IV) during fiscal year 2002, such additional payment amount shall be reduced by 3 percent; and

(V) during fiscal year 2003 and each subsequent fiscal year, such additional payment amount shall be reduced by 0 percent.

(x) Subject to clause (xiv), for purposes[679] of clause (iv)(VI) (relating to sole community hospitals), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) is less than 19.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: (P-15)(.65) + 2.5;

(II) is equal to or exceeds 19.3, but is less than 30.0, such adjustment percentage is equal to 5.25 percent; or

(III) is equal to or exceeds 30, such adjustment percentage is equal to 10 percent,

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[677] P.L. 108-173, §402(b)(1)(B), struck out "The formula" and substituted "Subject to clause (xiv), the formula", effective December 8, 2003.

[678] See Vol. II, P.L. 105–33, §4403(b) and §4403(c), with respect to the report on a new payment formula and data collection.

[679] P.L. 108-173, §402(b)(1)(C), struck out "For purposes" and substituted "Subject to clause (xiv), for purposes", effective December 8, 2003.

where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(xi) Subject to clause (xiv), for purposes[680] of clause (iv)(V) (relating to rural referral centers), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) is less than 19.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: (P-15)(.65) + 2.5;

(II) is equal to or exceeds 19.3, but is less than 30.0, such adjustment percentage is equal to 5.25 percent; or

(III) is equal to or exceeds 30, such adjustment percentage is determined in accordance with the following formula: (P–30)(.6) + 5.25,

where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(xii) Subject to clause (xiv), for purposes[681] of clause (iv)(III) (relating to small rural hospitals generally), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) is less than 19.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: (P–15)(.65) + 2.5; or

(II) is equal to or exceeds 19.3, such adjustment percentage is equal to 5.25 percent,

where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(xiii) Subject to clause (xiv), for purposes[682] of clause (iv)(II) (relating to urban hospitals with less than 100 beds), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) is less than 19.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: (P–15)(.65) + 2.5; or

(II) is equal to or exceeds 19.3, such adjustment percentage is equal to 5.25 percent,

where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(xiv)[683](I) In the case of discharges occurring on or after April 1, 2004, subject to subclause (II), there shall be substituted for the disproportionate share adjustment percentage otherwise determined under clause (iv) (other than subclause (I)) or under clause

[680] P.L. 108-173, §402(b)(1)(C), struck out "For purposes" and substituted "Subject to clause (xiv), for purposes", effective December 8, 2003.

[681] P.L. 108-173, §402(b)(1)(C), struck out "For purposes" and substituted "Subject to clause (xiv), for purposes", effective December 8, 2003.

[682] P.L. 108-173, §402(b)(1)(C), struck out "For purposes" and substituted "Subject to clause (xiv), for purposes", effective December 8, 2003.

[683] P.L. 108-173, §402(a), added clause (xiv), effective December 8, 2003.

(viii), (x), (xi), (xii), or (xiii), the disproportionate share adjustment percentage determined under clause (vii) (relating to large, urban hospitals).

(II) Under subclause (I), the disproportionate share adjustment percentage shall not exceed 12 percent for a hospital that is not classified as a rural referral center under subparagraph (C).

(G)(i) For any cost reporting period beginning on or after April 1, 1990, and before October 1, 1994, or discharges occurring on or after October 1, 1997, and before October 1, 2006, in the case of a subsection (d) hospital which is a medicare-dependent, small rural hospital, payment under paragraph (1)(A) shall be equal to the sum of the amount determined under clause (ii) and the amount determined under paragraph (1)(A)(iii).[684]

(ii) The amount determined under this clause is—

(I) for discharges occurring during the 36-month period beginning with the first day of the cost reporting period that begins on or after April 1, 1990, the amount by which the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(D)) exceeds the amount determined under paragraph (1)(A)(iii); and

(II) for discharges occurring during any subsequent cost reporting period (or portion thereof) and before October 1, 1994, or discharges occurring on or after October 1, 1997, and before October 1, 2006, 50 percent of the amount by which the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(D)) exceeds the amount determined under paragraph (1)(A)(iii).

(iii) In the case of a medicare dependent, small rural hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

(iv) The term "medicare-dependent, small rural hospital" means, with respect to any cost reporting period to which clause (i) applies, any hospital—

(I) located in a rural area,

(II) that has not more than 100 beds,

(III) that is not classified as a sole community hospital under subparagraph (D), and

(IV) for which not less than 60 percent of its inpatient days or discharges during the cost

[684] See Vol. II, P.L. 103–66, §13501(e)(2), with respect to permitting hospitals to decline reclassification.

reporting period beginning in fiscal year 1987, or two of the three most recently audited cost reporting periods for which the Secretary has a settled cost report, were attributable to inpatients entitled to benefits under part A.[685]

(H) The Secretary may provide for such adjustments to the payment amounts under this subsection as the Secretary deems appropriate to take into account the unique circumstances of hospitals located in Alaska and Hawaii.

(I)(i) The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate.

(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, not taking in account the effect of subparagraph (J), the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater or lesser than those that would have otherwise been made in such fiscal year.

(J)(i) The Secretary shall treat the term "transfer case" (as defined in subparagraph (I)(ii)) as including the case of a qualified discharge (as defined in clause (ii)), which is classified within a diagnosis–related group described in clause (iii), and which occurs on or after October 1, 1998. In the case of a qualified discharge for which a substantial portion of the costs of care are incurred in the early days of the inpatient stay (as defined by the Secretary), in no case may the payment amount otherwise provided under this subsection exceed an amount equal to the sum of—

(I) 50 percent of the amount of payment under this subsection for transfer cases (as established under subparagraph (I)(i)), and

(II) 50 percent of the amount of payment which would have been made under this subsection with respect to the qualified discharge if no transfer were involved.

(ii) For purposes of clause (i), subject to clause (iii), the term "qualified discharge" means a discharge classified with a diagnosis–related group (described in clause (iii)) of an individual from a subsection (d) hospital, if upon such discharge the individual—

(I) is admitted as an inpatient to a hospital or hospital unit that is not a subsection (d) hospital for the provision of inpatient hospital services;

(II) is admitted to a skilled nursing facility;

(III) is provided home health services from a home health

agency, if such services relate to the condition or diagnosis for which such individual received inpatient hospital services from the subsection (d) hospital, and if such services are provided

[685] See Vol. II, P.L. 103–66, §13501(e)(2) and (3), with respect to permitting hospitals to decline reclassification and requiring lump-sum retroactive payment.

within an appropriate period (as determined by the Secretary); or

(IV) for discharges occurring on or after October 1, 2000, the individual receives post discharge services described in clause (iv)(I).

(iii) Subject to clause (iv), a diagnosis–related group described in this clause is—

(I) 1 of 10 diagnosis–related groups selected by the Secretary based upon a high volume of discharges classified within such groups and a disproportionate use of post discharge services described in clause (ii); and

(II) a diagnosis–related group specified by the Secretary under clause (iv)(II).

(iv) The Secretary shall include in the proposed rule published under subsection (e)(5)(A) for fiscal year 2001, a description of the effect of this subparagraph. The Secretary may include in the proposed rule (and in the final rule published under paragraph (6)) for fiscal year 2001 or a subsequent fiscal year, a description of—

(I) post–discharge services not described in subclauses (I), (II), and (III) of clause (ii), the receipt of which results in a qualified discharge; and

(II) diagnosis–related groups described in clause (iii)(I) in addition to the 10 selected under such clause.

(K)(i)[686] Effective for discharges beginning on or after October 1, 2001, the Secretary shall establish a mechanism to recognize the costs of new medical services and technologies under the payment system established under this subsection. Such mechanism shall be established after notice and opportunity for public comment (in the publications required by subsection (e)(5) for a fiscal year or otherwise). Such mechanism shall be modified to meet the requirements of clause (viii).

(ii) The mechanism established pursuant to clause (i) shall—

(I)[687] apply to a new medical service or technology if, based on the estimated costs incurred with respect to discharges involving such service or technology, the DRG prospective payment rate otherwise applicable to such discharges under this subsection is inadequate (applying a threshold specified by the Secretary that is the lesser of 75 percent of the standardized amount (increased to reflect the difference between cost and charges) or 75 percent of one standard deviation for the diagnosis-related group involved);

(II) provide for the collection of data with respect to the costs of a new medical service or

[686] P.L. 108-173, §503(b)(2)(A), amended clause (i) in its entirety, effective December 8, 2003.
[687] P.L. 108-173, §503(b)(1), amended subclause (I) in its entirety, effective December 8, 2003.

technology described in subclause (I) for a period of not less than two years and not more than three years beginning on the date on which an inpatient hospital code is issued with respect to the service or technology;

(III)[688] provide for additional payment to be made under this subsection with respect to discharges involving a new medical service or technology described in subclause (I) that occur during the period described in subclause (II) in an amount that adequately reflects the estimated average cost of such service or technology; and

(IV) provide that discharges involving such a service or technology that occur after the close of the period described in subclause (II) will be classified within a new or existing diagnosis–related group with a weighting factor under paragraph (4)(B) that is derived from cost data collected with respect to discharges occurring during such period.

(iii) For purposes of clause (ii)(II), the term "inpatient hospital code" means any code that is used with respect to inpatient hospital services for which payment may be made under this subsection and includes an alphanumeric code issued under the International Classification of Diseases, 9th Revision, Clinical Modification ("ICD–9–CM") and its subsequent revisions.

(iv) For purposes of clause (ii)(III), the term "additional payment" means, with respect to a discharge for a new medical service or technology described in clause (ii)(I), an amount that exceeds the prospective payment rate otherwise applicable under this subsection to discharges involving such service or technology that would be made but for this subparagraph.

(v) The requirement under clause (ii)(III) for an additional payment may be satisfied by means of a new–technology group (described in subparagraph (L)), an add–on payment, a payment adjustment, or any other similar mechanism for increasing the amount otherwise payable with respect to a discharge under this subsection. The Secretary may not establish a separate fee schedule for such additional payment for such services and technologies, by utilizing a methodology established under subsection (a) or (h) of section 1834 to determine the amount of such additional payment, or by other similar mechanisms or methodologies.

(vi) For purposes of this subparagraph and subparagraph (L), a medical service or technology will be considered a "new medical service or technology" if the service or technology meets criteria established by the Secretary after notice and an opportunity for public comment.

[688] P.L. 108-173, §503(d)(1), struck out "subject to paragraph (4)(C)(iii)," effective December 8, 2003.

(vii)[689] Under the mechanism under this subparagraph, the Secretary shall provide for the addition of new diagnosis and procedure codes in April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) under this subsection until the fiscal year that begins after such date.

(viii)[690] The mechanism established pursuant to clause (i) shall be adjusted to provide, before publication of a proposed rule, for public input regarding whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of individuals entitled to benefits under part A as follows:

(I) The Secretary shall make public and periodically update a list of all the services and technologies for which an application for additional payment under this subparagraph is pending.

(II) The Secretary shall accept comments, recommendations, and data from the public regarding whether the service or technology represents a substantial improvement.

(III) The Secretary shall provide for a meeting at which organizations representing hospitals, physicians, such individuals, manufacturers, and any other interested party may present comments, recommendations, and data to the clinical staff of the Centers for Medicare and Medicaid Services before publication of a notice of proposed rulemaking regarding whether service or technology represents a substantial improvement.

(ix)[691] Before establishing any add-on payment under this subparagraph with respect to a new technology, the Secretary shall seek to identify one or more diagnosis-related groups associated with such technology, based on similar clinical or anatomical characteristics and the cost of the technology. Within such groups the Secretary shall assign an eligible new technology into a diagnosis-related group where the average costs of care most closely approximate the costs of care of using the new technology. No add-on payment under this subparagraph shall be made with respect to such new technology and this clause shall not affect the application of paragraph (4)(C)(iii).

(L)(i) In establishing the mechanism under subparagraph (K), the Secretary may establish new–technology groups into which a new medical service or technology will be classified if, based on the estimated average costs incurred with respect to discharges involving such service or technology, the DRG prospective payment rate otherwise applicable to such discharges under this subsection is inadequate.

[689] P.L. 108-173, §503(a), added clause (vii), effective December 8, 2003.
[690] P.L. 108-173, §503(b)(2)(B), added clause (viii), effective December 8, 2003.
[691] P.L. 108-173, §503(c), added clause (ix), effective December 8, 2003.

(ii) Such groups—

(I) shall not be based on the costs associated with a specific new medical service or technology; but

(II) shall, in combination with the applicable standardized amounts and the weighting factors assigned to such groups under paragraph (4)(B), reflect such cost cohorts as the Secretary determines are appropriate for all new medical services and technologies that are likely to be provided as inpatient hospital services in a fiscal year.

(iii) The methodology for classifying specific hospital discharges within a diagnosis–related group under paragraph (4)(A) or a new–technology group shall provide that a specific hospital discharge may not be classified within both a diagnosis–related group and a new–technology group.

(6) The Secretary shall provide for publication in the Federal Register, on or before the August 1 before each fiscal year (beginning with fiscal year 1984), of a description of the methodology and data used in computing the adjusted DRG prospective payment rates under this subsection, including any adjustments required under subsection (e)(1)(B).

(7) There shall be no administrative or judical review under section 1878 or otherwise of—

(A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1) or the determination of the applicable percentage increase under paragraph (12)(A)(ii)[692], and

(B) the establishment of diagnosis-related groups, of the methodology for the classification of discharges within such groups, and of the appropriate weighting factors thereof under paragraph (4).[693]

(8)(A) In the case of any hospital which is located in an area which is, at any time after April 20, 1983, reclassified from an urban to a rural area, payments to such hospital for the first two cost reporting periods for which such reclassification is effective shall be made as follows:

(i) For the first such cost reporting period, payment shall be equal to the amount payable to such hospital for such reporting period on the basis of the rural classification, plus an amount equal to two-thirds of the amount (if any) by which—

(I) the amount which would have been payable to such hospital for such reporting period on the basis of an urban classification, exceeds

(II) the amount payable to such hospital for such reporting period on the basis of the rural classification.

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[692] P.L. 108-173, §406(b), inserted "or the determination of the applicable percentage increase under paragraph (12)(A)(ii)", effective December 8, 2003.

[693] See Vol. II, P.L. 98–21, §601(g), with respect to determining whether a hospital is in an urban or rural area, and §604(b) with respect to a reduction in the payment amount under certain conditions.

(ii) For the second such cost reporting period, payment shall be equal to the amount payable to such hospital for such reporting period on the basis of the rural classification, plus an amount equal to one-third of the amount (if any) by which—

(I) the amount which would have been payable to such hospital for such reporting period on the basis of an urban classification, exceeds

(II) the amount payable to such hospital for such reporting period on the basis of the rural classification.[694]

(B)(i) For purposes of this subsection, the Secretary shall treat a hospital located in a rural county adjacent to one or more urban areas as being located in the urban metropolitan statistical area to which the greatest number of workers in the county commute, if the rural county would otherwise be considered part of an urban area, under the standards for designating Metropolitan Statistical Areas (and for designating New England County Metropolitan Areas) described in clause (ii), if the commuting rates used in determining outlying counties (or, for New England, similar recognized areas) were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of all contiguous Metropolitan Statistical Areas (or New England County Metropolitan Areas).

(ii) The standards described in this clause for cost reporting periods beginning in a fiscal year—

(I) before fiscal year 2003, are the standards published in the Federal Register on January 3, 1980, or, at the election of the hospital with respect to fiscal years 2001 and 2002, standards so published on March 30, 1990; and

(II) after fiscal year 2002, are the standards published in the Federal Register by the Director of the Office of Management and Budget based on the most recent available decennial population data.

Subparagraphs (C) and (D) shall not apply with respect to the application of subclause (I).

(C)(i) If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10), by treating hospitals located in a rural county or counties as being located in an urban area, or by treating hospitals located in one urban area as being located in another urban area—

(I) reduces the wage index for that urban area (as applied under this subsection) by 1 percentage point or less, the Secretary, in calculating such wage index under this subsection, shall exclude those hospitals so treated, or

(II) reduces the wage index for that urban area by more than 1 percentage point (as applied under

[694] See Vol. II, P.L. 98–21, §601(g), with respect to determining whether a hospital is in an urban or rural area; §603 with respect to reports, experiments, and demonstration projects; and §604(b) with respect to a reduction in the payment amount under certain conditions.

this subsection), the Secretary shall calculate and apply such wage index under this subsection separately to hospitals located in such urban area (excluding all the hospitals so treated) and to the hospitals so treated (as if such hospitals were located in such urban area).

(ii) If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10), by treating hospitals located in a rural county or counties as not being located in the rural area in a State, reduces the wage index for that rural area (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection as if the hospitals so treated had not been excluded from calculation of the wage index for that rural area.

(iii) The application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10) may not result in the reduction of any county's wage index to a level below the wage index for rural areas in the State in which the county is located.

(iv) The application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or of the Secretary under paragraph (10) may not result in a reduction in an urban area's wage index if—

(I) the urban area has a wage index below the wage index for rural areas in the State in which it is located; or

(II) the urban area is located in a State that is composed of a single urban area.

(v) This subparagraph shall apply with respect to discharges occurring in a fiscal year only if the Secretary uses a method for making adjustments to the DRG prospective payment rate for area differences in hospital wage levels under paragraph (3)(E) for the fiscal year that is based on the use of Metropolitan Statistical Area classifications.

(D) The Secretary shall make a proportional adjustment in the standardized amounts determined under paragraph (3) to assure that the provisions of subparagraphs (B) and (C) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10) do not result in aggregate payments under this section that are greater or less than those that would otherwise be made.[695]

(E)(i) For purposes of this subsection, not later than 60 days after the receipt of an application (in a form and manner determined by the Secretary) from a subsection (d) hospital described in clause (ii), the Secretary shall treat the hospital as being located in the rural area (as defined

[695] The provisions of this section shall apply to reclassifications of rural referral centers. See P.L. 105–33, §4202(b)(2).

in paragraph (2)(D)) of the State in which the hospital is located.

(ii) For purposes of clause (i), a subsection (d) hospital described in this clause is a subsection (d) hospital that is located in an urban area (as defined in paragraph (2)(D)) and satisfies any of the following criteria:

(I) The hospital is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).

(II) The hospital is located in an area designated by any law or regulation of such State as a rural area (or is designated by such State as a rural hospital).

(III) The hospital would qualify as a rural, regional, or national referral center under paragraph (5)(C) or as a sole community hospital under paragraph (5)(D) if the hospital were located in a rural area.

(IV) The hospital meets such other criteria as the Secretary may specify.

(9)(A) Notwithstanding section 1814(b) but subject to the provisions of section 1813, the amount of the payment with respect to the operating costs of inpatient hospital services of a subsection (d) Puerto Rico hospital for inpatient hospital discharges is equal to the sum of—

(i) the applicable Puerto Rico percentage (specified in subparagraph(E))[696] of the Puerto Rico adjusted DRG prospective payment rate (determined under subparagraph (B) or (C)) for such discharges,[697]

(ii)[698] the applicable Federal percentage (specified in subparagraph (E)) of—

(I) for discharges beginning in a fiscal year beginning on or after October 1, 1997, and before October 1, 2003, the discharge-weighted average of—

(aa) the national adjusted DRG prospective payment rate (determined under paragraph (3)(D)) for hospitals located in a large urban area,

(bb) such rate for hospitals located in other urban areas, and

(cc) such rate for hospitals located in a rural area, for such discharges, adjusted in the manner provided in paragraph (3)(E) for different area wage levels; and

[696] P.L. 108-173, §504(1)(A), struck out "for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent)" and substituted "the applicable Puerto Rico percentage (specified in subparagraph (E))".

[697] P.L. 108-173, §401(c)(1)(A), struck out "and".

[698] P.L. 108-173, §401(c)(1)(B), amended clause (ii) in its entirety, effective date December 8, 2003; §401(d)(1) provides that this amendment shall have no effect on the authority of the Secretary, under P.L. 108-89, §402(b)(2), to delay the implementation of the extension of provisions equalizing urban and rural standardized inpatient hospital payments under §402(o) of P.L. 108-89.

(II) for discharges in a fiscal year beginning on or after October 1, 2003, the national DRG prospective payment rate determined under paragraph (3)(D)(iii) for hospitals located in any area for such discharges, adjusted in the manner provided in paragraph (3)(E) for different area wage levels.

As used in this section, the term "subsection (d) Puerto Rico hospital" means a hospital that is located in Puerto Rico and that would be a subsection (d) hospital (as defined in paragraph (1)(B)) if it were located in one of the 50 States.

(B) The Secretary shall determine a Puerto Rico adjusted DRG prospective payment rate, for each inpatient hospital discharge in fiscal year 1988 involving inpatient hospital services of a subsection (d) Puerto Rico hospital for which payment may be made under part A of this title. Such rate shall be determined for such hospitals located in urban or rural areas within Puerto Rico, as follows:

(i) The Secretary shall determine the target amount (as defined in subsection (b)(3)(A)) for the hospital for the cost reporting period beginning in fiscal year 1987 and increase such amount by prorating the applicable percentage increase (as defined in subsection (b)(3)(B)) to update the amount to the midpoint in fiscal year 1988.

(ii) The Secretary shall standardize the amount determined under clause (i) for each hospital by—

(I) excluding an estimate of indirect medical education costs,

(II) adjusting for variations among hospitals by area in the average hospital wage level,

(III) adjusting for variations in case mix among hospitals, and

(IV) excluding an estimate of the additional payments to certain subsection (d) Puerto Rico hospitals to be made under subparagraph (D)(iii) (relating to disproportionate share payments).

(iii) The Secretary shall compute a discharge weighted average of the standardized amounts determined under clause (ii) for all hospitals located in an urban area and for all hospitals located in a rural area (as such terms are defined in paragraph (2)(D)).

(iv) The Secretary shall reduce the average standardized amount by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this paragraph which are additional payments described in subparagraph (D)(i) (relating to outlier payments).

(v) For each discharge classified within a diagnosis-related group for hospitals located in an urban or rural area, respectively, the Secretary shall establish a Puerto Rico DRG prospective payment rate equal to the product of—

(I) the average standardized amount (computed under clause (iii) and reduced under clause (iv))

for hospitals located in an urban or rural area, respectively, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

(vi) The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the Puerto Rico DRG prospective payment rate computed under clause (v) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the Puerto Rican average hospital wage level.

(C) The Secretary shall determine a Puerto Rico adjusted DRG prospective payment rate, for each inpatient hospital discharge after fiscal year 1988 involving inpatient hospital services of a subsection (d) Puerto Rico hospital for which payment may be made under part A of this title. Such rate shall be determined for hospitals located in urban or rural areas within Puerto Rico as follows:

(i) The Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area equal to the respective average standardized amount computed for the previous fiscal year under subparagraph (B)(iii) or under this clause, increased for fiscal year 1989 by the applicable percentage increase under subsection (b)(3)(B), and adjusted for subsequent fiscal years in accordance with the final determination of the Secretary under subsection (e)(4), and adjusted to reflect the most recent case-mix data available.

(ii) The Secretary shall reduce each of the average standardized amounts by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this paragraph which are additional payments described in subparagraph (D)(i) (relating to outlier payments).

(iii) For each discharge classified within a diagnosis-related group for hospitals located in an urban or rural area, respectively, the Secretary shall establish a Puerto Rico DRG prospective payment rate equal to the product of—

(I) the average standardized amount (computed under clause (i) and reduced under clause (ii)) for hospitals located in an urban or rural area, respectively, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

(iv)(I)[699] The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the Puerto Rico DRG prospective payment rate computed under clause (iii) for area differences in hospital wage levels by a factor (estab-

[699] P.L. 108-173, §403(b)(1), added "(I)", effective December 8, 2003.

lished by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the Puerto Rico average hospital wage level. The second and third sentences of paragraph (3)(E)(i)[700] shall apply to subsection (d) Puerto Rico hospitals under this clause in the same manner as they apply to subsection (d) hospitals under such paragraph and, for purposes of this clause, any reference in such paragraph to a subsection (d) hospital is deemed a reference to a subsection (d) Puerto Rico hospital.

(II)[701] For discharges occurring on or after October 1, 2004, the Secretary shall substitute "62 percent" for the proportion described in the first sentence of clause (i), unless the application of this subclause would result in lower payments to a hospital than would otherwise be made.

(D) The following provisions of paragraph (5) shall apply to subsection (d) Puerto Rico hospitals receiving payment under this paragraph in the same manner and to the extent as they apply to subsection (d) hospitals receiving payment under this subsection:

(i) Subparagraph (A) (relating to outlier payments).

(ii) Subparagraph (B) (relating to payments for indirect medical education costs), except that for this purpose the sum of the amount determined under subparagraph (A) of this paragraph and the amount paid to the hospital under clause (i) of this subparagraph shall be substituted for the sum referred to in paragraph (5)(B)(i)(I).

(iii) Subparagraph (F) (relating to disproportionate share payments), except that for this purpose the sum described in clause (ii) of this subparagraph shall be substituted for the sum referred to in paragraph (5)(F)(ii)(I).

(iv) Subparagraph (H) (relating to exceptions and adjustments).

(E)[702] For purposes of subparagraph (A), for discharges occurring—

(i) on or after October 1, 1987, and before October 1, 1997, the applicable Puerto Rico percentage is 75 percent and the applicable Federal percentage is 25 percent;

(ii) on or after October 1, 1997, and before April 1, 2004, the applicable Puerto Rico percentage is 50 percent and the applicable Federal percentage is 50 percent;

(iii) on or after April 1, 2004, and before October 1, 2004, the applicable Puerto Rico percentage is 37.5 percent and the applicable Federal percentage is 62.5 percent; and

[700] P.L. 108-173, §403(b)(2), struck out "paragraph (3)(E)", and substituted "paragraph (3)(E)(i)", effective December 8, 2003.
[701] P.L. 108-173, §403(b)(3), added subclause (II), effective December 8, 2003.
[702] P.L. 108-173, §504(2), added subparagraph (E), effective December 8, 2003.

(iv) on or after October 1, 2004, the applicable Puerto Rico percentage is 25 percent and the applicable Federal percentage is 75 percent.

(10)(A) There is hereby established the Medicare Geographic Classification Review Board (hereinafter in this paragraph referred to as the "Board").

(B)(i) The Board shall be composed of 5 members appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. Two of such members shall be representative of subsection (d) hospitals located in a rural area under paragraph (2)(D). At least 1 member shall be knowledgeable in the field of analyzing costs with respect to the provision of inpatient hospital services.

(ii) The Secretary shall make initial appointments to the Board as provided in this paragraph within 180 days after the date of the enactment of this paragraph.

(C)(i) The Board shall consider the application of any subsection (d) hospital requesting that the Secretary change the hospital's geographic classification for purposes of determining for a fiscal year—

(I) the hospital's average standardized amount under paragraph (2)(D), or

(II) the factor used to adjust the DRG prospective payment rate for area differences in hospital wage levels that applies to such hospital under paragraph (3)(E).

(ii) A hospital requesting a change in geographic classification under clause (i) for a fiscal year shall submit its application to the Board not later than the first day of the 13–month period ending on September 30 of the preceding fiscal year. [703]

(iii)(I) The Board shall render a decision on an application submitted under clause (i) not later than 180 days after the deadline referred to in clause (ii).

(II) Appeal of decisions of the Board shall be subject to the provisions of section 557b of title 5, United States Code. The Secretary shall issue a decision on such an appeal not later than 90 days after the date on which the appeal is filed. The decision of the Secretary shall be final and shall not be subject to judicial review.

(D)(i) The Secretary shall publish guidelines to be utilized by the Board in rendering decisions on applications submitted under this paragraph, and shall include in such guidelines the following:

(I) Guidelines for comparing wages, taking into account (to the extent the Secretary determines appropriate) occupational mix, in the area in which the hospital is classified and the area in which the hospital is applying to be classified.

(II) Guidelines for determining whether the county in which the hospital is located should be

[703] See Vol. II, P.L. 105–33, §4644(c)(2), with respect to the special rule for applications received in fiscal year 1997.

treated as being a part of a particular Metropolitan Statistical Area.

(III) Guidelines for considering information provided by an applicant with respect to the effects of the hospital's geographic classification on access to inpatient hospital services by medicare beneficiaries.

(IV) Guidelines for considering the appropriateness of the criteria used to define New England County Metropolitan Areas.

(ii) Notwithstanding clause (i), if the Secretary uses a method for making adjustments to the DRG prospective payment rate for area differences in hospital wage levels under paragraph (3)(E) that is not based on the use of Metropolitan Statistical Area classifications, the Secretary may revise the guidelines published under clause (i) to the extent such guidelines are used to determine the appropriateness of the geographic area in which the hospital is determined to be located for purposes of making such adjustments.

(iii) Under the guidelines published by the Secretary under clause (i), in the case of a hospital which has ever been classified by the Secretary as a rural referral center under paragraph (5)(C), the Board may not reject the application of the hospital under this paragraph on the basis of any comparison between the average hourly wage of the hospital and the average hourly wage of hospitals in the area in which it is located.

(iv) The Secretary shall publish the guidelines described in clause (i) by July 1, 1990.

(v) Any decision of the Board to reclassify a subsection (d) hospital for purposes of the adjustment factor described in subparagraph (C)(i)(II) for fiscal year 2001 or any fiscal year thereafter shall be effective for a period of 3 fiscal years, except that the Secretary shall establish procedures under which a subsection (d) hospital may elect to terminate such reclassification before the end of such period.

(vi) Such guidelines shall provide that, in making decisions on applications for reclassification for the purposes described in clause (v) for fiscal year 2003 and any succeeding fiscal year, the Board shall base any comparison of the average hourly wage for the hospital with the average hourly wage for hospitals in an area on—

(I) an average of the average hourly wage amount for the hospital from the most recently published hospital wage survey data of the Secretary (as of the date on which the hospital applies for reclassification) and such amount from each of the two immediately preceding surveys; and

(II) an average of the average hourly wage amount for hospitals in such area from the most recently published hospital wage survey data of

the Secretary (as of the date on which the hospital applies for reclassification) and such amount from each of the two immediately preceding surveys.

(E)(i) The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this title or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this paragraph. In the course of any hearing the Board may administer oaths and affirmations. The provisions of subsections (d) and (e) of section 205 with respect to subpenas shall apply to the Board to the same extent as such provisions apply to the Secretary with respect to title II.

(ii) The Board is authorized to engage such technical assistance and to receive such information as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Board such secretarial, clerical, and other assistance as the Board may require to carry out its functions.

(F)(i) Each member of the Board who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for grade GS-18 of the General Schedule under section 5332 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Board. Each member of the Board who is an officer or employee of the United States shall serve without compensation in addition to that received for service as an officer or employee of the United States.

(ii) Members of the Board shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Board.[704]

(11) ADDITIONAL PAYMENTS FOR MANAGED CARE ENROLLEES.—

(A) IN GENERAL.—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount for each applicable discharge of any subsection (d) hospital that has an approved medical residency training program.

(B) APPLICABLE DISCHARGE.—For purposes of this paragraph, the term "applicable discharge" means the discharge of any individual who is enrolled under a risk–sharing contract with an eligible organization under section 1876 and who is entitled to benefits under part A or any individual who is enrolled with a Medicare+Choice organization under part C.

(C) DETERMINATION OF AMOUNT.—The amount of the payment under this paragraph with respect to any applicable discharge shall be equal to the applicable percentage

[704] See Vol. II, P.L. 100–203, §4003(d), with respect to a special rule for certain hospitals; and §4004(b), with respect to calculating the clinic hospital wage index in the case of certain hospitals.

(as defined in subsection (h)(3)(D)(ii)) of the estimated average per discharge amount that would otherwise have been paid under paragraph (5)(B) if the individuals had not been enrolled as described in subparagraph (B).

(D) SPECIAL RULE FOR HOSPITALS UNDER REIMBURSEMENT SYSTEM.—The Secretary shall establish rules for the application of this paragraph to a hospital reimbursed under a reimbursement system authorized under section 1814(b)(3) in the same manner as it would apply to the hospital if it were not reimbursed under such section.

(12)[705] Payment adjustment for low-volume hospitals.—

(A) In general.—In addition to any payments calculated under this section for a subsection (d) hospital, for discharges occurring during a fiscal year (beginning with fiscal year 2005), the Secretary shall provide for an additional payment amount to each low-volume hospital (as defined in subparagraph (C)(i)) for discharges occurring during that fiscal year that is equal to the applicable percentage increase (determined under subparagraph (B) for the hospital involved) in the amount paid to such hospital under this section for such discharges (determined without regard to this paragraph).

(B) Applicable percentage increase.—The Secretary shall determine an applicable percentage increase for purposes of subparagraph (A) as follows:

(i) The Secretary shall determine the empirical relationship for subsection (d) hospitals between the standardized cost-per-case for such hospitals and the total number of discharges of such hospitals and the amount of the additional incremental costs (if any) that are associated with such number of discharges.

(ii) The applicable percentage increase shall be determined based upon such relationship in a manner that reflects, based upon the number of such discharges for a subsection (d) hospital, such additional incremental costs.

(iii) In no case shall the applicable percentage increase exceed 25 percent.

(C) Definitions.—

(i) Low-volume hospital.—For purposes of this paragraph, the term "low-volume hospital" means, for a fiscal year, a subsection (d) hospital (as defined in paragraph (1)(B)) that the Secretary determines is located more than 25 road miles from another subsection (d) hospital and has less than 800 discharges during the fiscal year.

(ii) Discharge.—For purposes of subparagraph (B) and clause (i), the term 'discharge' means an inpatient acute care discharge of an individual regardless of whether the individual is entitled to benefits under part A.

(13)[706](A) In order to recognize commuting patterns among geographic areas, the Secretary shall establish a process

[705] P.L. 108–173, §406(a), added paragraph (12), effective December 8, 2003.
[706] P.L. 108–173, §505(a), added paragraph (13), effective December 8, 2003.

through application or otherwise for an increase of the wage index applied under paragraph (3)(E) for subsection (d) hospitals located in a qualifying county described in subparagraph (B) in the amount computed under subparagraph (D) based on out-migration of hospital employees who reside in that county to any higher wage index area.

(B) The Secretary shall establish criteria for a qualifying county under this subparagraph based on the out-migration referred to in subparagraph (A) and differences in the area wage indices. Under such criteria the Secretary shall, utilizing such data as the Secretary determines to be appropriate, establish—

(i) a threshold percentage, established by the Secretary, of the weighted average of the area wage index or indices for the higher wage index areas involved;

(ii) a threshold (of not less than 10 percent) for minimum out-migration to a higher wage index area or areas; and

(iii) a requirement that the average hourly wage of the hospitals in the qualifying county equals or exceeds the average qualifying county is located.

(C) For purposes of this paragraph, the term 'higher wage index area' means, with respect to a county, an area with a wage index that exceeds that of the county.

(D) The increase in the wage index under subparagraph (A) for a qualifying county shall be equal to the percentage of the hospital employees residing in the qualifying county who are employed in any higher wage index area multiplied by the sum of the products, for each higher wage index area of—

(i) the difference between—

(I) the wage index for such higher wage index area, and

(II) the wage index of the qualifying county; and

(ii) the number of hospital employees residing in the qualifying county who are employed in such higher wage index area divided by the total number of hospital employees residing in the qualifying county who are employed in any higher wage index area.

(E) The process under this paragraph may be based upon the process used by the Medicare Geographic Classification Review Board under paragraph (10). As the Secretary determines to be appropriate to carry out such process, the Secretary may require hospitals (including subsection (d) hospitals and other hospitals) and critical access hospitals, as required under section 1866(a)(1)(T), to submit data regarding the location of residence, or the Secretary may use data from other sources.

(F) A wage index increase under this paragraph shall be effective for a period of 3 fiscal years, except that the Secretary shall establish procedures under which a subsection (d) hospital may elect to waive the application of such wage index increase.

(G) A hospital in a county that has a wage index increase under this paragraph for a period and that has not waived the application of such an increase under subpara-

graph (F) is not eligible for reclassification under paragraph (8) or (10) during that period.

(H) Any increase in a wage index under this paragraph for a county shall not be taken into account for purposes of—

(i) computing the wage index for portions of the wage index area (not including the county) in which the county is located; or

(ii) applying any budget neutrality adjustment with respect to such index under paragraph (8)(D).

(I) The thresholds described in subparagraph (B), data on hospital employees used under this paragraph, and any determination of the Secretary under the process described in subparagraph (E) shall be final and shall not be subject to judicial review.

(e)(1)(A) For cost reporting periods of hospitals beginning in fiscal year 1984 or fiscal year 1985, the Secretary shall provide for such proportional adjustment in the applicable percentage increase (otherwise applicable to the periods under subsection (b)(3)(B)) as may be necessary to assure that—

(i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(I) for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1866(a)(1)(F)),

are not greater or less than—

(ii) the target percentage (as defined in subsection (d)(1)(C)) of the payment amounts which would have been payable for such services for those same hospitals for that fiscal year under this section under the law as in effect before the date of the enactment of the Social Security Amendments of 1983[707] (excluding payments made under section 1866(a)(1)(F));

except that the adjustment made under this subparagraph shall apply only to subsection (d) hospitals and shall not apply for purposes of making computations under subsection (d)(2)(B)(ii) or subsection (d)(3)(A).

(B) For discharges occurring in fiscal year 1984 or fiscal year 1985, the Secretary shall provide under subsections (d)(2)(F) and (d)(3)(C) for such equal proportional adjustment in each of the average standardized amounts otherwise computed for that fiscal year as may be necessary to assure that—

(i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(II) and (d)(5) for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1866(a)(1)(F)),

are not greater or less than—

(ii) the DRG percentage (as defined in subsection (d)(1)(C)) of the payment amounts which would have been payable for such services for those same hospitals for that fiscal year under this section under the law as in effect before the date of the enactment of the

[707] April 20, 1983 [P.L. 98–21; 97 Stat. 65].

Social Security Amendments of 1983[708] (excluding payments made under section 1866(a)(1)(F)).

(C) For discharges occurring in fiscal year 1988, the Secretary shall provide for such equal proportional adjustment in each of the average standardized amounts otherwise computed under subsection (d)(3) for that fiscal year as may be necessary to assure that—

(i) the aggregate payment amounts otherwise provided under subsections (d)(1)(A)(iii), (d)(5), and (d)(9) for that fiscal year for operating costs of inpatient hospital services of subsection (d) hospitals and subsection (d) Puerto Rico hospitals,

are not greater or less than—

(ii) the payment amounts that would have been payable for such services for those same hospitals for that fiscal year but for the enactment of the amendments made by section 9304 of the Omnibus Budget Reconciliation Act of 1986.[709]

(2) [Stricken.[710]]

(3) The Secretary, not later than April 1, 1987, for fiscal year 1988 and not later than March 1 before the beginning of each fiscal year (beginning with fiscal year 1989), shall report to the Congress the Secretary's initial estimate of the percentage change that the Secretary will recommend under paragraph (4) with respect to that fiscal year.

(4)(A) Taking into consideration the recommendations of the Commission, the Secretary shall recommend for each fiscal year (beginning with fiscal year 1988) an appropriate change factor for inpatient hospital services for discharges in that fiscal year which will take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. The appropriate change factor may be different for all large urban subsection (d) hospitals, other urban subsection (d) hospitals, urban subsection (d) Puerto Rico hospitals, rural subsection (d) hospitals, and rural subsection (d) Puerto Rico hospitals, and all other hospitals and units not paid under subsection (d), and may vary among such other hospitals and units.

(B) In addition to the recommendation made under subparagraph (A), the Secretary shall, taking into consideration the recommendations of the Commission under paragraph (2)(B), recommend for each fiscal year (beginning with fiscal year 1992) other appropriate changes in each existing reimbursement policy under this title under which payments to an institution are based upon prospectively determined rates.

(5) The Secretary shall cause to have published in the Federal Register, not later than—

(A) the April 1 before each fiscal year (beginning with fiscal year 1986), the Secretary's proposed recommendations under paragraph (4) for that fiscal year for public comment, and

[708] April 20, 1983 [P.L. 98–21; 97 Stat. 65].
[709] P.L. 99–509.
[710] P.L. 105–33, §4022(b)(1)(A)(i); 111 Stat. 354.

(B) the August 1 before such fiscal year after such consideration of public comment on the proposal as is feasible in the time available, the Secretary's final recommendations under such paragraph for that year.

The Secretary shall include in the publication referred to in subparagraph (A) for a fiscal year the report of the Commission's recommendations submitted under paragraph (3) for that fiscal year. To the extent that the Secretary's recommendations under paragraph (4) differ from the Commission's recommendations for that fiscal year, the Secretary shall include in the publication referred to in subparagraph (A) an explanation of the Secretary's grounds for not following the Commission's recommendations.

(f)(1)(A) The Secretary shall maintain a system for the reporting of costs of hospitals receiving payments computed under subsection (d).

(B)(i) Subject to clause (ii), the Secretary shall place into effect a standardized electronic cost reporting format for hospitals under this title.

(ii) The Secretary may delay or waive the implementation of such format in particular instances where such implementation would result in financial hardship (in particular with respect to hospitals with a small percentage of inpatients entitled to benefits under this title).

(2) If the Secretary determines, based upon information supplied by a utilization and quality control peer review organization under part B of title XI, that a hospital, in order to circumvent the payment method established under subsection (b) or (d) of this section, has taken an action that results in the admission of individuals entitled to benefits under part A unnecessarily, unnecessary multiple admissions of the same such individuals, or other inappropriate medical or other practices with respect to such individuals, the Secretary may—

(A) deny payment (in whole or in part) under part A with respect to inpatient hospital services provided with respect to such an unnecessary admission (or subsequent admission of the same individual), or

(B) require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice.

(3) The provisions of subsections (c) through (g) of section 1128 shall apply to determinations made under paragraph (2) in the same manner as they apply to exclusions effected under section 1128(b)(13).

(g)(1)(A) Notwithstanding section 1861(v), instead of any amounts that are otherwise payable under this title with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary shall, for hospital cost reporting periods beginning on or after October 1, 1991, provide for payments for such costs in accordance with a prospective payment system established by the Secretary. Aggregate payments made under subsection (d) and this subsection during fiscal years 1992 through 1995 shall be reduced in a manner that results in a reduction (as estimated by the Secretary) in the amount of such payments equal to a 10 percent reduction in the amount of payments attributable to capital-related costs that would otherwise have been made dur-

ing such fiscal year had the amount of such payments been based on reasonable costs (as defined in section 1861(v)). For discharges occurring after September 30, 1993, the Secretary shall reduce by 7.4 percent the unadjusted standard Federal capital payment rate (as described in 42 CFR 412.308(c), as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993) and shall (for hospital cost reporting periods beginning on or after October 1, 1993) redetermine which payment methodology is applied to the hospital under such system to take into account such reduction. In addition to the reduction described in the preceding sentence, for discharges occurring on or after October 1, 1997, the Secretary shall apply the budget neutrality adjustment factor used to determine the Federal capital payment rate in effect on September 30, 1995 (as described in section 412.352 of title 42 of the Code of Federal Regulations), to (i) the unadjusted standard Federal capital payment rate (as described in section 412.308(c) of that title, as in effect on September 30, 1997), and (ii) the unadjusted hospital–specific rate (as described in section 412.328(e)(1) of that title, as in effect on September 30, 1997), and, for discharges occurring on or after October 1, 1997, and before October 1, 2002, reduce the rates described in clauses (i) and (ii) by 2.1 percent.

(B) Such system—

(i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;

(ii) may provide for an adjustment to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located;

(iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and

(iv) may provide for suitable adjustment to reflect hospital occupancy rate.

(C) In this paragraph, the term "capital-related costs" has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.

(2)(A) The Secretary shall provide that the amount which is allowable, with respect to reasonable costs of inpatient hospital services for which payment may be made under this title, for a return on equity capital for hospitals shall, for cost reporting periods beginning on or after the date of the enactment of this subsection[711] , be equal to amounts otherwise allowable under regulations in effect on March 1, 1983, except that the rate of return to be recognized shall be equal to the applicable percentage (described in subparagraph (B)) of the average of the rates of interest, for each of the months any part of which is included in the reporting period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

(B) In this paragraph, the "applicable percentage" is—

(i) 75 percent, for cost reporting periods beginning during fiscal year 1987,

[711] April 20, 1983 [P.L. 98–21; 97 Stat. 65].

(ii) 50 percent, for cost reporting periods beginning during fiscal year 1988,

(iii) 25 percent, for cost reporting periods beginning during fiscal year 1989, and

(iv) 0 percent, for cost reporting periods beginning on or after October 1, 1989.

(3)(A) Except as provided in subparagraph (B), in determining the amount of the payments that may be made under this title with respect to all the capital-related costs of inpatient hospital services of a subsection (d) hospital and a subsection (d) Puerto Rico hospital, the Secretary shall reduce the amounts of such payments otherwise established under this title by—

(i) 3.5 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1987,

(ii) 7 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during fiscal year 1988 on or after October 1, 1987, and before January 1, 1988,

(iii) 12 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) in fiscal year 1988, occurring on or after January 1, 1988,

(iv) 15 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during fiscal year 1989, and

(v) 15 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during the period beginning January 1, 1990, and ending September 30, 1991.

(B) Subparagraph (A) shall not apply to payments with respect to the capital-related costs of any hospital that is a sole community hospital (as defined in subsection (as defined in subsection (d)(5)(D)(iii)) [712] or a critical access hospital (as defined in section 1861(mm)(1)).

(4) In determining the amount of the payments that are attributable to portions of cost reporting periods occurring during fiscal years 1998 through 2002 and that may be made under this title with respect to capital–related costs of inpatient hospital services of a hospital which is described in clause (i), (ii), or (iv) of subsection (d)(1)(B) or a unit described in the matter after clause (v) of such subsection, the Secretary shall reduce the amounts of such payments otherwise determined under this title by 15 percent. In addition to the reduction described in the preceding sentence, for discharges occurring on or after October 1, 1997, the Secretary shall apply the budget neutrality adjustment factor used to determine the Federal capital payment rate in effect on September 30, 1995 (as described in section 412.352 of title 42 of the Code of Federal Regulations), to (i) the unadjusted standard Federal capital payment rate (as described in section 412.308(c) of that title, as in effect on September 30, 1997), and (ii) the unadjusted hospital–specific rate

[712] P.L. 108-173, §736(a)(15), struck out "(as defined in subsection (d)(5)(D)(iii)" and substituted "(as defined in subsection (d)(5)(D)(iii))", effective December 8, 2003.

(as described in section 412.328(e)(1) of that title, as in effect on September 30, 1997), and, for discharges occurring on or after October 1, 1997, and before September 30, 2002, reduce the rates described in clauses (i) and (ii) by 2.1 percent.

(h) PAYMENTS FOR DIRECT GRADUATE MEDICAL EDUCATION COSTS.—

(1) SUBSTITUTION OF SPECIAL PAYMENT RULES.—Notwithstanding section 1861(v), instead of any amounts that are otherwise payable under this title with respect to the reasonable costs of hospitals for direct graduate medical education costs, the Secretary shall provide for payments for such costs in accordance with paragraph (3) of this subsection. In providing for such payments, the Secretary shall provide for an allocation of such payments between part A and part B (and the trust funds established under the respective parts) as reasonably reflects the proportion of direct graduate medical education costs of hospitals associated with the provision of services under each respective part.

(2) DETERMINATION OF HOSPITAL-SPECIFIC APPROVED FTE RESIDENT AMOUNTS.—The Secretary shall determine, for each hospital with an approved medical residency training program, an approved FTE resident amount for each cost reporting period beginning on or after July 1, 1985, as follows:

(A) DETERMINING ALLOWABLE AVERAGE COST PER FTE RESIDENT IN A HOSPITAL'S BASE PERIOD.—The Secretary shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this title for direct graduate medical education costs of the hospital for each full-time-equivalent resident.

(B) UPDATING TO THE FIRST COST REPORTING PERIOD.—

(i) IN GENERAL.—The Secretary shall update each average amount determined under subparagraph (A) by the percentage increase in the consumer price index during the 12-month cost reporting period described in such subparagraph.

(ii) EXCEPTION.—The Secretary shall not perform an update under clause (i) in the case of a hospital if the hospital's reporting period, described in subparagraph (A), began on or after July 1, 1984, and before October 1, 1984.

(C) AMOUNT FOR FIRST COST REPORTING PERIOD.—For the first cost reporting period of the hospital beginning on or after July 1, 1985, the approved FTE resident amount for the hospital is equal to the amount determined under subparagraph (B) increased by 1 percent.

(D) AMOUNT FOR SUBSEQUENT COST REPORTING PERIODS.—

(i) IN GENERAL.—Except as provided in a subsequent clause, for each subsequent cost reporting period, the approved FTE resident amount for the hospital is equal to the approved FTE resident amount determined under this paragraph for the previous cost reporting period updated, through the midpoint of the period, by projecting the estimated percentage change in the consumer price index during the 12-month pe-

riod ending at that midpoint, with appropriate adjustments to reflect previous under–or over–estimations under this subparagraph in the projected percentage change in the consumer price index.

(ii) FREEZE IN UPDATE FOR FISCAL YEARS 1994 AND 1995.—For cost reporting periods beginning during fiscal year 1994 or fiscal year 1995, the approved FTE resident amount for a hospital shall not be updated under clause (i) for a resident who is not a primary care resident (as defined in paragraph (5)(H)) or a resident enrolled in an approved medical residency training program in obstetrics and gynecology.

(iii) FLOOR FOR LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—The approved FTE resident amount for a hospital for the cost reporting period beginning during fiscal year 2001 shall not be less than 70 percent, and for the cost reporting period beginning during fiscal year 2002 shall not be less than 85 percent, of the locality adjusted national average per resident amount computed under subparagraph (E) for the hospital and period.

(iv) ADJUSTMENT IN RATE OF INCREASE FOR HOSPITALS WITH FTE APPROVED AMOUNT ABOVE 140 PERCENT OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—

(I) FREEZE FOR FISCAL YEARS 2001 AND 2002 AND 2004 THROUGH 2013 [713].—For a cost reporting period beginning during fiscal year 2001 or fiscal year 2002 or during the period beginning with fiscal year 2004 and ending with fiscal year 2013 [714], if the approved FTE resident amount for a hospital for the preceding cost reporting period exceeds 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital and period, subject to subclause (III), the approved FTE resident amount for the period involved shall be the same as the approved FTE resident amount for the hospital for such preceding cost reporting period.

(II) 2 PERCENT DECREASE IN UPDATE FOR FISCAL YEARS 2003, 2004, AND 2005.— For the [715] cost reporting period beginning during fiscal year 2003, [716] if the approved FTE resident amount for a hospital for the preceding cost reporting period exceeds 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital and preceding period, the approved FTE resident amount for the period involved shall be updated in the manner described in subparagraph (D)(i)

[713] P.L. 108-173, §711(1)(A), added "and 2004 through 2013".

[714] P.L. 108-173, §711(1)(B), added "or during the period beginning with fiscal year 2004 and ending with fiscal year 2013", effective December 8, 2003.

[715] P.L. 108-173, §711(2)(B), struck out "For a" and substituted "For the", effective December 8, 2003.

[716] P.L. 108-173, §711(2)(A), struck out "fiscal year 2004, or fiscal year 2005,".

except that, subject to subclause (III), the consumer price index applied for a 12–month period shall be reduced (but not below zero) by 2 percentage points.

(III) NO ADJUSTMENT BELOW 140 PERCENT.—In no case shall subclause (I) or (II) reduce an approved FTE resident amount for a hospital for a cost reporting period below 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for such hospital and period.

(E) DETERMINATION OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—The Secretary shall determine a locality adjusted national average per resident amount with respect to a cost reporting period of a hospital beginning during a fiscal year as follows:

(i) DETERMINING HOSPITAL SINGLE PER RESIDENT AMOUNT.—The Secretary shall compute for each hospital operating an approved graduate medical education program a single per resident amount equal to the average (weighted by number of full–time equivalent residents, as determined under paragraph (4)) of the primary care per resident amount and the non–primary care per resident amount computed under paragraph (2) for cost reporting periods ending during fiscal year 1997.

(ii) STANDARDIZING PER RESIDENT AMOUNTS.—The Secretary shall compute a standardized per resident amount for each such hospital by dividing the single per resident amount computed under clause (i) by an average of the 3 geographic index values (weighted by the national average weight for each of the work, practice expense, and malpractice components) as applied under section 1848(e) for 1999 for the fee schedule area in which the hospital is located.

(iii) COMPUTING OF WEIGHTED AVERAGE.—The Secretary shall compute the average of the standardized per resident amounts computed under clause (ii) for such hospitals, with the amount for each hospital weighted by the average number of full–time equivalent residents at such hospital (as determined under paragraph (4)).

(iv) COMPUTING NATIONAL AVERAGE PER RESIDENT AMOUNT.—The Secretary shall compute the national average per resident amount, for a hospital's cost reporting period that begins during fiscal year 2001, equal to the weighted average computed under clause (iii) increased by the estimated percentage increase in the consumer price index for all urban consumers during the period beginning with the month that represents the midpoint of the cost reporting periods described in clause (i) and ending with the midpoint of the hospital's cost reporting period that begins during fiscal year 2001.

(v) ADJUSTING FOR LOCALITY.—The Secretary shall compute the product of—

(I) the national average per resident amount computed under clause (iv) for the hospital, and

(II) the geographic index value average (described and applied under clause (ii)) for the fee schedule area in which the hospital is located.

(vi) COMPUTING LOCALITY ADJUSTED AMOUNT.—The locality adjusted national per resident amount for a hospital for—

(I) the cost reporting period beginning during fiscal year 2001 is the product computed under clause (v); or

(II) each subsequent cost reporting period is equal to the locality adjusted national per resident amount for the hospital for the previous cost reporting period (as determined under this clause) updated, through the midpoint of the period, by projecting the estimated percentage change in the consumer price index for all urban consumers during the 12–month period ending at that midpoint.

(F) TREATMENT OF CERTAIN HOSPITALS.—In the case of a hospital that did not have an approved medical residency training program or was not participating in the program under this title for a cost reporting period beginning during fiscal year 1984, the Secretary shall, for the first such period for which it has such a residency training program and is participating under this title, provide for such approved FTE resident amount as the Secretary determines to be appropriate, based on approved FTE resident amounts for comparable programs.

(3) HOSPITAL PAYMENT AMOUNT PER RESIDENT.—

(A) IN GENERAL.—The payment amount, for a hospital cost reporting period beginning on or after July 1, 1985, is equal to the product of—

(i) the aggregate approved amount (as defined in subparagraph (B)) for that period, and

(ii) the hospital's medicare patient load (as defined in subparagraph (C)) for that period.

(B) AGGREGATE APPROVED AMOUNT.—As used in subparagraph (A), the term "aggregate approved amount" means, for a hospital cost reporting period, the product of—

(i) the hospital's approved FTE resident amount (determined under paragraph (2)) for that period, and

(ii) the weighted average number of full-time-equivalent residents (as determined under paragraph (4)) in the hospital's approved medical residency training programs in that period.

The Secretary shall reduce the aggregate approved amount to the extent payment is made under subsection (k) for residents included in the hospital's count of full–time equivalent residents.

(C) MEDICARE PATIENT LOAD.—As used in subparagraph (A), the term "medicare patient load" means, with respect to a hospital's cost reporting period, the fraction of the total number of inpatient-bed-days (as established by the

Secretary) during the period which are attributable to patients with respect to whom payment may be made under part A.

(D) PAYMENT FOR MANAGED CARE ENROLLEES.—

(i) IN GENERAL.—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount under this subsection for services furnished to individuals who are enrolled under a risk–sharing contract with an eligible organization under section 1876 and who are entitled to part A or with a Medicare+Choice organization under part C. The amount of such a payment shall equal the applicable percentage of the product of—

(I) the aggregate approved amount (as defined in subparagraph (B)) for that period; and

(II) the fraction of the total number of inpatient–bed days (as established by the Secretary) during the period which are attributable to such enrolled individuals.

(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the applicable percentage is—

(I) 20 percent in 1998,

(II) 40 percent in 1999,

(III) 60 percent in 2000,[717]

(IV) 80 percent in 2001, and

(V) 100 percent in 2002 and subsequent years.

(iii) SPECIAL RULE FOR HOSPITALS UNDER REIMBURSEMENT SYSTEM.—The Secretary shall establish rules for the application of this subparagraph to a hospital reimbursed under a reimbursement system authorized under section 1814(b)(3) in the same manner as it would apply to the hospital if it were not reimbursed under such section.

(4) DETERMINATION OF FULL-TIME-EQUIVALENT RESIDENTS.—

(A) RULES.—The Secretary shall establish rules consistent with this paragraph for the computation of the number of full-time-equivalent residents in an approved medical residency training program.

(B) ADJUSTMENT FOR PART-YEAR OR PART-TIME RESIDENTS.—Such rules shall take into account individuals who serve as residents for only a portion of a period with a hospital or simultaneously with more than one hospital.

(C) WEIGHTING FACTORS FOR CERTAIN RESIDENTS.—Subject to subparagraph (D), such rules shall provide, in calculating the number of full-time-equivalent residents in an approved residency program—

(i) before July 1, 1986, for each resident the weighting factor is 1.00,

(ii) on or after July 1, 1986, for a resident who is in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is 1.00,

(iii) on or after July 1, 1986, and before July 1, 1987, for a resident who is not in the resident's initial resi-

[717] P.L. 108-173, §736(c)(6), struck out "and".

dency period (as defined in paragraph (5)(F)), the weighting factor is .75, and

(iv) on or after July 1, 1987, for a resident who is not in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is .50.

(D) FOREIGN MEDICAL GRADUATES REQUIRED TO PASS FMGEMS EXAMINATION.—

(i) IN GENERAL.—Except as provided in clause (ii), such rules shall provide that, in the case of an individual who is a foreign medical graduate (as defined in paragraph (5)(D)), the individual shall not be counted as a resident on or after July 1, 1986, unless—

(I) the individual has passed the FMGEMS examination (as defined in paragraph (5)(E)), or

(II) the individual has previously received certification from, or has previously passed the examination of, the Educational Commission for Foreign Medical Graduates.

(ii) TRANSITION FOR CURRENT FMGS.—On or after July 1, 1986, but before July 1, 1987, in the case of a foreign medical graduate who—

(I) has served as a resident before July 1, 1986, and is serving as a resident after that date, but

(II) has not passed the FMGEMS examination or a previous examination of the Educational Commission for Foreign Medical Graduates before July 1, 1986,

the individual shall be counted as a resident at a rate equal to one-half of the rate at which the individual would otherwise be counted.

(E) COUNTING TIME SPENT IN OUTPATIENT SETTINGS.—Such rules shall provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

(F) LIMITATION ON NUMBER OF RESIDENTS IN ALLOPATHIC AND OSTEOPATHIC MEDICINE.—IN GENERAL.—

(i) Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1997, subject to paragraph (7)[718], the total number of full–time equivalent residents before application of weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic medicine and osteopathic medicine may not exceed the number (or, 130 percent of such number in the case of a hospital located in a rural area) of such full–time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.

[718] P.L. 108–173, §422(a)(1), inserted "subject to paragraph (7),", effective December 8, 2003.

(ii) COUNTING PRIMARY CARE RESIDENTS ON CERTAIN APPROVED LEAVES OF ABSENCE IN BASE YEAR FTE COUNT.—

(I) IN GENERAL.—In determining the number of such full–time equivalent residents for a hospital's most recent cost reporting period ending on or before December 31, 1996, for purposes of clause (i), the Secretary shall count an individual to the extent that the individual would have been counted as a primary care resident for such period but for the fact that the individual, as determined by the Secretary, was on maternity or disability leave or a similar approved leave of absence.

(II) LIMITATION TO 3 FTE RESIDENTS FOR ANY HOSPITAL.—The total number of individuals counted under subclause (I) for a hospital may not exceed 3 full–time equivalent residents.

(G) COUNTING INTERNS AND RESIDENTS FOR FY 1998 AND SUBSEQUENT YEARS.—

(i) IN GENERAL.—For cost reporting periods beginning during fiscal years beginning on or after October 1, 1997, subject to the limit described in subparagraph (F), the total number of full–time equivalent residents for determining a hospital's graduate medical education payment shall equal the average of the actual full–time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods.

(ii) ADJUSTMENT FOR SHORT PERIODS.—If any cost reporting period beginning on or after October 1, 1997, is not equal to twelve months, the Secretary shall make appropriate modifications to ensure that the average full–time equivalent resident counts pursuant to clause (i) are based on the equivalent of full twelve–month cost reporting periods.

(iii) TRANSITION RULE FOR 1998.—In the case of a hospital's first cost reporting period beginning on or after October 1, 1997, clause (i) shall be applied by using the average for such period and the preceding cost reporting period.

(H) SPECIAL RULES FOR APPLICATION OF SUBPARAGRAPHS (F) AND (G).—

(i) NEW FACILITIES.—The Secretary shall, consistent with the principles of subparagraphs (F) and (G) and subject to paragraph (7),[719] prescribe rules for the application of such subparagraphs in the case of medical residency training programs established on or after January 1, 1995. In promulgating such rules for purposes of subparagraph (F), the Secretary shall give special consideration to facilities that meet the needs of underserved rural areas.

(ii) AGGREGATION.—The Secretary may prescribe rules which allow institutions which are members of the same affiliated group (as defined by the Secretary)

[719] P.L. 108-173, §422(a)(2), inserted "subject to paragraph (7),", effective December 8, 2003.

to elect to apply the limitation of subparagraph (F) on an aggregate basis.

(iii) DATA COLLECTION.—The Secretary may require any entity that operates a medical residency training program and to which subparagraphs (F) and (G) apply to submit to the Secretary such additional information as the Secretary considers necessary to carry out such subparagraphs.

(iv) NONRURAL HOSPITALS OPERATING TRAINING PROGRAMS IN RURAL AREAS.—In the case of a hospital that is not located in a rural area but establishes separately accredited approved medical residency training programs (or rural tracks) in an rural area or has an accredited training program with an integrated rural track, the Secretary shall adjust the limitation under subparagraph (F) in an appropriate manner insofar as it applies to such programs in such rural areas in order to encourage the training of physicians in rural areas.

(5) DEFINITIONS AND SPECIAL RULES.—As used in this subsection:

(A) APPROVED MEDICAL RESIDENCY TRAINING PROGRAM.—The term "approved medical residency training program" means a residency or other postgraduate medical training program participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary.

(B) CONSUMER PRICE INDEX.—The term "consumer price index" refers to the Consumer Price Index for All Urban Consumers (United States city average), as published by the Secretary of Commerce.

(C) DIRECT GRADUATE MEDICAL EDUCATION COSTS.—The term "direct graduate medical education costs" means direct costs of approved educational activities for approved medical residency training programs.

(D) FOREIGN MEDICAL GRADUATE.—The term "foreign medical graduate" means a resident who is not a graduate of—

(i) a school of medicine accredited by the Liaison Committee on Medical Education of the American Medical Association and the Association of American Medical Colleges (or approved by such Committee as meeting the standards necessary for such accreditation),

(ii) a school of osteopathy accredited by the American Osteopathic Association, or approved by such Association as meeting the standards necessary for such accreditation, or

(iii) a school of dentistry or podiatry which is accredited (or meets the standards for accreditation) by an organization recognized by the Secretary for such purpose.

(E) FMGEMS EXAMINATION.—The term "FMGEMS examination" means parts I and II of the Foreign Medical Graduate Examination in the Medical Sciences or any suc-

cessor examination recognized by the Secretary for this purpose.

(F) INITIAL RESIDENCY PERIOD.—The term "initial residency period" means the period of board eligibility, except that—

(i) except as provided in clause (ii), in no case shall the initial period of residency exceed an aggregate period of formal training of more than five years for any individual, and

(ii) a period, of not more than two years, during which an individual is in a geriatric residency or fellowship program or a preventive medicine residency or fellowship program which meets such criteria as the Secretary may establish, shall be treated as part of the initial residency period, but shall not be counted against any limitation on the initial residency period.

Subject to subparagraph (G)(v), the initial residency period shall be determined, with respect to a resident, as of the time the resident enters the residency training program.

(G) PERIOD OF BOARD ELIGIBILITY.—

(i) GENERAL RULE.—Subject to clauses (ii), (iii), (iv) and (v) the term "period of board eligibility" means, for a resident, the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training.

(ii) APPLICATION OF 1985–1986 DIRECTORY.—Except as provided in clause (iii), the period of board eligibility shall be such period specified in the 1985–1986 Directory of Residency Training Programs published by the Accreditation Council on Graduate Medical Education.

(iii) CHANGES IN PERIOD OF BOARD ELIGIBILITY.—On or after July 1, 1989, if the Accreditation Council on Graduate Medical Education, in its Directory of Residency Training Programs—

(I) increases the minimum number of years of formal training necessary to satisfy the requirements for a specialty, above the period specified in its 1985–1986 Directory, the Secretary may increase the period of board eligibility for that specialty, but not to exceed the period of board eligibility specified in that later Directory, or

(II) decreases the minimum number of years of formal training necessary to satisfy the requirements for a specialty, below the period specified in its 1985–1986 Directory, the Secretary may decrease the period of board eligibility for that specialty, but not below the period of board eligibility specified in that later Directory.

(iv) SPECIAL RULE FOR CERTAIN PRIMARY CARE COMBINED RESIDENCY PROGRAMS.—

(I) In the case of a resident enrolled in a combined medical residency training program in which all of the individual programs (that are

combined) are for training a primary care resident (as defined in subparagraph (H)), the period of board eligibility shall be the minimum number of years of formal training required to satisfy the requirements for initial board eligibility in the longest of the individual programs plus one additional year.

(II) A resident enrolled in a combined medical residency training program that includes an obstetrics and gynecology program shall qualify for the period of board eligibility under subclause (I) if the other programs such resident combines with such obstetrics and gynecology program are for training a primary care resident.

(v) CHILD NEUROLOGY TRAINING PROGRAMS.—In the case of a resident enrolled in a child neurology residency training program, the period of board eligibility and the initial residency period shall be the period of board eligibility for pediatrics plus 2 years.

(H) PRIMARY CARE RESIDENT.—The term "primary care resident" means a resident enrolled in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or osteopathic general practice.

(I) RESIDENT.—The term "resident" includes an intern or other participant in an approved medical residency training program.

(J) ADJUSTMENTS FOR CERTAIN FAMILY PRACTICE RESIDENCY PROGRAMS.—

(i) IN GENERAL.—In the case of an approved medical residency training program (meeting the requirements of clause (ii)) of a hospital which received funds from the United States, a State, or a political subdivision of a State or an instrumentality of such a State or political subdivision (other than payments under this title or a State plan under title XIX) for the program during the cost reporting period that began during fiscal year 1984, the Secretary shall—

(I) provide for an average amount under paragraph (2)(A) that takes into account the Secretary's estimate of the amount that would have been recognized as reasonable under this title if the hospital had not received such funds, and

(II) reduce the payment amount otherwise provided under this subsection in an amount equal to the proportion of such program funds received during the cost reporting period involved that is allocable to this title.

(ii) ADDITIONAL REQUIREMENTS.—A hospital's approved medical residency program meets the requirements of this clause if—

(I) the program is limited to training for family and community medicine;

(II) the program is the only approved medical residency program of the hospital; and

(III) the average amount determined under paragraph (2)(A) for the hospital (as determined without regard to the increase in such amount described in clause (i)(I)) does not exceed $10,000.

(6) INCENTIVE PAYMENT UNDER PLANS FOR VOLUNTARY REDUCTION IN NUMBER OF RESIDENTS.—

(A) IN GENERAL.—In the case of a voluntary residency reduction plan for which an application is approved under subparagraph (B), subject to subparagraph (F), each hospital which is part of the qualifying entity submitting the plan shall be paid an applicable hold harmless percentage (as specified in subparagraph (E)) of the sum of—

(i) the amount (if any) by which—

(I) the amount of payment which would have been made under this subsection if there had been a 5–percent reduction in the number of full–time equivalent residents in the approved medical education training programs of the hospital as of June 30, 1997, exceeds

(II) the amount of payment which is made under this subsection, taking into account the reduction in such number effected under the reduction plan; and

(ii) the amount of the reduction in payment under subsection (d)(5)(B) for the hospital that is attributable to the reduction in number of residents effected under the plan below 95 percent of the number of full–time equivalent residents in such programs of the hospital as of June 30, 1997.

The determination of the amounts under clauses (i) and (ii) for any year shall be made on the basis of the provisions of this title in effect on the application deadline date for the first calendar year to which the reduction plan applies.

(B) APPROVAL OF PLAN APPLICATIONS.—The Secretary may not approve the application of an qualifying entity unless—

(i) the application is submitted in a form and manner specified by the Secretary and by not later than November 1, 1999,

(ii) the application provides for the operation of a plan for the reduction in the number of full–time equivalent residents in the approved medical residency training programs of the entity consistent with the requirements of subparagraph (D);

(iii) the entity elects in the application the period of residency training years (not greater than 5) over which the reduction will occur;

(iv) the entity will not reduce the proportion of its residents in primary care (to the total number of residents) below such proportion as in effect as of the applicable time described in subparagraph (D)(v); and

(v) the Secretary determines that the application and the entity and such plan meet such other requirements as the Secretary specifies in regulations.

(C) QUALIFYING ENTITY.—For purposes of this paragraph, any of the following may be a qualifying entity:

(i) Individual hospitals operating one or more approved medical residency training programs.

(ii) Two or more hospitals that operate such programs and apply for treatment under this paragraph as a single qualifying entity.

(iii) A qualifying consortium (as described in section 4628 of the Balanced Budget Act of 1997).

(D) RESIDENCY REDUCTION REQUIREMENTS.—

(i) INDIVIDUAL HOSPITAL APPLICANTS.—In the case of a qualifying entity described in subparagraph (C)(i), the number of full–time equivalent residents in all the approved medical residency training programs operated by or through the entity shall be reduced as follows:

(I) If the base number of residents exceeds 750 residents, by a number equal to at least 20 percent of such base number.

(II) Subject to subclause (IV), if the base number of residents exceeds 600 but is less than 750 residents, by 150 residents.

(III) Subject to subclause (IV), if the base number of residents does not exceed 600 residents, by a number equal to at least 25 percent of such base number.

(IV) In the case of a qualifying entity which is described in clause (v) and which elects treatment under this subclause, by a number equal to at least 20 percent of the base number.

(ii) JOINT APPLICANTS.—In the case of a qualifying entity described in subparagraph (C)(ii), the number of full–time equivalent residents in the aggregate for all the approved medical residency training programs operated by or through the entity shall be reduced as follows:

(I) Subject to subclause (II), by a number equal to at least 25 percent of the base number.

(II) In the case of such a qualifying entity which is described in clause (v) and which elects treatment under this subclause, by a number equal to at least 20 percent of the base number.

(iii) CONSORTIA.—In the case of a qualifying entity described in subparagraph (C)(iii), the number of full–time equivalent residents in the aggregate for all the approved medical residency training programs operated by or through the entity shall be reduced by a number equal to at least 20 percent of the base number.

(iv) MANNER OF REDUCTION.—The reductions specified under the preceding provisions of this subparagraph for a qualifying entity shall be below the base number of residents for that entity and shall be fully effective not later than the 5th residency training year in which the application under subparagraph (B) is effective.

(v) ENTITIES PROVIDING ASSURANCE OF INCREASE IN PRIMARY CARE RESIDENTS.—An entity is described in this clause if—

(I) the base number of residents for the entity is less than 750 or the entity is described in subparagraph (C)(ii); and

(II) the entity represents in its application under subparagraph (B) that it will increase the number of full–time equivalent residents in primary care by at least 20 percent (from such number included in the base number of residents) by not later than the 5th residency training year in which the application under subparagraph (B) is effective.

If a qualifying entity fails to comply with the representation described in subclause (II) by the end of such 5th residency training year, the entity shall be subject to repayment of all amounts paid under this paragraph, in accordance with procedures established to carry out subparagraph (F).

(vi) BASE NUMBER OF RESIDENTS DEFINED.—For purposes of this paragraph, the term "base number of residents" means, with respect to a qualifying entity (or its participating hospitals) operating approved medical residency training programs, the number of full–time equivalent residents in such programs (before application of weighting factors) of the entity as of the most recent residency training year ending before June 30, 1997, or, if less, for any subsequent residency training year that ends before the date the entity makes application under this paragraph.

(E) APPLICABLE HOLD HARMLESS PERCENTAGE.—For purposes of subparagraph (A), the "applicable hold harmless percentage" for the—

(i) first and second residency training years in which the reduction plan is in effect, 100 percent,

(ii) third such year, 75 percent,

(iii) fourth such year, 50 percent, and

(iv) fifth such year, 25 percent.

(F) PENALTY FOR NONCOMPLIANCE.—

(i) IN GENERAL.—No payment may be made under this paragraph to a hospital for a residency training year if the hospital has failed to reduce the number of full–time equivalent residents (in the manner required under subparagraph (D)) to the number agreed to by the Secretary and the qualifying entity in approving the application under this paragraph with respect to such year.

(ii) INCREASE IN NUMBER OF RESIDENTS IN SUBSEQUENT YEARS.—If payments are made under this paragraph to a hospital, and if the hospital increases the number of full–time equivalent residents above the number of such residents permitted under the reduction plan as of the completion of the plan, then, as specified by the Secretary, the entity is liable for re-

payment to the Secretary of the total amounts paid under this paragraph to the entity.

(G) TREATMENT OF ROTATING RESIDENTS.—In applying this paragraph, the Secretary shall establish rules regarding the counting of residents who are assigned to institutions the medical residency training programs in which are not covered under approved applications under this paragraph.

(7)[720] REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.—

(A) REDUCTION IN LIMIT BASED ON UNUSED POSITIONS—

(i) PROGRAMS SUBJECT TO REDUCTION.—

(I) IN GENERAL.—Except as provided in subclause (II), if a hospital's reference resident level (specified in clause (ii)) is less than the otherwise applicable resident limit (as defined in subparagraph (C)(ii)), effective for portions of cost reporting periods occurring on or after July 1, 2005, the otherwise applicable resident limit shall be reduced by 75 percent of the difference between such otherwise applicable resident limit and such reference resident level.

(II) EXCEPTION FOR SMALL RURAL HOSPITALS.—This subparagraph shall not apply to a hospital located in a rural area (as defined in subsection (d)(2)(D)(ii)) with fewer than 250 acute care inpatient beds.

(ii) REFERENCE RESIDENT LEVEL.—

(I) IN GENERAL.—Except as otherwise provided in subclauses (II) and (III), the reference resident level specified in this clause for a hospital is the resident level for the most recent cost reporting period of the hospital ending on or before September 30, 2002, for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

(II) USE OF MOST RECENT ACCOUNTING PERIOD TO RECOGNIZE EXPANSION OF EXISTING PROGRAMS.—If a hospital submits a timely request to increase its resident level due to an expansion of an existing residency training program that is not reflected on the most recent settled cost report, after audit and subject to the discretion of the Secretary, the reference resident level for such hospital is the resident level for the cost reporting period that includes July 1, 2003, as determined by the Secretary.

(III) Expansions under newly approved programs.—Upon the timely request of a hospital, the Secretary shall adjust the reference resident level specified under subclause (I) or (II) to include the number of medical residents that were approved in an application for a medical residency training program that was approved by an appropriate accrediting organization (as

[720] P.L. 108-173, §422(a)(3), added subparagraph (7), effective December 8, 2003.

determined by the Secretary) before January 1, 2002, but which was not in operation during the cost reporting period used under subclause (I) or (II), as the case may be, as determined by the Secretary.

(iii) AFFILIATION.—The provisions of clause (i) shall be applied to hospitals which are members of the same affiliated group (as defined by the Secretary under paragraph (4)(H)(ii)) as of July 1, 2003.

(B) REDISTRIBUTION.—

(i) IN GENERAL.—The Secretary is authorized to increase the otherwise applicable resident limit for each qualifying hospital that submits a timely application under this subparagraph by such number as the Secretary may approve for portions of cost reporting periods occurring on or after July 1, 2005. The aggregate number of increases in the otherwise applicable resident limits under this subparagraph may not exceed the Secretary's estimate of the aggregate reduction in such limits attributable to subparagraph (A).

(ii) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under clause (i), the Secretary shall take into account the demonstrated likelihood of the hospital filling the positions within the first 3 cost reporting periods beginning on or after July 1, 2005, made available under this subparagraph, as determined by the Secretary.

(iii) PRIORITY FOR RURAL AND SMALL URBAN AREAS.—In determining for which hospitals and residency training programs an increase in the otherwise applicable resident limit is provided under clause (i), the Secretary shall distribute the increase to programs of hospitals located in the following priority order:

(I) First, to hospitals located in rural areas (as defined in subsection (d)(2)(D)(ii)).

(II) Second, to hospitals located in urban areas that are not large urban areas (as defined for purposes of subsection (d)).

(III) Third, to other hospitals in a State if the residency training program involved is in a specialty for which there are not other residency training programs in the State. Increases of residency limits within the same priority category under this clause shall be determined by the Secretary.

(iv) LIMITATION.—In no case shall more than 25 full-time equivalent additional residency positions be made available under this subparagraph with respect to any hospital.

(v) APPLICATION OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—With respect to additional residency positions in a hospital attributable to the increase provided under this subparagraph, notwithstanding any other provision of this subsection, the approved FTE resident amount is deemed to be

equal to the locality adjusted national average per resident amount computed under paragraph (4)(E) for that hospital.

(vi) CONSTRUCTION.—Nothing in this subparagraph shall be construed as permitting the redistribution of reductions in residency positions attributable to voluntary reduction programs under paragraph (6), under a demonstration project approved as of October 31, 2003, under the authority of section 402 of Public Law 90-248, or as affecting the ability of a hospital to establish new medical residency training programs under paragraph (4)(H).

(C) RESIDENT LEVEL AND LIMIT DEFINED.—In this paragraph:

(i) RESIDENT LEVEL.—The term "resident level" means, with respect to a hospital, the total number of full-time equivalent residents, before the application of weighting factors (as determined under paragraph (4)), in the fields of allopathic and osteopathic medicine for the hospital.

(ii) OTHERWISE APPLICABLE RESIDENT LIMIT.—The term "otherwise applicable resident limit" means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph.

(D) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, with respect to determinations made under this paragraph..

(i) AVOIDING DUPLICATIVE PAYMENTS TO HOSPITALS PARTICIPATING IN RURAL DEMONSTRATION PROGRAMS.—The Secretary shall reduce any payment amounts otherwise determined under this section to the extent necessary to avoid duplication of any payment made under section 4005(e) of the Omnibus Budget Reconciliation Act of 1987 [721].

(j) PROSPECTIVE PAYMENT FOR INPATIENT REHABILITATION SERVICES.—

(1) PAYMENT DURING TRANSITION PERIOD.—

(A) IN GENERAL.—Notwithstanding section 1814(b), but subject to the provisions of section 1813, the amount of the payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation hospital or a rehabilitation unit (in this subsection referred to as a "rehabilitation facility"), other than a facility making an election under subparagraph (F) in a cost reporting period beginning on or after October 1, 2000, and before October 1, 2002, is equal to the sum of—

(i) the TEFRA percentage (as defined in subparagraph (C)) of the amount that would have been paid under part A with respect to such costs if this subsection did not apply, and

(ii) prospective payment percentage (as defined in subparagraph (C)) of the product of (I) the per unit

[721] See Vol. II, P.L. 100–203, §4005(e).

payment rate established under this subsection for the fiscal year in which the payment unit of service occurs, and (II) the number of such payment units occurring in the cost reporting period.

(B) FULLY IMPLEMENTED SYSTEM.—Notwithstanding section 1814(b), but subject to the provisions of section 1813, the amount of the payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation facility for a payment unit in a cost reporting period beginning on or after October 1, 2002, or, in the case of a facility making an election under subparagraph (F), for any cost reporting period described in such subparagraph, is equal to the per unit payment rate established under this subsection for the fiscal year in which the payment unit of service occurs.

(C) TEFRA AND PROSPECTIVE PAYMENT PERCENTAGES SPECIFIED.—For purposes of subparagraph (A), for a cost reporting period beginning—

(i) on or after October 1, 2000, and before October 1, 2001, the "TEFRA percentage" is 66 ⅔ percent and the "prospective payment percentage" is 33 ⅓ percent; and

(ii) on or after October 1, 2001, and before October 1, 2002, the "TEFRA percentage" is 33 ⅓ percent and the "prospective payment percentage" is 66 ⅔ percent.

(D) PAYMENT UNIT.—For purposes of this subsection, the term "payment unit" means a discharge.

(E) CONSTRUCTION RELATING TO TRANSFER AUTHORITY.—Nothing in this subsection shall be construed as preventing the Secretary from providing for an adjustment to payments to take into account the early transfer of a patient from a rehabilitation facility to another site of care.

(F) ELECTION TO APPLY FULL PROSPECTIVE PAYMENT SYSTEM.—A rehabilitation facility may elect, not later than 30 days before its first cost reporting period for which the payment methodology under this subsection applies to the facility, to have payment made to the facility under this subsection under the provisions of subparagraph (B) (rather than subparagraph (A)) for each cost reporting period to which such payment methodology applies.

(2) PATIENT CASE MIX GROUPS.—

(A) ESTABLISHMENT.—The Secretary shall establish—

(i) classes of patient discharges of rehabilitation facilities by functional–related groups (each in this subsection referred to as a "case mix group"), based on impairment, age, comorbidities, and functional capability of the patient and such other factors as the Secretary deems appropriate to improve the explanatory power of functional independence measure–function related groups; and

(ii) a method of classifying specific patients in rehabilitation facilities within these groups.

(B) WEIGHTING FACTORS.—For each case mix group the Secretary shall assign an appropriate weighting which reflects the relative facility resources used with respect to

patients classified within that group compared to patients classified within other groups.

(C) ADJUSTMENTS FOR CASE MIX.—

(i) IN GENERAL.—The Secretary shall from time to time adjust the classifications and weighting factors established under this paragraph as appropriate to reflect changes in treatment patterns, technology, case mix, number of payment units for which payment is made under this title, and other factors which may affect the relative use of resources. Such adjustments shall be made in a manner so that changes in aggregate payments under the classification system are a result of real changes and are not a result of changes in coding that are unrelated to real changes in case mix.

(ii) ADJUSTMENT.—Insofar as the Secretary determines that such adjustments for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under the classification system during the fiscal year that are a result of changes in the coding or classification of patients that do not reflect real changes in case mix, the Secretary shall adjust the per payment unit payment rate for subsequent years so as to eliminate the effect of such coding or classification changes.

(D) DATA COLLECTION.—The Secretary is authorized to require rehabilitation facilities that provide inpatient hospital services to submit such data as the Secretary deems necessary to establish and administer the prospective payment system under this subsection.

(3) PAYMENT RATE.—

(A) IN GENERAL.—The Secretary shall determine a prospective payment rate for each payment unit for which such rehabilitation facility is entitled to receive payment under this title. Subject to subparagraph (B), such rate for payment units occurring during a fiscal year shall be based on the average payment per payment unit under this title for inpatient operating and capital costs of rehabilitation facilities using the most recent data available (as estimated by the Secretary as of the date of establishment of the system) adjusted—

(i) by updating such per–payment–unit amount to the fiscal year involved by the weighted average of the applicable percentage increases provided under subsection (b)(3)(B)(ii) (for cost reporting periods beginning during the fiscal year) covering the period from the midpoint of the period for such data through the midpoint of fiscal year 2000 and by an increase factor (described in subparagraph (C)) specified by the Secretary for subsequent fiscal years up to the fiscal year involved;

(ii) by reducing such rates by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary) based on prospective payment amounts which are additional payments described in

paragraph (4) (relating to outlier and related payments);

(iii) for variations among rehabilitation facilities by area under paragraph (6);

(iv) by the weighting factors established under paragraph (2)(B); and

(v) by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities.

(B) BUDGET NEUTRAL RATES.—The Secretary shall establish the prospective payment amounts under this subsection for payment units during fiscal years 2001 and 2002 at levels such that, in the Secretary's estimation, the amount of total payments under this subsection for such fiscal years (including any payment adjustments pursuant to paragraphs (4) and (6) but not taking into accounting any payment adjustment resulting from an election permitted under paragraph (i)(F)) shall be equal to 98 percent of the amount of payments that would have been made under this title during the fiscal years for operating and capital costs of rehabilitation facilities had this subsection not been enacted. In establishing such payment amounts, the Secretary shall consider the effects of the prospective payment system established under this subsection on the total number of payment units from rehabilitation facilities and other factors described in subparagraph (A).

(C) INCREASE FACTOR.—For purposes of this subsection for payment units in each fiscal year (beginning with fiscal year 2001), the Secretary shall establish an increase factor. Such factor shall be based on an appropriate percentage increase in a market basket of goods and services comprising services for which payment is made under this subsection, which may be the market basket percentage increase described in subsection (b)(3)(B)(iii).

(4) OUTLIER AND SPECIAL PAYMENTS.—

(A) OUTLIERS.—

(i) IN GENERAL.—The Secretary may provide for an additional payment to a rehabilitation facility for patients in a case mix group, based upon the patient being classified as an outlier based on an unusual length of stay, costs, or other factors specified by the Secretary.

(ii) PAYMENT BASED ON MARGINAL COST OF CARE.—The amount of such additional payment under clause (i) shall be determined by the Secretary and shall approximate the marginal cost of care beyond the cutoff point applicable under clause (i).

(iii) TOTAL PAYMENTS.—The total amount of the additional payments made under this subparagraph for payment units in a fiscal year may not exceed 5 percent of the total payments projected or estimated to be made based on prospective payment rates for payment units in that year.

(B) ADJUSTMENT.—The Secretary may provide for such adjustments to the payment amounts under this sub-

section as the Secretary deems appropriate to take into account the unique circumstances of rehabilitation facilities located in Alaska and Hawaii.

(5) PUBLICATION.—The Secretary shall provide for publication in the Federal Register, on or before August 1 before each fiscal year (beginning with fiscal year 2001), of the classification and weighting factors for case mix groups under paragraph (2) for such fiscal year and a description of the methodology and data used in computing the prospective payment rates under this subsection for that fiscal year.

(6) AREA WAGE ADJUSTMENT.—The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of rehabilitation facilities' costs which are attributable to wages and wage–related costs, of the prospective payment rates computed under paragraph (3) for area differences in wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for such facilities. Not later than October 1, 2001 (and at least every 36 months thereafter), the Secretary shall update the factor under the preceding sentence on the basis of information available to the Secretary (and updated as appropriate) of the wages and wage–related costs incurred in furnishing rehabilitation services. Any adjustments or updates made under this paragraph for a fiscal year shall be made in a manner that assures that the aggregated payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment.

(7) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of the establishment of—

(A) case mix groups, of the methodology for the classification of patients within such groups, and of the appropriate weighting factors thereof under paragraph (2),

(B) the prospective payment rates under paragraph (3),

(C) outlier and special payments under paragraph (4), and

(D) area wage adjustments under paragraph (6).

(k) PAYMENT TO NONHOSPITAL PROVIDERS.—

(1) IN GENERAL.—For cost reporting periods beginning on or after October 1, 1997, the Secretary may establish rules for payment to qualified nonhospital providers for their direct costs of medical education, if those costs are incurred in the operation of an approved medical residency training program described in subsection (h). Such rules shall specify the amounts, form, and manner in which such payments will be made and the portion of such payments that will be made from each of the trust funds under this title.

(2) QUALIFIED NONHOSPITAL PROVIDERS.—For purposes of this subsection, the term "qualified nonhospital providers" means—

(A) a Federally qualified health center, as defined in section 1861(aa)(4);

(B) a rural health clinic, as defined in section 1861(aa)(2);

(C) Medicare+Choice organizations; and

(D) such other providers (other than hospitals) as the Secretary determines to be appropriate.

(l)[722] PAYMENT FOR NURSING AND ALLIED HEALTH EDUCATION FOR MANAGED CARE ENROLLEES.—

(1) IN GENERAL.—For portions of cost reporting periods occurring in a year (beginning with 2000), the Secretary shall provide for an additional payment amount for any hospital that receives payments for the costs of approved educational activities for nurse and allied health professional training under section 1861(v)(1).

(2) PAYMENT AMOUNT.—The additional payment amount under this subsection for each hospital for portions of cost reporting periods occurring in a year shall be an amount specified by the Secretary in a manner consistent with the following:

(A) DETERMINATION OF MANAGED CARE ENROLLEE PAYMENT RATIO FOR GRADUATE MEDICAL EDUCATION PAYMENTS.—The Secretary shall estimate the ratio of payments for all hospitals for portions of cost reporting periods occurring in the year under subsection (h)(3)(D) to total direct graduate medical education payments estimated for such portions of periods under subsection (h)(3).

(B) APPLICATION TO FEE-FOR-SERVICE NURSING AND ALLIED HEALTH EDUCATION PAYMENTS.—Such ratio shall be applied to the Secretary's estimate of total payments for nursing and allied health education determined under section 1861(v) for portions of cost reporting periods occurring in the year to determine a total amount of additional payments for nursing and allied health education to be distributed to hospitals under this subsection for portions of cost reporting periods occurring in the year; except that in no case shall such total amount exceed $60,000,000 in any year.

(C) APPLICATION TO HOSPITAL.—The amount of payment under this subsection to a hospital for portions of cost reporting periods occurring in a year is equal to the total amount of payments determined under subparagraph (B) for the year multiplied by the ratio of—[723]

(i) the product of (I) the Secretary's estimate of the ratio of the amount of payments made under section 1861(v) to the hospital for nursing and allied health education activities for the hospital's cost reporting period ending in the second preceding fiscal year, to the hospital's total inpatient days for such period, and (II) the total number of inpatient days (as established by the Secretary) for such period which are attributable to services furnished to individuals who are enrolled under a risk sharing contract with an eligible organization under section 1876 and who are entitled to ben-

[722] P.L. 106-113, §1000(a)(6), Appendix F, Subtitle D, §541(a), added subsection (l), effective November 29, 1999.

[723] P.L. 106-554, Appendix F, §1(a)(6)[512(a)], struck out "by the Secretary's estimate of the ratio of the amount of payments made under section 1861(v) to the hospital for nursing and allied health education activities for the hospital's cost reporting period ending in the second preceding fiscal year to the total of such amounts for all hospitals for such cost reporting periods." and substituted "the ratio of—" and clauses (i) and (ii), applicable to portions of cost reporting periods occurring on or after January 1, 2001.

efits under part A or who are enrolled with a Medicare+Choice organization under part C; to

(ii) the sum of the products determined under clause (i) for such cost reporting periods.

PAYMENT OF PROVIDER-BASED PHYSICIANS AND PAYMENT UNDER CERTAIN PERCENTAGE ARRANGEMENTS

SEC. 1887. [42 U.S.C. 1395xx] (a)(1) The Secretary shall by regulation determine criteria for distinguishing those services (including inpatient and outpatient services) rendered in hospitals or skilled nursing facilities—

(A) which constitute professional medical services, which are personally rendered for an individual patient by a physician and which contribute to the diagnosis or treatment of an individual patient, and which may be reimbursed as physicians' services under part B, and

(B) which constitute professional services which are rendered for the general benefit to patients in a hospital or skilled nursing facility and which may be reimbursed only on a reasonable cost basis or on the bases described in section 1886.

(2)(A) For purposes of cost reimbursement, the Secretary shall recognize as a reasonable cost of a hospital or skilled nursing facility only that portion of the costs attributable to services rendered by a physician in such hospital or facility which are services described in paragraph (1)(B), apportioned on the basis of the amount of time actually spent by such physician rendering such services.

(B) In determining the amount of the payments which may be made with respect to services described in paragraph (1)(B), after apportioning costs as required by subparagraph (A), the Secretary may not recognize as reasonable (in the efficient delivery of health services) such portion of the provider's costs for such services to the extent that such costs exceed the reasonable compensation equivalent for such services. The reasonable compensation equivalent for any service shall be established by the Secretary in regulations.

(C) The Secretary may, upon a showing by a hospital or facility that it is unable to recruit or maintain an adequate number of physicians for the hospital or facility on account of the reimbursement limits established under this subsection, grant exceptions to such reimbursement limits as may be necessary to allow such provider to provide a compensation level sufficient to provide adequate physician services in such hospital or facility.

(b)(1) Except as provided in paragraph (2), in the case of a provider of services which is paid under this title on a reasonable cost basis, or other basis related to costs that are reasonable, and which has entered into a contract for the purpose of having services furnished for or on behalf of it, the Secretary may not include any cost incurred by the provider under the contract if the amount payable under the contract by the provider for that cost is determined on the basis of a percentage (or other proportion) of the provider's charges, revenues, or claim for reimbursement.

(2) Paragraph (1) shall not apply—

(A) to services furnished by a physician and described in subsection (a)(1)(B) and covered by regulations in effect under subsection (a), and

(B) under regulations established by the Secretary, where the amount involved under the percentage contract is reasonable and the contract—

(i) is a customary commercial business practice, or

(ii) provides incentives for the efficient and economical operation of the provider of services.

PAYMENT TO SKILLED NURSING FACILITIES FOR ROUTINE SERVICE COSTS [724]

SEC. 1888. [42 U.S.C. 1395yy] (a) The Secretary, in determining the amount of the payments which may be made under this title with respect to routine service costs of extended care services shall not recognize as reasonable (in the efficient delivery of health services) per diem costs of such services to the extent that such per diem costs exceed the following per diem limits, except as otherwise provided in this section:

(1) With respect to freestanding skilled nursing facilities located in urban areas, the limit shall be equal to 112 percent of the mean per diem routine service costs for freestanding skilled nursing facilities located in urban areas.

(2) With respect to freestanding skilled nursing facilities located in rural areas, the limit shall be equal to 112 percent of the mean per diem routine service costs for freestanding skilled nursing facilities located in rural areas.

(3) With respect to hospital-based skilled nursing facilities located in urban areas, the limit shall be equal to the sum of the limit for freestanding skilled nursing facilities located in urban areas, plus 50 percent of the amount by which 112 percent of the mean per diem routine service costs for hospital-based skilled nursing facilities located in urban areas exceeds the limit for freestanding skilled nursing facilities located in urban areas.

(4) With respect to hospital-based skilled nursing facilities located in rural areas, the limit shall be equal to the sum of the limit for freestanding skilled nursing facilities located in rural areas, plus 50 percent of the amount by which 112 percent of the mean per diem routine service costs for hospital-based skilled nursing facilities located in rural areas exceeds the limit for freestanding skilled nursing facilities located in rural areas. [725]

In applying this subsection the Secretary shall make appropriate adjustments to the labor related portion of the costs based upon an appropriate wage index, and shall, for cost reporting periods begin-

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[724] See Vol. II, P.L. 103–66, §13503(a)(1), with respect to cost limits; and §13503(b), with respect to payments determined on a prospective basis.

See Vol. II, P.L. 105–33, §4432(c), with respect to a medical review process.

See Vol. II, P.L. 106–113, §1000(a)(6)[101], with respect to a temporary increase in payment for certain high cost patients; [105(c)], with respect to a report to Congress regarding the resource use of patients of skilled nursing facilities.

See Vol. II, P.L. 106–554, §1(a)(6)[311(b)], with respect to a special rule for payment for fiscal year 2001; [311(d)], with respect to a GAO report on adequacy of SNF payment rates; [311(e)], with respect to a HCFA study of classification systems for SNF residents; [312(b)] with respect to a GAO audit of nursing staff ratios; [313(d)] with respect to oversight of payments; [315], with respect to the establishment of a process for geographic reclassification; and [547(b)], with respect to temporary payment increases to skilled nursing facility services.

See Vol. II, P.L. 108-173, §513, with respect to a study on portable diagnostic ultrasound services for beneficiaries in skilled nursing facilities.

[725] See Vol. II, P.L. 103–432, §106(a), with respect to construction of a skilled nursing facility wage index adjustment to the routine service cost limits.

ning on or after October 1, 1992, on or after October 1, 1995, and every 2 years thereafter, provide for an update to the per diem cost limits described in this subsection, except that the limits effective for cost reporting periods beginning on or after October 1, 1997, shall be based on the limits effective for cost reporting periods beginning on or after October 1, 1996.

(b) With respect to a hospital-based skilled nursing facility, the Secretary may not recognize as reasonable the portion of the cost differences between hospital-based and freestanding skilled nursing facilities attributable to excess overhead allocations.

(c) The Secretary may make adjustments in the limits set forth in subsection (a) with respect to any skilled nursing facility to the extent the Secretary deems appropriate, based upon case mix or circumstances beyond the control of the facility. The Secretary shall publish the data and criteria to be used for purposes of this subsection on an annual basis.

(d)(1)[726] Subject to subsection (c), any skilled nursing facility may choose to be paid under this subsection on the basis of a prospective payment for all routine service costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this title) and capital-related costs of extended care services provided in a cost reporting period if such facility had, in the preceding cost reporting period, fewer than 1,500 patient days with respect to which payments were made under this title. Such prospective payment shall be in lieu of payments which would otherwise be made for routine service costs pursuant to section 1861(v) and subsections (a) through (c) of this section and capital-related costs pursuant to section 1861(v). This subsection shall not apply to a facility for any cost reporting period immediately following a cost reporting period in which such facility had 1,500 or more patient days with respect to which payments were made under this title, without regard to whether payments were made under this subsection during such preceding cost reporting period.

(2)(A) The amount of the payment under this section shall be determined on a per diem basis.

(B) Subject to the limitations of subparagraph (C), for skilled nursing facilities located—

(i) in an urban area, the amount shall be equal to 105 percent of the mean of the per diem reasonable routine service and capital-related costs of extended care services for skilled nursing facilities in urban areas within the same region, determined without regard to the limitations of subsection (a) and adjusted for different area wage levels, and

(ii) in a rural area the amount shall be equal to 105 percent of the mean of the per diem reasonable routine service and capital-related costs of extended care services for skilled nursing facilities in rural areas within the same region, determined without regard to the limitations of subsection (a) and adjusted for different area wage levels.

[726] See Vol. II, P.L. 103–66, §13503(b), with respect to payments determined on prospective basis.

(C) The per diem amounts determined under subparagraph (B) shall not exceed the limit on routine service costs determined under subsection (a) with respect to the facility, adjusted to take into account average capital-related costs with respect to the type and location of the facility.

(3) For purposes of this subsection, urban and rural areas shall be determined in the same manner as for purposes of subsection (a), and the term "region" shall have the same meaning as under section 1886(d)(2)(D).

(4) The Secretary shall establish the prospective payment amounts for cost reporting periods beginning in a fiscal year at least 90 days prior to the beginning of such fiscal year, on the basis of the most recent data available for a 12-month period. A skilled nursing facility must notify the Secretary of its intention to be paid pursuant to this subsection for a cost reporting period no later than 30 days before the beginning of that period.

(5) The Secretary shall provide for a simplified cost report to be filed by facilities being paid pursuant to this subsection, which shall require only the cost information necessary for determining prospective payment amounts pursuant to paragraph (2) and reasonable costs of ancillary services.

(6) In lieu of payment on a cost basis for ancillary services provided by a facility which is being paid pursuant to this subsection, the Secretary may pay for such ancillary services on a reasonable charge basis if the Secretary determines that such payment basis will provide an equitable level of reimbursement and will ease the reporting burden of the facility.

(7) In computing the rates of payment to be made under this subsection, there shall be taken into account the costs described in the last sentence of section 1861(v)(1)(E) (relating to compliance with nursing facility requirements and of conducting nurse aide training and competency evaluation programs and competency evaluation programs).

(e) PROSPECTIVE PAYMENT.—

(1) PAYMENT PROVISION.—Notwithstanding any other provision of this title, subject to paragraph (7), (11) and (12), the amount of the payment for all costs (as defined in paragraph (2)(B)) of covered skilled nursing facility services (as defined in paragraph (2)(A)) for each day of such services furnished—

(A) in a cost reporting period during the transition period (as defined in paragraph (2)(E)), is equal to the sum of—

(i) the non–Federal percentage of the facility–specific per diem rate (computed under paragraph (3)), and

(ii) the Federal percentage of the adjusted Federal per diem rate (determined under paragraph (4)) applicable to the facility; and

(B) after the transition period is equal to the adjusted Federal per diem rate applicable to the facility.

(2) DEFINITIONS.—For purposes of this subsection:

(A) COVERED SKILLED NURSING FACILITY SERVICES.—

(i) IN GENERAL.—The term "covered skilled nursing facility services"—

(I) means post–hospital extended care services as defined in section 1861(i) for which benefits are provided under part A; and

(II) includes all items and services (other than items and services described in clause (ii), (iii), and (iv)[727] for which payment may be made under part B and which are furnished to an individual who is a resident of a skilled nursing facility during the period in which the individual is provided covered post–hospital extended care services.

(ii) SERVICES EXCLUDED.—Services described in this clause are physicians' services, services described by clauses (i) and (ii) of section 1861(s)(2)(K), certified nurse–midwife services, qualified psychologist services, services of a certified registered nurse anesthetist, items and services described in subparagraphs (F) and (O) of section 1861(s)(2), and, only with respect to services furnished during 1998, the transportation costs of electrocardiogram equipment for electrocardiogram test services (HCPCS Code R0076). Services described in this clause do not include any physical, occupational, or speech–language therapy services regardless of whether or not the services are furnished by, or under the supervision of, a physician or other health care professional.

(iii) EXCLUSION OF CERTAIN ADDITIONAL ITEMS AND SERVICES.— Items and services described in this clause are the following:

(I) Ambulance services furnished to an individual in conjunction with renal dialysis services described in section 1861(s)(2)(F).

(II) Chemotherapy items (identified as of July 1, 1999, by HCPCS codes J9000–J9020; J9040–J9151; J9170–J9185; J9200–J9201; J9206–J9208; J9211; J9230–J9245; and J9265–J9600 (and as subsequently modified by the Secretary)) and any additional chemotherapy items identified by the Secretary.

(III) Chemotherapy administration services (identified as of July 1, 1999, by HCPCS codes 36260–36262; 36489;36530–36535; 36640; 36823; and 96405–96542 (and as subsequently modified by the Secretary)) and any additional chemotherapy administration services identified by the Secretary.

(IV) Radioisotope services (identified as of July 1, 1999, by HCPCS codes 79030–79440 (and as subsequently modified by the Secretary)) and any additional radioisotope services identified by the Secretary.

(V) Customized prosthetic devices (commonly known as artificial limbs or components of

[727] P.L. 108-173, §410(a)(1), struck out "clauses (ii) and (iii)" and substituted "clauses (ii), (iii), and (iv)", applicable to services furnished on or after January 1, 2005.

artificial limbs) under the following HCPCS codes (as of July 1, 1999 (and as subsequently modified by the Secretary)), and any additional customized prosthetic devices identified by the Secretary, if delivered to an inpatient for use during the stay in the skilled nursing facility and intended to be used by the individual after discharge from the facility: L5050–L5340; L5500–L5611; L5613–L5986; L5988; L6050–L6370; L6400–L6880; L6920–L7274; and L7362–7366.

(iv)[728] Exclusion of certain rural health clinic and federally qualified health center services.—Services described in this clause are—

(I) rural health clinic services (as defined in paragraph (1) of section 1861(aa)); and

(II) federally qualified health center services (as defined in paragraph (3) of such section);

that would be described in clause (ii) if such services were furnished by an individual not affiliated with a rural health clinic or a federally qualified health center.

(B) ALL COSTS.—The term "all costs" means routine service costs, ancillary costs, and capital–related costs of covered skilled nursing facility services, but does not include costs associated with approved educational activities.

(C) NON–FEDERAL PERCENTAGE; FEDERAL PERCENTAGE.—For—

(i) the first cost reporting period (as defined in subparagraph (D)) of a facility, the "non–Federal percentage" is 75 percent and the "Federal percentage" is 25 percent;

(ii) the next cost reporting period of such facility, the "non–Federal percentage" is 50 percent and the "Federal percentage" is 50 percent; and

(iii) the subsequent cost reporting period of such facility, the "non–Federal percentage" is 25 percent and the "Federal percentage" is 75 percent.

(D) FIRST COST REPORTING PERIOD.—The term "first cost reporting period" means, with respect to a skilled nursing facility, the first cost reporting period of the facility beginning on or after July 1, 1998.

(E) TRANSITION PERIOD.—

(i) IN GENERAL.—The term "transition period" means, with respect to a skilled nursing facility, the 3 cost reporting periods of the facility beginning with the first cost reporting period.

(ii) TREATMENT OF NEW SKILLED NURSING FACILITIES.—In the case of a skilled nursing facility that first received payment for services under this title on or after October 1, 1995, payment for such services shall be made under this subsection as if all services were furnished after the transition period.

[728] P.L. 108-173, 410(a)(2), added clause (iv), applicable to services furnished on or after January 1, 2005.

(3) DETERMINATION OF FACILITY SPECIFIC PER DIEM RATES.—The Secretary shall determine a facility–specific per diem rate for each skilled nursing facility not described in paragraph (2)(E)(ii) for a cost reporting period as follows:

(A) DETERMINING BASE PAYMENTS.—The Secretary shall determine, on a per diem basis, the total of—

(i) the allowable costs of extended care services for the facility for cost reporting periods beginning in fiscal year 1995, including costs associated with facilities described in subsection (d), with appropriate adjustments (as determined by the Secretary) to non–settled cost reports or, in the case of a facility partipating in the Nursing Home Case–Mix and Quality Demonstration (RUGS–III), the RUGS–III rate received by the facility during the cost reporting period beginning in 1997, and

(ii) an estimate of the amounts that would be payable under part B (disregarding any applicable deductibles, coinsurance, and copayments) for covered skilled nursing facility services described in paragraph (2)(A)(i)(II) the applicable cost reporting period described in clause (i) to an individual who is a resident of the facility, regardless of whether or not the payment was made to the facility or to another entity.

In making appropriate adjustments under clause (i), the Secretary shall take into account exceptions and shall take into account exemptions but, with respect to exemptions, only to the extent that routine costs do not exceed 150 percent of the routine cost limits otherwise applicable but for the exemption.

(B) UPDATE TO FIRST COST REPORTING PERIOD.—The Secretary shall update the amount determined under subparagraph (A), for each cost reporting period after the applicable cost reporting period described in subparagraph (A)(i) and up to the first cost reporting period by a factor equal to the skilled nursing facility market basket percentage increase minus 1.0 percentage point.

(C) UPDATING TO APPLICABLE COST REPORTING PERIOD.—The Secretary shall update the amount determined under subparagraph (B) for each cost reporting period beginning with the first cost reporting period and up to and including the cost reporting period involved by a factor equal to the facility–specific update factor.

(D) FACILITY–SPECIFIC UPDATE FACTOR.—For purposes of this paragraph, the "facility–specific update factor" for cost reporting periods beginning during—

(i) during each of fiscal years 1998 and 1999, is equal to the skilled nursing facility market basket percentage increase for such fiscal year minus 1 percentage point, and

(ii) during each subsequent fiscal year is equal to the skilled nursing facility market basket percentage increase for such fiscal year.

(4) FEDERAL PER DIEM RATE.—

(A) DETERMINATION OF HISTORICAL PER DIEM FOR FACILITIES.–For each skilled nursing facility that received pay-

ments for post–hospital extended care services during a cost reporting period beginning in fiscal year 1995 and that was subject to (and not exempted from) the per diem limits referred to in paragraph (1) or (2) of subsection (a) (and facilities described in subsection (d)), the Secretary shall estimate, on a per diem basis for such cost reporting period, the total of—

(i) the allowable costs of extended care services (excluding exceptions payments) for the facility for cost reporting periods beginning in 1995 with appropriate adjustments (as determined by the Secretary) to non–settled cost reports, and

(ii) an estimate of the amounts that would be payable under part B (disregarding any applicable deductibles, coinsurance, and copayments) for covered skilled nursing facility services described in paragraph (2)(A)(i)(II) furnished during such period to an individual who is a resident of the facility, regardless of whether or not the payment was made to the facility or to another entity.

(B) UPDATE TO FIRST FISCAL YEAR.—The Secretary shall update the amount determined under subparagraph (A), for each cost reporting period after the cost reporting period described in subparagraph (A)(i) and up to the first cost reporting period by a factor equal to the skilled nursing facility market basket percentage increase reduced (on an annualized basis) by 1 percentage point.

(C) COMPUTATION OF STANDARDIZED PER DIEM RATE.—The Secretary shall standardize the amount updated under subparagraph (B) for each facility by—

(i) adjusting for variations among facilities by area in the average facility wage level per diem, and

(ii) adjusting for variations in case mix per diem among facilities.

(D) COMPUTATION OF WEIGHTED AVERAGE PER DIEM RATES.—

(i) ALL FACILITIES.—The Secretary shall compute a weighted average per diem rate for all facilities by computing an average of the standardized amounts computed under subparagraph (C), weighted for each facility by the number of days of extended care services furnished during the cost reporting period referred to in subparagraph (A).

(ii) FREESTANDING FACILITIES.—The Secretary shall compute a weighted average per diem rate for freestanding facilities by computing an average of the standardized amounts computed under subparagraph (C) only for such facilities, weighted for each facility by the number of days of extended care services furnished during the cost reporting period referred to in subparagraph (A).

(iii) SEPARATE COMPUTATION.—The Secretary may compute and apply such averages separately for facilities located in urban and rural areas (as defined in section 1886(d)(2)(D)).

(E) UPDATING.—

(i) INITIAL PERIOD.—For the initial period beginning on July 1, 1998, and ending on September 30, 1999, the Secretary shall compute for skilled nursing facilities an unadjusted Federal per diem rate equal to the average of the weighted average per diem rates computed under clauses (i) and (ii) of subparagraph (D), increased by skilled nursing facility market basket percentage change for such period minus 1 percentage point.

(ii) SUBSEQUENT FISCAL YEARS.—The Secretary shall compute an unadjusted Federal per diem rate equal to the Federal per diem rate computed under this subparagraph—

(I) for fiscal year 2000, the rate computed for the initial period described in clause (i), increased by the skilled nursing facility market basket percentage change for the initial period minus 1 percentage point;

(II) for fiscal year 2001, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year;

(III) for each of fiscal years 2002 and 2003, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year involved minus 0.5 percentage points; and

(IV) for each subsequent fiscal year, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year involved.

(F) ADJUSTMENT FOR CASE MIX CREEP.—Insofar as the Secretary determines that the adjustments under subparagraph (G)(i) for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under this subsection during the fiscal year that are a result of changes in the coding or classification of residents that do not reflect real changes in case mix, the Secretary may adjust unadjusted Federal per diem rates for subsequent fiscal years so as to eliminate the effect of such coding or classification changes.

(G) DETERMINATION OF FEDERAL RATE.—The Secretary shall compute for each skilled nursing facility for each fiscal year (beginning with the initial period described in subparagraph (E)(i)) an adjusted Federal per diem rate equal to the unadjusted Federal per diem rate determined under subparagraph (E), as adjusted under subparagraph (F), and as further adjusted as follows:

(i) ADJUSTMENT FOR CASE MIX.—The Secretary shall provide for an appropriate adjustment to account for case mix. Such adjustment shall be based on a resident classification system, established by the Secretary, that accounts for the relative resource utilization of different patient types. The case mix adjust-

ment shall be based on resident assessment data and other data that the Secretary considers appropriate.

(ii) ADJUSTMENT FOR GEOGRAPHIC VARIATIONS IN LABOR COSTS.—The Secretary shall adjust the portion of such per diem rate attributable to wages and wage–related costs for the area in which the facility is located compared to the national average of such costs using an appropriate wage index as determined by the Secretary. Such adjustment shall be done in a manner that does not result in aggregate payments under this subsection that are greater or less than those that would otherwise be made if such adjustment had not been made.

(iii) ADJUSTMENT FOR EXCLUSION OF CERTAIN ADDITIONAL ITEMS AND SERVICES.—The Secretary shall provide for an appropriate proportional reduction in payments so that beginning with fiscal year 2001, the aggregate amount of such reductions is equal to the aggregate increase in payments attributable to the exclusion effected under clause (iii) of paragraph (2)(A).

(H) PUBLICATION OF INFORMATION ON PER DIEM RATES.—The Secretary shall provide for publication in the Federal Register, before May 1, 1998 (with respect to fiscal period described in subparagraph (E)(i)) and before the August 1 preceding each succeeding fiscal year (with respect to that succeeding fiscal year), of—

(i) the unadjusted Federal per diem rates to be applied to days of covered skilled nursing facility services furnished during the fiscal year,

(ii) the case mix classification system to be applied under subparagraph (G)(i) with respect to such services during the fiscal year, and

(iii) the factors to be applied in making the area wage adjustment under subparagraph (G)(ii) with respect to such services.

(5) SKILLED NURSING FACILITY MARKET BASKET INDEX AND PERCENTAGE.—For purposes of this subsection:

(A) SKILLED NURSING FACILITY MARKET BASKET INDEX.—The Secretary shall establish a skilled nursing facility market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered skilled nursing facility services.

(B) SKILLED NURSING FACILITY MARKET BASKET PERCENTAGE.–The term "skilled nursing facility market basket percentage" means, for a fiscal year or other annual period and as calculated by the Secretary, the percentage change in the skilled nursing facility market basket index (established under subparagraph (A)) from the midpoint of the prior fiscal year (or period) to the midpoint of the fiscal year (or other period) involved.

(6) SUBMISSION OF RESIDENT ASSESSMENT DATA.—A skilled nursing facility, or a facility described in paragraph (7)(B), shall provide the Secretary, in a manner and within the timeframes prescribed by the Secretary, the resident assessment data necessary to develop and implement the rates under this subsection. For purposes of meeting such requirement, a

skilled nursing facility, or a facility described in paragraph (7), may submit the resident assessment data required under section 1819(b)(3), using the standard instrument designated by the State under section 1819(e)(5).

(7) TREATMENT OF MEDICARE SWING BED HOSPITALS.—

(A) TRANSITION.—Subject to subparagraph (C), the Secretary shall determine an appropriate manner in which to apply this subsection to the facilities described in subparagraph (B), (other than critical access hospitals) taking into account the purposes of this subsection, and shall provide that at the end of the transition period (as defined in paragraph (2)(E)) such facilities shall be paid only under this subsection. Payment shall not be made under this subsection to such facilities for cost reporting periods beginning before such date (not earlier than July 1, 1999) as the Secretary specifies.

(B) FACILITIES DESCRIBED.—The facilities described in this subparagraph are facilities that have in effect an agreement described in section 1883.

(C) EXEMPTION FROM PPS OF SWING–BED SERVICES FURNISHED IN CRITICAL ACCESS HOSPITALS.— The prospective payment system established under this subsection shall not apply to services furnished by a critical access hospital pursuant to an agreement under section 1883.

(8) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

(A) the establishment of Federal per diem rates under paragraph (4), including the computation of the standardized per diem rates under paragraph (4)(C), adjustments and corrections for case mix under paragraphs (4)(F) and (4)(G)(i), adjustments for variations in labor–related costs under paragraph (4)(G)(ii) and adjustments under paragraph (4)(G)(iii);

(B) the establishment of facility specific rates before July 1, 1999, (except any determination of costs paid under part A of this title); and

(C) the establishment of transitional amounts under paragraph (7).”

(9) PAYMENT FOR CERTAIN SERVICES.—In the case of an item or service furnished to a resident of a skilled nursing facility or a part of a facility that includes a skilled nursing facility (as determined under regulations) for which payment would (but for this paragraph) be made under part B in an amount determined in accordance with section 1833(a)(2)(B), the amount of the payment under such part shall be the amount provided under the fee schedule for such item or service. In the case of an item or service described in clause (iii) of paragraph (2)(A) that would be payable under part A but for the exclusion of such item or service under such clause, payment shall be made for the item or service, in an amount otherwise determined under part B of this title for such item or service, from the Federal Hospital Insurance Trust Fund under section 1817 (rather than from the Federal Supplementary Medical Insurance Trust Fund under section 1841).

(10) REQUIRED CODING.—No payment may be made under part B for items and services (other than services described in paragraph (2)(A)(ii)) furnished to an individual who is a resident of a skilled nursing facility or of a part of a facility that includes a skilled nursing facility (as determined under regulations), unless the claim for such payment includes a code (or codes) under a uniform coding system specified by the Secretary that identifies the items or services furnished.

(11) PERMITTING FACILITIES TO WAIVE 3–YEAR TRANSITION.—Notwithstanding paragraph (1)(A), a facility may elect to have the amount of the payment for all costs of covered skilled nursing facility services for each day of such services furnished in cost reporting periods beginning no earlier than 30 days before the date of such election determined pursuant to paragraph (1)(B).

(12)[729] PAYMENT RULE FOR CERTAIN FACILITIES.—

(A) IN GENERAL.—In the case of a qualified acute skilled nursing facility described in subparagraph (B), the per diem amount of payment shall be determined by applying the non–Federal percentage and Federal percentage specified in paragraph (2)(C)(ii).

(B) FACILITY DESCRIBED.—For purposes of subparagraph (A), a qualified acute skilled nursing facility is a facility that—

(i) was certified by the Secretary as a skilled nursing facility eligible to furnish services under this title before July 1, 1992;

(ii) is a hospital-based facility; and

(iii) for the cost reporting period beginning in fiscal year 1998, the facility had more than 60 percent of total patient days comprised of patients who are described in subparagraph (C).

(C) DESCRIPTION OF PATIENTS.—For purposes of subparagraph (B), a patient described in this subparagraph is an individual who—

(i) is entitled to benefits under part A; and

(ii) is immuno–compromised secondary to an infectious disease, with specific diagnoses as specified by the Secretary.

PROVIDER EDUCATION AND TECHNICAL ASSISTANCE[730]

SEC. 1889. [42 U.S.C 1395zz.] (a)[731] COORDINATION OF EDUCATION FUNDING.—The Secretary shall coordinate the educational activities provided through medicare contractors (as defined in subsection (g), including under section 1893) in order to maximize the effectiveness of Federal education efforts for providers of services and suppliers.

[729] P.L. 108–173, §511(a), amended §1888(e)(12) in its entirety, applicable to services furnished on or after October 1, 2004, pursuant to §511(b). For subparagraph (12) as it formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L. 108-173.

[730] See Vol. II, P.L. 108–173, §922, with respect to a small provider technical assistance demonstration program.

[731] P.L. 108-173, §921(a), added subsection (a), effective December 8, 2003.

(b)[732] ENHANCED EDUCATION AND TRAINING.—

(1) ADDITIONAL RESOURCES.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) such sums as may be necessary for fiscal years beginning with fiscal year 2005.

(2) USE.—The funds made available under paragraph (1) shall be used to increase the conduct by medicare contractors of education and training of providers of services and suppliers regarding billing, coding, and other appropriate items and may also be used to improve the accuracy, consistency, and timeliness of contractor responses.

(c) TAILORING EDUCATION AND TRAINING ACTIVITIES FOR SMALL PROVIDERS OR SUPPLIERS.—

(1) IN GENERAL.—Insofar as a medicare contractor conducts education and training activities, it shall tailor such activities to meet the special needs of small providers of services or suppliers (as defined in paragraph (2)). Such education and training activities for small providers of services and suppliers may include the provision of technical assistance (such as review of billing systems and internal controls to determine program compliance and to suggest more efficient and effective means of achieving such compliance).

(2) SMALL PROVIDER OF SERVICES OR SUPPLIER.—In this subsection, the term "small provider of services or supplier" means—

(A) a provider of services with fewer than 25 full-time-equivalent employees; or

(B) a supplier with fewer than 10 full-time-equivalent employees.

(d)[733] INTERNET WEBSITES; FAQS.—The Secretary, and each medicare contractor insofar as it provides services (including claims processing) for providers of services or suppliers, shall maintain an Internet website which—

(1) provides answers in an easily accessible format to frequently asked questions, and

(2) includes other published materials of the contractor, that relate to providers of services and suppliers under the programs under this title (and title XI insofar as it relates to such programs).

(e)[734] ENCOURAGEMENT OF PARTICIPATION IN EDUCATION PROGRAM ACTIVITIES.—A medicare contractor may not use a record of attendance at (or failure to attend) educational activities or other information gathered during an educational program conducted under this section or otherwise by the Secretary to select or track providers of services or suppliers for the purpose of conducting any type of audit or prepayment review.

(f) CONSTRUCTION.—Nothing in this section or section 1893(g) shall be construed as providing for disclosure by a medicare contractor—

(1) of the screens used for identifying claims that will be subject to medical review; or

[732] P.L. 108-173, §921(d), added subsections (b) and (c), effective October 1, 2004.
[733] P.L. 108-173, §921(e), added subsection (d), effective October 1, 2004.
[734] P.L. 108-173, §921(f), added subsections (e), (f) and (g), effective December 8, 2003.

(2) of information that would compromise pending law enforcement activities or reveal findings of law enforcement-related audits.

(g) DEFINITIONS.—For purposes of this section, the term 'medicare contractor' includes the following:

(1) A medicare administrative contractor with a contract under section 1874A, including a fiscal intermediary with a contract under section 1816 and a carrier with a contract under section 1842.

(2) An eligible entity with a contract under section 1893.

Such term does not include, with respect to activities of a specific provider of services or supplier an entity that has no authority under this title or title IX with respect to such activities and such provider of services or supplier.

SEC. 1890. [Redesignated.[735]]

CONDITIONS OF PARTICIPATION FOR HOME HEALTH AGENCIES; HOME HEALTH QUALITY[736]

SEC. 1891. [42 U.S.C. 1395bbb] (a) The conditions of participation that a home health agency is required to meet under this subsection are as follows:

(1) The agency protects and promotes the rights of each individual under its care, including each of the following rights:

(A) The right to be fully informed in advance about the care and treatment to be provided by the agency, to be fully informed in advance of any changes in the care or treatment to be provided by the agency that may affect the individual's well-being, and (except with respect to an individual adjudged incompetent) to participate in planning care and treatment or changes in care or treatment.

(B) The right to voice grievances with respect to treatment or care that is (or fails to be) furnished without discrimination or reprisal for voicing grievances.

(C) The right to confidentiality of the clinical records described in section 1861(o)(3).

(D) The right to have one's property treated with respect.

(E) The right to be fully informed orally and in writing (in advance of coming under the care of the agency) of—

(i) all items and services furnished by (or under arrangements with) the agency for which payment may be made under this title,

(ii) the coverage available for such items and services under this title, title XIX, and any other Federal program of which the agency is reasonably aware,

(iii) any charges for items and services not covered under this title and any charges the individual may have to pay with respect to items and services furnished by (or under arrangements with) the agency, and

[735] P.L. 100–360, §411(i)(4)(D)(ii)(II) and (V), redesignated §1890 as 1862(e)(2) and transferred such paragraph accordingly.

[736] See Vol. II, P.L. 106–554, §1(a)(6)[506], with respect to the treatment of branch offices.

(iv) any changes in the charges or items and services described in clause (i), (ii), or (iii).

(F) The right to be fully informed in writing (in advance of coming under the care of the agency) of the individual's rights and obligations under this title.

(G) The right to be informed of the availability of the State home health agency hot-line established under section 1864(a).

(2) The agency notifies the State entity responsible for the licensing or certification of the agency of a change in—

(A) the persons with an ownership or control interest (as defined in section 1124(a)(3)) in the agency,

(B) the persons who are officers, directors, agents, or managing employees (as defined in section 1126(b)) of the agency, and

(C) the corporation, association, or other company responsible for the management of the agency.

Such notice shall be given at the time of the change and shall include the identity of each new person or company described in the previous sentence.

(3)(A) The agency must not use as a home health aide (on a full-time, temporary, per diem, or other basis), any individual to provide items or services described in section 1861(m) on or after January 1, 1990, unless the individual—

(i) has completed a training and competency evaluation program, or a competency evaluation program, that meets the minimum standards established by the Secretary under subparagraph (D), and

(ii) is competent to provide such items and services.

For purposes of clause (i), an individual is not considered to have completed a training and competency evaluation program, or a competency evaluation program if, since the individual's most recent completion of such a program, there has been a continuous period of 24 consecutive months during none of which the individual provided items and services described in section 1861(m) for compensation.

(B)(i) The agency must provide, with respect to individuals used as a home health aide by the agency as of July 1, 1989, for a competency evaluation program (as described in subparagraph (A)(i)) and such preparation as may be necessary for the individual to complete such a program by January 1, 1990.

(ii) The agency must provide such regular performance review and regular in-service education as assures that individuals used to provide items and services described in section 1861(m) are competent to provide those items and services.

(C) The agency must not permit an individual, other than in a training and competency evaluation program that meets the minimum standards established by the Secretary under subparagraph (D), to provide items or services of a type for which the individual has not demonstrated competency.

(D)(i) The Secretary shall establish minimum standards for the programs described in subparagraph (A) by not later than October 1, 1988.

(ii) Such standards shall include the content of the curriculum, minimum hours of training, qualification of instructors, and procedures for determination of competency.

(iii) Such standards may permit approval of programs offered by or in home health agencies, as well as outside agencies (including employee organizations), and of programs in effect on the date of the enactment of this section[737]; except that they may not provide for the approval of a program offered by or in a home health agency which, within the previous 2 years—

(I) has been determined to be out of compliance with subparagraph (A), (B), or (C);

(II) has been subject to an extended (or partial extended) survey under subsection (c)(2)(D);

(III) has been assessed a civil money penalty described in subsection (f)(2)(A)(i) of not less than $5,000; or

(IV) has been subject to the remedies described in subsection (e)(1) or in clauses (ii) or (iii) of subsection (f)(2)(A).

(iv) Such standards shall permit a determination that an individual who has completed (before July 1, 1989) a training and competency evaluation program or a competency evaluation program shall be deemed for purposes of subparagraph (A) to have completed a program that is approved by the Secretary under the standards established under this subparagraph if the Secretary determines that, at the time the program was offered, the program met such standards.

(E) In this paragraph, the term "home health aide" means any individual who provides the items and services described in section 1861(m), but does not include an individual—

(i) who is a licensed health professional (as defined in subparagraph (F)), or

(ii) who volunteers to provide such services without monetary compensation.

(F) In this paragraph, the term "licensed health professional" means a physician, physician assistant, nurse practitioner, physical, speech, or occupational therapist, physical or occupational therapy assistant, registered professional nurse, licensed practical nurse, or licensed or certified social worker.

(4) The agency includes an individual's plan of care required under section 1861(m) as part of the clinical records described in section 1861(o)(3).

(5) The agency operates and provides services in compliance with all applicable Federal, State, and local laws and regulations (including the requirements of section 1124) and with accepted professional standards and principles which apply to professionals providing items and services in such an agency.

[737] December 22, 1987 [P.L. 100–203; 101 Stat. 1330].

(6) The agency complies with the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).

(b) It is the duty and responsibility of the Secretary to assure that the conditions of participation and requirements specified in or pursuant to section 1861(o) and subsection (a) of this section and the enforcement of such conditions and requirements are adequate to protect the health and safety of individuals under the care of a home health agency and to promote the effective and efficient use of public moneys.

(c)(1) Any agreement entered into or renewed by the Secretary pursuant to section 1864 relating to home health agencies shall provide that the appropriate State or local agency shall conduct, without any prior notice, a standard survey of each home health agency. Any individual who notifies (or causes to be notified) a home health agency of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A. The Secretary shall review each State's or local agency's procedures for scheduling and conduct of standard surveys to assure that the State or agency has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

(2)(A) Except as provided in subparagraph (B), each home health agency shall be subject to a standard survey not later than 36 months after the date of the previous standard survey conducted under this paragraph. The Secretary shall establish a frequency for surveys of home health agencies within this 36–month interval commensurate with the need to assure the delivery of quality home health services.

(B) If not otherwise conducted under subparagraph (A), a standard survey (or an abbreviated standard survey) of an agency—

(i) may be conducted within 2 months of any change of ownership, administration, or management of the agency to determine whether the change has resulted in any decline in the quality of care furnished by the agency, and

(ii) shall be conducted within 2 months of when a significant number of complaints have been reported with respect to the agency to the Secretary, the State, the entity responsible for the licensing of the agency, the State or local agency responsible for maintaining a toll-free hotline and investigative unit (under section 1864(a)), or any other appropriate Federal, State, or local agency.

(C) A standard survey conducted under this paragraph with respect to a home health agency—

(i) shall include (to the extent practicable), for a case-mix stratified sample of individuals furnished items or services by the agency—

(I) visits to the homes of such individuals, but only with the consent of such individuals, for the

purpose of evaluating (in accordance with a standardized reproducible assessment instrument (or instruments) approved by the Secretary under subsection (d)) the extent to which the quality and scope of items and services furnished by the agency attained and maintained the highest practicable functional capacity of each such individual as reflected in such individual's written plan of care required under section 1861(m) and clinical records required under section 1861(o)(3); and

(II) a survey of the quality of care and services furnished by the agency as measured by indicators of medical, nursing, and rehabilitative care;

(ii) shall be based upon a protocol that is developed, tested, and validated by the Secretary not later than January 1, 1989; and

(iii) shall be conducted by an individual—

(I) who meets minimum qualifications established by the Secretary not later than July 1, 1989,

(II) who is not serving (or has not served within the previous 2 years) as a member of the staff of, or as a consultant to, the home health agency surveyed respecting compliance with the conditions of participation specified in or pursuant to section 1861(o) or subsection (a) of this section, and

(III) who has no personal or familial financial interest in the home health agency surveyed.

(D) Each home health agency that is found, under a standard survey, to have provided substandard care shall be subject to an extended survey to review and identify the policies and procedures which produced such substandard care and to determine whether the agency has complied with the conditions of participation specified in or pursuant to section 1861(o) or subsection (a) of this section. Any other agency may, at the Secretary's or State's discretion, be subject to such an extended survey (or a partial extended survey). The extended survey shall be conducted immediately after the standard survey (or, if not practical, not later than 2 weeks after the date of completion of the standard survey).

(E) Nothing in this paragraph shall be construed as requiring an extended (or partial extended) survey as a prerequisite to imposing a sanction against an agency under subsection (e) on the basis of the findings of a standard survey.

(d)(1) Not later than January 1, 1989, the Secretary shall designate an assessment instrument (or instruments) for use by an agency in complying with subsection (c)(2)(C)(i)(I)[738].

(2)(A) Not later than January 1, 1992, the Secretary shall—

[738] P.L. 108-173, §736(c)(3), struck out "subsection (c)(2)(C) (I)", and substituted "subsection (c)(2)(C)(i)(I)".

(i) evaluate the assessment process,

(ii) report to Congress on the results of such evaluation, and

(iii) based on such evaluation, make such modifications in the assessment process as the Secretary determines are appropriate.

(B) The Secretary shall periodically update the evaluation conducted under subparagraph (A), report the results of such update to Congress, and, based on such update, make such modifications in the assessment process as the Secretary determines are appropriate.

(3) The Secretary shall provide for the comprehensive training of State and Federal surveyors in matters relating to the performance of standard and extended surveys under this section, including the use of any assessment instrument (or instruments) designated under paragraph (1).

(e)(1) If the Secretary determines on the basis of a standard, extended, or partial extended survey or otherwise, that a home health agency that is certified for participation under this title is no longer in compliance with the requirements specified in or pursuant to section 1861(o) or subsection (a) and determines that the deficiencies involved immediately jeopardize the health and safety of the individuals to whom the agency furnishes items and services, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subsection (f)(2)(A)(iii) or terminate the certification of the agency, and may provide, in addition, for 1 or more of the other remedies described in subsection (f)(2)(A).

(2) If the Secretary determines on the basis of a standard, extended, or partial extended survey or otherwise, that a home health agency that is certified for participation under this title is no longer in compliance with the requirements specified in or pursuant to section 1861(o) or subsection (a) and determines that the deficiencies involved do not immediately jeopardize the health and safety of the individuals to whom the agency furnishes items and services, the Secretary may (for a period not to exceed 6 months) impose intermediate sanctions developed pursuant to subsection (f), in lieu of terminating the certification of the agency. If, after such a period of intermediate sanctions, the agency is still no longer in compliance with the requirements specified in or pursuant to section 1861(o) or subsection (a), the Secretary shall terminate the certification of the agency.

(3) If the Secretary determines that a home health agency that is certified for participation under this title is in compliance with the requirements specified in or pursuant to section 1861(o) or subsection (a) but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subsection (f)(2)(A)(i) for the days in which it finds that the agency was not in compliance with such requirements.

(4) The Secretary may continue payments under this title with respect to a home health agency not in compliance with the requirements specified in or pursuant to section 1861(o) or subsection (a) over a period of not longer than 6 months, if—

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

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

The Secretary shall establish guidelines for approval of corrective actions requested by home health agencies under this subparagraph.

(f)(1) The Secretary shall develop and implement, by not later than April 1, 1989—

(A) a range of intermediate sanctions to apply to home health agencies under the conditions described in subsection (e), and

(B) appropriate procedures for appealing determinations relating to the imposition of such sanctions.

(2)(A) The intermediate sanctions developed under paragraph (1) shall include—

(i) civil money penalties in an amount not to exceed $10,000 for each day of noncompliance,

(ii) suspension of all or part of the payments to which a home health agency would otherwise be entitled under this title with respect to items and services furnished by a home health agency on or after the date on which the Secretary determines that intermediate sanctions should be imposed pursuant to subsection (e)(2), and

(iii) the appointment of temporary management to oversee the operation of the home health agency and to protect and assure the health and safety of the individuals under the care of the agency while improvements are made in order to bring the agency into compliance with all the requirements specified in or pursuant to section 1861(o) or subsection (a).

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). The temporary management under clause (iii) shall not be terminated until the Secretary has determined that the agency has the management capability to ensure continued compliance with all the requirements referred to in that clause.

(B) The sanctions specified in subparagraph (A) are in addition to sanctions otherwise available under State or Federal law and shall not be construed as limiting other remedies, including any remedy available to an individual at common law.

(C) A finding to suspend payment under subparagraph (A)(ii) shall terminate when the Secretary finds that the home health agency is in substantial compliance with all the requirements specified in or pursuant to section 1861(o) and subsection (a).

(3) The Secretary shall develop and implement, by not later than April 1, 1989, specific procedures with respect to the conditions under which each of the intermediate sanctions developed under paragraph (1) is to be applied, including the amount of any fines and the severity of each of these sanctions. Such procedures shall be designed so as to minimize the time between identification of deficiencies and imposition of these sanctions and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies.

(g) PAYMENT ON BASIS OF LOCATION OF SERVICE.—A home health agency shall submit claims for payment for home health services under this title only on the basis of the geographic location at which the service is furnished, as determined by the Secretary.

OFFSET OF PAYMENTS TO INDIVIDUALS TO COLLECT PAST-DUE OBLIGATIONS ARISING FROM BREACH OF SCHOLARSHIP AND LOAN CONTRACT[739]

SEC. 1892. [42 U.S.C. 1395ccc] (a) IN GENERAL.—

(1)(A) Subject to subparagraph (B), the Secretary shall enter into an agreement under this section with any individual who, by reason of a breach of a contract entered into by such individual pursuant to the National Health Service Corps Scholarship Program, the Physician Shortage Area Scholarship Program, or the Health Education Assistance Loan Program, owes a past-due obligation to the United States (as defined in subsection (b)).

(B) The Secretary shall not enter into an agreement with an individual under this section to the extent—

(i)(I) the individual has entered into a contract with the Secretary pursuant to section 204(a)(1) of the Public Health Service Amendments of 1987[740], and

(II) the individual has fulfilled or (as determined by the Secretary) is fulfilling the terms of such contract; or

(ii) the liability of the individual under such section 204(a)(1) has otherwise been relieved under such section; or

(iii) the individual is performing such physician's service obligation under a forbearance agreement entered into with the Secretary under subpart II of part D of title III of the Public Health Service Act[741].

(2) The agreement under this section shall provide that—

(A) deductions shall be made from the amounts otherwise payable to the individual under this title, in accordance with a formula and schedule agreed to by the Secretary and the individual, until such past-due obligation (and accrued interest) have been repaid;

(B) payment under this title for services provided by such individual shall be made only on an assignment-related basis;

(C) if the individual does not provide services, for which payment would otherwise be made under this title, of a

[739] See Vol. II, P.L. 94–437, §108(l)(1) and (2), with respect to the Indian Health Service loan repayment program.
[740] See Vol. II, P.L. 100–177.
[741] P.L. 78–410.

sufficient quantity to maintain the offset collection according to the agreed upon formula and schedule—

(i) the Secretary shall immediately inform the Attorney General, and the Attorney General shall immediately commence an action to recover the full amount of the past-due obligation, and

(ii) subject to paragraph (4), the Secretary shall immediately exclude the individual from the program under this title, until such time as the entire past-due obligation has been repaid.

(3) If the individual refuses to enter into an agreement or breaches any provision of the agreement—

(A) the Secretary shall immediately inform the Attorney General, and the Attorney General shall immediately commence an action to recover the full amount of the past-due obligation, and

(B) subject to paragraph (4), the Secretary shall immediately exclude the individual from the program under this title, until such time as the entire past-due obligation has been repaid.

(4) The Secretary shall not exclude an individual pursuant to paragraph (2)(C)(ii) or paragraph (3)(B) if such individual is a sole community practitioner or sole source of essential specialized services in a community if a State requests that the individual not be excluded.

(b) PAST-DUE OBLIGATION.—For purposes of this section, a past-due obligation is any amount—

(1) owed by an individual to the United States by reason of a breach of a scholarship contract under section 338E of the Public Health Service Act[742] or under subpart III of part F of title VII of such Act (as in effect before October 1, 1976) and which has not been paid by the deadline established by the Secretary pursuant to such respective section, and has not been canceled, waived, or suspended by the Secretary pursuant to such section; or

(2) owed by an individual to the United States by reason of a loan covered by Federal loan insurance under subpart I of part C of title VII of the Public Health Service Act and payment for which has not been cancelled, waived, or suspended by the Secretary under such subpart.

(c) COLLECTION UNDER THIS SECTION SHALL NOT BE EXCLUSIVE.—This section shall not preclude the United States from applying other provisions of law otherwise applicable to the collection of obligations owed to the United States, including (but not limited to) the use of tax refund offsets pursuant to section 3720A of title 31, United States Code, and the application of other procedures provided under chapter 37 of title 31, United States Code[743].

(d) COLLECTION FROM PROVIDERS AND HEALTH MAINTENANCE ORGANIZATIONS.—

(1) In the case of an individual who owes a past-due obligation, and who is an employee of, or affiliated by a medical services agreement with, a provider having an agreement under section 1866 or a health maintenance organization or competi-

[742] See Vol. II, P.L. 78–410.
[743] See Vol. II, Title 31.

tive medical plan having a contract under section 1833 or section 1876, the Secretary shall deduct the amounts of such past-due obligation from amounts otherwise payable under this title to such provider, organization, or plan.

(2) Deductions shall be in accordance with a formula and schedule agreed to by the Secretary, the individual and the provider, organization, or plan. The deductions shall be made from the amounts otherwise payable to the individual under this title as long as the individual continues to be employed or affiliated by a medical services agreement.

(3) Such deduction shall not be made until 6 months after the Secretary notifies the provider, organization, or plan of the amount to be deducted and the particular physicians to whom the deductions are attributable.

(4) A deduction made under this subsection shall relieve the individual of the obligation (to the extent of the amount collected) to the United States, but the provider, organization, or plan shall have a right of action to collect from such individual the amount deducted pursuant to this subsection (including accumulated interest).

(5) No deduction shall be made under this subsection if, within the 6-month period after notice is given to the provider, organization, or plan, the individual pays the past-due obligation, or ceases to be employed by the provider, organization, or plan.

(6) The Secretary shall also apply the provisions of this subsection in the case of an individual who is a member of a group practice, if such group practice submits bills under this program as a group, rather than by individual physicians.

(e) TRANSFER FROM TRUST FUNDS.—Amounts equal to the amounts deducted pursuant to this section shall be transferred from the Trust Fund from which the payment to the individual, provider, or other entity would otherwise have been made, to the general fund in the Treasury, and shall be credited as payment of the past-due obligation of the individual from whom (or with respect to whom) the deduction was made.

MEDICARE INTEGRITY PROGRAM

SEC. 1893. [42 U.S.C. 1395ddd] (a) ESTABLISHMENT OF PROGRAM.—There is hereby established the Medicare Integrity Program (in this section referred to as the "Program") under which the Secretary shall promote the integrity of the medicare program[744] by entering into contracts in accordance with this section with eligible entities to carry out the activities described in subsection (b).

(b) ACTIVITIES DESCRIBED.—The activities described in this subsection are as follows:

(1) Review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under this title (including skilled nursing facilities and home health agencies), including medical and utilization review and fraud review (employing similar standards, processes, and technologies used by private health plans, including equipment and software technologies which surpass

[744] P.L. 108-173, §736(c)(7), struck out "Medicare program", and substituted "medicare program".

the capability of the equipment and technologies used in the review of claims under this title as of the date of the enactment of this section).

(2) Audit of cost reports.

(3) Determinations as to whether payment should not be, or should not have been, made under this title by reason of section 1862(b), and recovery of payments that should not have been made.

(4) Education of providers of services, beneficiaries, and other persons with respect to payment integrity and benefit quality assurance issues.

(5) Developing (and periodically updating) a list of items of durable medical equipment in accordance with section 1834(a)(15) which are subject to prior authorization under such section.

(c) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract under the Program to carry out any of the activities described in subsection (b) if—

(1) the entity has demonstrated capability to carry out such activities;

(2) in carrying out such activities, the entity agrees to cooperate with the Inspector General of the Department of Health and Human Services, the Attorney General, and other law enforcement agencies, as appropriate, in the investigation and deterrence of fraud and abuse in relation to this title and in other cases arising out of such activities;

(3) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement; and

(4) the entity meets such other requirements as the Secretary may impose.

In the case of the activity described in subsection (b)(5), an entity shall be deemed to be eligible to enter into a contract under the Program to carry out the activity if the entity is a carrier with a contract in effect under section 1842.

(d) PROCESS FOR ENTERING INTO CONTRACTS.—The Secretary shall enter into contracts under the Program in accordance with such procedures as the Secretary shall be regulation establish, except that such procedures shall include the following:

(1) Procedures for identifying, evaluating, and resolving organizational conflicts of interest that are generally applicable to Federal acquisition and procurement.

(2) Competitive procedures to be used—

(A) when entering into new contracts under this section;

(B) when entering into contracts that may result in the elimination of responsibilities of an individual fiscal intermediary or carrier under section 202(b) of the Health Insurance Portability and Accountability Act of 1996; and

(C) at any other time considered appropriate by the Secretary,

except that the Secretary may continue to contract with entities that are carrying out the activities described in this section pursuant to agreements under section 1816 or contracts under section 1842 in effect on the date of the enactment of this section.

(3) Procedures under which a contract under this section may be renewed without regard to any provision of law requiring competition if the contractor has met or exceeded the performance requirements established in the current contract.

The Secretary may enter into such contracts without regard to final rules having been promulgated.

(e) LIMITATION ON CONTRACTOR LIABILITY.—The Secretary shall by regulation provide for the limitation of a contractor's liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1157.

(f)[745] RECOVERY OF OVERPAYMENTS.—

(1)[746] USE OF REPAYMENT PLANS.—

(A) IN GENERAL.—If the repayment, within 30 days by a provider of services or supplier, of an overpayment under this title would constitute a hardship (as described in subparagraph (B)), subject to subparagraph (C), upon request of the provider of services or supplier the Secretary shall enter into a plan with the provider of services or supplier for the repayment (through offset or otherwise) of such overpayment over a period of at least 6 months but not longer than 3 years (or not longer than 5 years in the case of extreme hardship, as determined by the Secretary). Interest shall accrue on the balance through the period of repayment. Such plan shall meet terms and conditions determined to be appropriate by the Secretary.

(B) HARDSHIP.—

(i) IN GENERAL.—For purposes of subparagraph (A), the repayment of an overpayment (or overpayments) within 30 days is deemed to constitute a hardship if—

(I) in the case of a provider of services that files cost reports, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this title to the provider of services for the cost reporting period covered by the most recently submitted cost report; or

(II) in the case of another provider of services or supplier, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this title to the provider of services or supplier for the previous calendar year.

(ii) RULE OF APPLICATION.—The Secretary shall establish rules for the application of this subparagraph in the case of a provider of services supplier that was not paid under this title during the previous year or was paid under this title only during a portion of that year.

(iii) TREATMENT OF PREVIOUS OVERPAYMENTS.—If a provider of services or supplier has entered into a repayment plan under subparagraph (A) with respect to a specific overpayment amount, such payment amount under the repayment plan shall not be taken into ac-

[745] P.L. 108-173, §935(a), added subsection (f), effective December 8, 2003.

[746] P.L. 108-173, §935(a), added paragraph (1), applicable to requests for repayment plans made after December 8, 2003 pursuant to §935(b)(1).

count under clause (i) with respect to subsequent overpayment amounts.

(C) EXCEPTIONS.—Subparagraph (A) shall not apply if—

(i) the Secretary has reason to suspect that the provider of services or supplier may file for bankruptcy or otherwise cease to do business or discontinue participation in the program under this title; or

(ii) there is an indication of fraud or abuse committed against the program.

(D) IMMEDIATE COLLECTION IF VIOLATION OF REPAYMENT PLAN.—If a provider of services or supplier fails to make a payment in accordance with a repayment plan under this paragraph, the Secretary may immediately seek to offset or otherwise recover the total balance outstanding (including applicable interest) under the repayment plan.

(E) RELATION TO NO FAULT PROVISION.—Nothing in this paragraph shall be construed as affecting the application of section 1870(c) (relating to no adjustment in the cases of certain overpayments).

(2)[747] LIMITATION ON RECOUPMENT.—

(A) IN GENERAL.—In the case of a provider of services or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration by a qualified independent contractor on such determination under section 1869(b)(1), the Secretary may not take any action (or authorize any other person, including any medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered. If the provisions of section 1869(b)(1) (providing for such a reconsideration by a qualified independent contractor) are not in effect, in applying the previous sentence any reference to such a reconsideration shall be treated as a reference to a redetermination by the fiscal intermediary or carrier involved

(B) COLLECTION WITH INTEREST.—Insofar as the determination on such appeal is against the provider of services or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment. Insofar as such determination against the provider of services or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest at the same rate as would apply under the previous sentence for the period in which the amount was recouped.

(C) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term "medicare contractor" has the meaning given such term in section 1889(g).

(3)[748] LIMITATION ON USE OF EXTRAPOLATION.—A medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise unless the Secretary determines that—

(A) there is a sustained or high level of payment error; or

[747] P.L. 108-173, §935(a), added paragraph (2), applicable to actions taken after December 8, 2003 pursuant to §935(b)(2).

[748] P.L. 108-173, §935(a), added paragraph (3), applicable to statistically valid random samples initiated after December 8, 2003 pursuant to §935(b)(3).

(B) documented educational intervention has failed to correct the payment error.

There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of determinations by the Secretary of sustained or high levels of payment errors under this paragraph.

(4)[749] PROVISION OF SUPPORTING DOCUMENTATION.—In the case of a provider of services or supplier with respect to which amounts were previously overpaid, a medicare contractor may request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing.

(5)[750] CONSENT SETTLEMENT REFORMS.—

(A) IN GENERAL.—The Secretary may use a consent settlement (as defined in subparagraph (D)) to settle a projected overpayment.

(B) OPPORTUNITY TO SUBMIT ADDITIONAL INFORMATION BEFORE CONSENT SETTLEMENT OFFER.—Before offering a provider of services or supplier a consent settlement, the Secretary shall—

(i) communicate to the provider of services or supplier—

(I) that, based on a review of the medical records requested by the Secretary, a preliminary evaluation of those records indicates that there would be an overpayment;

(II) the nature of the problems identified in such evaluation; and

(III) the steps that the provider of services or supplier should take to address the problems; and

(ii) provide for a 45-day period during which the provider of services or supplier may furnish additional information concerning the medical records for the claims that had been reviewed.

(C) CONSENT SETTLEMENT OFFER.—The Secretary shall review any additional information furnished by the provider of services or supplier under subparagraph (B)(ii). Taking into consideration such information, the Secretary shall determine if there still appears to be an overpayment. If so, the Secretary—

(i) shall provide notice of such determination to the provider of services or supplier, including an explanation of the reason for such determination; and

(ii) in order to resolve the overpayment, may offer the provider of services or supplier—

(I) the opportunity for a statistically valid random sample; or

(II) a consent settlement.

The opportunity provided under clause (ii)(I) does not waive any appeal rights with respect to the alleged overpayment involved.

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[749] P.L. 108-173, §935(a), added paragraph (4), effective December 8, 2003 pursuant to §935(b)(4).

[750] P.L. 108-173, §935(a), added paragraph (5), applicable to consent settlements entered into after December 8, 2003 pursuant to §935(b)(5).

(D) CONSENT SETTLEMENT DEFINED.—For purposes of this paragraph, the term 'consent settlement' means an agreement between the Secretary and a provider of services or supplier whereby both parties agree to settle a projected overpayment based on less than a statistically valid sample of claims and the provider of services or supplier agrees not to appeal the claims involved.

(6)[751] NOTICE OF OVER-UTILIZATION OF CODES.—The Secretary shall establish, in consultation with organizations representing the classes of providers of services and suppliers, a process under which the Secretary provides for notice to classes of providers of services and suppliers served by the contractor in cases in which the contractor has identified that particular billing codes may be overutilized by that class of providers of services or suppliers under the programs under this title (or provisions of title XI insofar as they relate to such programs).

(7)[752] PAYMENT AUDITS.—

(A) WRITTEN NOTICE FOR POST-PAYMENT AUDITS.—Subject to subparagraph (C), if a medicare contractor decides to conduct a post-payment audit of a provider of services or supplier under this title, the contractor shall provide the provider of services or supplier with written notice (which may be in electronic form) of the intent to conduct such an audit.

(B) EXPLANATION OF FINDINGS FOR ALL AUDITS.—Subject to subparagraph (C), if a medicare contractor audits a provider of services or supplier under this title, the contractor shall—

(i) give the provider of services or supplier a full review and explanation of the findings of the audit in a manner that is understandable to the provider of services or supplier and permits the development of an appropriate corrective action plan;

(ii) inform the provider of services or supplier of the appeal rights under this title as well as consent settlement options (which are at the discretion of the Secretary);

(iii) give the provider of services or supplier an opportunity to provide additional information to the contractor; and

(iv) take into account information provided, on a timely basis, by the provider of services or supplier under clause (iii).

(C) EXCEPTION.—Subparagraphs (A) and (B) shall not apply if the provision of notice or findings would compromise pending law enforcement activities, whether civil or criminal, or reveal findings of law enforcement-related audits.

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[751] P.L. 108-173, §935(a), added paragraph (6); §935(b)(6), provides that:
"Not later than 1 year after the date of the enactment of this Act (December 1, 2004), the Secretary shall first establish the process for notice of overutilization of billing codes under section 1893(A)(f)(6)* of the Social Security Act, as added by subsection (a)."
* probably should read section 1893(f)(8)

[752] P.L. 108-173, §935(a), added paragraph (7), applicable to audits initiated after December 8, 2003 pursuant to §935(b)(7).

(8)[753] STANDARD METHODOLOGY FOR PROBE SAMPLING.—The Secretary shall establish a standard methodology for medicare contractors to use in selecting a sample of claims for review in the case of an abnormal billing pattern.

PAYMENTS TO, AND COVERAGE OF BENEFITS UNDER, PROGRAMS OF ALL–INCLUSIVE CARE FOR THE ELDERLY (PACE)[754]

SEC. 1894. [42 U.S.C. 1395eee] (a) RECEIPT OF BENEFITS THROUGH ENROLLMENT IN PACE PROGRAM; DEFINITIONS FOR PACE PROGRAM RELATED TERMS.—

(1) BENEFITS THROUGH ENROLLMENT IN A PACE PROGRAM.—In accordance with this section, in the case of an individual who is entitled to benefits under part A or enrolled under part B and who is a PACE program eligible individual (as defined in paragraph (5)) with respect to a PACE program offered by a PACE provider under a PACE program agreement—

(A) the individual may enroll in the program under this section; and

(B) so long as the individual is so enrolled and in accordance with regulations—

(i) the individual shall receive benefits under this title solely through such program; and

(ii) the PACE provider is entitled to payment under and in accordance with this section and such agreement for provision of such benefits.

(2) PACE PROGRAM DEFINED.—For purposes of this section, the term PACE program means a program of all–inclusive care for the elderly that meets the following requirements:

(A) OPERATION.—The entity operating the program is a PACE provider (as defined in paragraph (3)).

(B) COMPREHENSIVE BENEFITS.—The program provides comprehensive health care services to PACE program eligible individuals in accordance with the PACE program agreement and regulations under this section.

(C) TRANSITION.—In the case of an individual who is enrolled under the program under this section and whose enrollment ceases for any reason (including that the individual no longer qualifies as a PACE program eligible individual, the termination of a PACE program agreement, or otherwise), the program provides assistance to the individual in obtaining necessary transitional care through appropriate referrals and making the individual's medical records available to new providers.

(3) PACE PROVIDER DEFINED.—

(A) IN GENERAL.—For purposes of this section, the term PACE provider means an entity that—

(i) subject to subparagraph (B), is (or is a distinct part of) a public entity or a private, nonprofit entity

[753] P.L. 108-173, §935(a), added paragraph (8); §935(b)(6), provides that:
"Not later than 1 year after the date of the enactment of this Act (December 8, 2003), the Secretary shall first establish a standard methodology for selection of sample claims for abnormal billing patterns under section 1893(f)(8) of the Social Security Act, as added by subsection (a)."

[754] See Vol. II, P.L. 105–33, §4803, with respect to regulations, and expansion and transition for PACE demonstration project waivers.
See Vol. II, P.L. 105–33, §4804(a), with respect to a study and §4804(b), with respect to a report regarding the PACE program.

organized for charitable purposes under section 501(c)(3) of the Internal Revenue Code of 1986; and

(ii) has entered into a PACE program agreement with respect to its operation of a PACE program.

(B) TREATMENT OF PRIVATE, FOR–PROFIT PROVIDERS.—Clause (i) of subparagraph (A) shall not apply—

(i) to entities subject to a demonstration project waiver under subsection (h); and

(ii) after the date the report under section 4804(b) of the Balanced Budget Act of 1997 is submitted, unless the Secretary determines that any of the findings described in subparagraph (A), (B), (C), or (D) of paragraph (2) of such section are true.

(4) PACE PROGRAM AGREEMENT DEFINED.—For purposes of this section, the term PACE program agreement means, with respect to a PACE provider, an agreement, consistent with this section, section 1934 (if applicable), and regulations promulgated to carry out such sections, between the PACE provider and the Secretary, or an agreement between the PACE provider and a State administering agency for the operation of a PACE program by the provider under such sections.

(5) PACE PROGRAM ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, the term PACE program eligible individual means, with respect to a PACE program, an individual who—

(A) is 55 years of age or older;

(B) subject to subsection (c)(4), is determined under subsection (c) to require the level of care required under the State medicaid plan for coverage of nursing facility services;

(C) resides in the service area of the PACE program; and

(D) meets such other eligibility conditions as may be imposed under the PACE program agreement for the program under subsection (e)(2)(A)(ii).

(6) PACE PROTOCOL.—For purposes of this section, the term PACE protocol means the Protocol for the Program of All–inclusive Care for the Elderly (PACE), as published by On Lok, Inc., as of April 14, 1995, or any successor protocol that may be agreed upon between the Secretary and On Lok, Inc.

(7) PACE DEMONSTRATION WAIVER PROGRAM DEFINED.—For purposes of this section, the term PACE demonstration waiver program means a demonstration program under either of the following sections (as in effect before the date of their repeal):

(A) Section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21), as extended by section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272).

(B) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509).

(8) STATE ADMINISTERING AGENCY DEFINED.—For purposes of this section, the term State administering agency means, with respect to the operation of a PACE program in a State, the agency of that State (which may be the single agency responsible for administration of the State plan under title XIX in the State) responsible for administering PACE program agreements under this section and section 1934 in the State.

(9) TRIAL PERIOD DEFINED.—

(A) IN GENERAL.—For purposes of this section, the term trial period means, with respect to a PACE program operated by a PACE provider under a PACE program agreement, the first 3 contract years under such agreement with respect to such program.

(B) TREATMENT OF ENTITIES PREVIOUSLY OPERATING PACE DEMONSTRATION WAIVER PROGRAMS.—Each contract year (including a year occurring before the effective date of this section) during which an entity has operated a PACE demonstration waiver program shall be counted under subparagraph (A) as a contract year during which the entity operated a PACE program as a PACE provider under a PACE program agreement.

(10) REGULATIONS.—For purposes of this section, the term regulations refers to interim final or final regulations promulgated under subsection (f) to carry out this section and section 1934.

(b) SCOPE OF BENEFITS; BENEFICIARY SAFEGUARDS.—

(1) IN GENERAL.—Under a PACE program agreement, a PACE provider shall—

(A) provide to PACE program eligible individuals enrolled with the provider, regardless of source of payment and directly or under contracts with other entities, at a minimum—

(i) all items and services covered under this title (for individuals enrolled under this section) and all items and services covered under title XIX, but without any limitation or condition as to amount, duration, or scope and without application of deductibles, copayments, coinsurance, or other cost–sharing that would otherwise apply under this title or such title, respectively; and

(ii) all additional items and services specified in regulations, based upon those required under the PACE protocol;

(B) provide such enrollees access to necessary covered items and services 24 hours per day, every day of the year;

(C) provide services to such enrollees through a comprehensive, multidisciplinary health and social services delivery system which integrates acute and long–term care services pursuant to regulations; and

(D) specify the covered items and services that will not be provided directly by the entity, and to arrange for delivery of those items and services through contracts meeting the requirements of regulations.

(2) QUALITY ASSURANCE; PATIENT SAFEGUARDS.—The PACE program agreement shall require the PACE provider to have in effect at a minimum—

(A) a written plan of quality assurance and improvement, and procedures implementing such plan, in accordance with regulations; and

(B) written safeguards of the rights of enrolled participants (including a patient bill of rights and procedures for grievances and appeals) in accordance with regulations

and with other requirements of this title and Federal and State law that are designed for the protection of patients.

(3)[755] TREATMENT OF MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—

(A) APPLICATION OF MEDICARE ADVANTAGE REQUIREMENT WITH RESPECT TO MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—Section 1852(k)(1) (relating to limitations on balance billing against MA organizations for noncontract physicians and other entities with respect to services covered under this title) shall apply to PACE providers, PACE program eligible individuals enrolled with such PACE providers, and physicians and other entities that do not have a contract or other agreement establishing payment amounts for services furnished to such an individual in the same manner as such section applies to MA organizations, individuals enrolled with such organizations, and physicians and other entities referred to in such section.

(B) REFERENCE TO RELATED PROVISION FOR NONCONTRACT PROVIDERS OF SERVICES.—For the provision relating to limitations on balance billing against PACE providers for services covered under this title furnished by noncontract providers of services, see section 1866(a)(1)(O).

(4) REFERENCE TO RELATED PROVISION FOR SERVICES COVERED UNDER TITLE XIX BUT NOT UNDER THIS TITLE.—For provisions relating to limitations on payments to providers participating under the State plan under title XIX that do not have a contract or other agreement with a PACE provider establishing payment amounts for services covered under such plan (but not under this title) when such services are furnished to enrollees of that PACE provider, see section 1902(a)(66).

(c) ELIGIBILITY DETERMINATIONS.—

(1) IN GENERAL.—The determination of whether an individual is a PACE program eligible individual—

(A) shall be made under and in accordance with the PACE program agreement; and

(B) who is entitled to medical assistance under title XIX, shall be made (or who is not so entitled, may be made) by the State administering agency.

(2) CONDITION.—An individual is not a PACE program eligible individual (with respect to payment under this section) unless the individual's health status has been determined by the Secretary or the State administering agency, in accordance with regulations, to be comparable to the health status of individuals who have participated in the PACE demonstration waiver programs. Such determination shall be based upon information on health status and related indicators (such as medical diagnoses and measures of activities of daily living, instrumental activities of daily living, and cognitive impairment) that are part of a uniform minimum data set collected by PACE providers on potential PACE program eligible individuals.

(3) ANNUAL ELIGIBILITY RECERTIFICATIONS.—

[755] P.L. 108-173, §236(a)(2), added paragraphs (3) and (4) , effective date applicable to services furnished on or after January 1, 2004.

(A) IN GENERAL.—Subject to subparagraph (B), the determination described in subsection (a)(5)(B) for an individual shall be reevaluated at least annually.

(B) EXCEPTION.—The requirement of annual reevaluation under subparagraph (A) may be waived during a period in accordance with regulations in those cases where the State administering agency determines that there is no reasonable expectation of improvement or significant change in an individual's condition during the period because of the severity of chronic condition, or degree of impairment of functional capacity of the individual involved.

(4) CONTINUATION OF ELIGIBILITY.—An individual who is a PACE program eligible individual may be deemed to continue to be such an individual notwithstanding a determination that the individual no longer meets the requirement of subsection (a)(5)(B) if, in accordance with regulations, in the absence of continued coverage under a PACE program the individual reasonably would be expected to meet such requirement within the succeeding 6–month period.

(5) ENROLLMENT; DISENROLLMENT.—

(A) VOLUNTARY DISENROLLMENT AT ANY TIME.—The enrollment and disenrollment of PACE program eligible individuals in a PACE program shall be pursuant to regulations and the PACE program agreement and shall permit enrollees to voluntarily disenroll without cause at any time.

(B) LIMITATIONS ON DISENROLLMENT.—

(i) IN GENERAL.—Regulations promulgated by the Secretary under this section and section 1934, and the PACE program agreement, shall provide that the PACE program may not disenroll a PACE program eligible individual except—

(I) for nonpayment of premiums (if applicable) on a timely basis; or

(II) for engaging in disruptive or threatening behavior, as defined in such regulations (developed in close consultation with State administering agencies).

(ii) NO DISENROLLMENT FOR NONCOMPLIANT BEHAVIOR.—Except as allowed under regulations promulgated to carry out clause (i)(II), a PACE program may not disenroll a PACE program eligible individual on the ground that the individual has engaged in noncompliant behavior if such behavior is related to a mental or physical condition of the individual. For purposes of the preceding sentence, the term noncompliant behavior includes repeated noncompliance with medical advice and repeated failure to appear for appointments.

(iii) TIMELY REVIEW OF PROPOSED NONVOLUNTARY DISENROLLMENT.—A proposed disenrollment, other than a voluntary disenrollment, shall be subject to timely review and final determination by the Secretary or by the State administering agency (as applicable), prior to the proposed disenrollment becoming effective.

(d) PAYMENTS TO PACE PROVIDERS ON A CAPITATED BASIS.—

(1) IN GENERAL.—In the case of a PACE provider with a PACE program agreement under this section, except as provided in this subsection or by regulations, the Secretary shall make prospective monthly payments of a capitation amount for each PACE program eligible individual enrolled under the agreement under this section in the same manner and from the same sources as payments are made to a Medicare+Choice organization under section 1853 (or, for periods beginning before January 1, 1999, to an eligible organization under a risk–sharing contract under section 1876). Such payments shall be subject to adjustment in the manner described in section 1853(a)(2) or section 1876(a)(1)(E), as the case may be.

(2) CAPITATION AMOUNT.—The capitation amount to be applied under this subsection for a provider for a contract year shall be an amount specified in the PACE program agreement for the year. Such amount shall be based upon payment rates established for purposes of payment under section 1853 (or, for periods before January 1, 1999, for purposes of risk–sharing contracts under section 1876) and shall be adjusted to take into account the comparative frailty of PACE enrollees and such other factors as the Secretary determines to be appropriate. Such amount under such an agreement shall be computed in a manner so that the total payment level for all PACE program eligible individuals enrolled under a program is less than the projected payment under this title for a comparable population not enrolled under a PACE program.

(e) PACE PROGRAM AGREEMENT.—

(1) REQUIREMENT.—

(A) IN GENERAL.—The Secretary, in close cooperation with the State administering agency, shall establish procedures for entering into, extending, and terminating PACE program agreements for the operation of PACE programs by entities that meet the requirements for a PACE provider under this section, section 1934, and regulations.

(B) NUMERICAL LIMITATION.—

(i) IN GENERAL.—The Secretary shall not permit the number of PACE providers with which agreements are in effect under this section or under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 to exceed—(I) 40 as of the date of the enactment of this section; or (II) as of each succeeding anniversary of such date, the numerical limitation under this subparagraph for the preceding year plus 20. Subclause (II) shall apply without regard to the actual number of agreements in effect as of a previous anniversary date.

(ii) TREATMENT OF CERTAIN PRIVATE, FOR–PROFIT PROVIDERS.—The numerical limitation in clause (i) shall not apply to a PACE provider that—

(I) is operating under a demonstration project waiver under subsection (h); or

(II) was operating under such a waiver and subsequently qualifies for PACE provider status pursuant to subsection (a)(3)(B)(ii).

(2) SERVICE AREA AND ELIGIBILITY.—

(A) IN GENERAL.—A PACE program agreement for a PACE program—

(i) shall designate the service area of the program;

(ii) may provide additional requirements for individuals to qualify as PACE program eligible individuals with respect to the program;

(iii) shall be effective for a contract year, but may be extended for additional contract years in the absence of a notice by a party to terminate and is subject to termination by the Secretary and the State administering agency at any time for cause (as provided under the agreement);

(iv) shall require a PACE provider to meet all applicable State and local laws and requirements; and

(v) shall contain such additional terms and conditions as the parties may agree to, so long as such terms and conditions are consistent with this section and regulations.

(B) SERVICE AREA OVERLAP.—In designating a service area under a PACE program agreement under subparagraph (A)(i), the Secretary (in consultation with the State administering agency) may exclude from designation an area that is already covered under another PACE program agreement, in order to avoid unnecessary duplication of services and avoid impairing the financial and service viability of an existing program.

(3) DATA COLLECTION; DEVELOPMENT OF OUTCOME MEASURES.—

(A) DATA COLLECTION.—

(i) IN GENERAL.—Under a PACE program agreement, the PACE provider shall—

(I) collect data;

(II) maintain, and afford the Secretary and the State administering agency access to, the records relating to the program, including pertinent financial, medical, and personnel records; and

(III) make available to the Secretary and the State administering agency reports that the Secretary finds (in consultation with State administering agencies) necessary to monitor the operation, cost, and effectiveness of the PACE program under this section and section 1934 .

(ii) REQUIREMENTS DURING TRIAL PERIOD.— During the first 3 years of operation of a PACE program (either under this section or under a PACE demonstration waiver program), the PACE provider shall provide such additional data as the Secretary specifies in regulations in order to perform the oversight required under paragraph (4)(A).

(B) DEVELOPMENT OF OUTCOME MEASURES.—Under a PACE program agreement, the PACE provider, the Secretary, and the State administering agency shall jointly cooperate in the development and implementation of health status and quality of life outcome measures with respect to PACE program eligible individuals.

(4) OVERSIGHT.—

(A) ANNUAL, CLOSE OVERSIGHT DURING TRIAL PERIOD.—During the trial period (as defined in subsection(a)(9))with respect to a PACE program operated by a PACE provider, the Secretary (in cooperation with the State administering agency) shall conduct a comprehensive annual review of the operation of the PACE program by the provider in order to assure compliance with the requirements of this section and regulations. Such a review shall include—

(i) an on–site visit to the program site;

(ii) comprehensive assessment of a provider's fiscal soundness;

(iii) comprehensive assessment of the provider's capacity to provide all PACE services to all enrolled participants;

(iv) detailed analysis of the entity's substantial compliance with all significant requirements of this section and regulations; and

(v) any other elements the Secretary or State administering agency considers necessary or appropriate.

(B) CONTINUING OVERSIGHT.—After the trial period, the Secretary (in cooperation with the State administering agency) shall continue to conduct such review of the operation of PACE providers and PACE programs as may be appropriate, taking into account the performance level of a provider and compliance of a provider with all significant requirements of this section and regulations.

(C) DISCLOSURE.—The results of reviews under this paragraph shall be reported promptly to the PACE provider, along with any recommendations for changes to the provider's program, and shall be made available to the public upon request.

(5) TERMINATION OF PACE PROVIDER AGREEMENTS.—

(A) IN GENERAL.—Under regulations—

(i) the Secretary or a State administering agency may terminate a PACE program agreement for cause; and

(ii) a PACE provider may terminate an agreement after appropriate notice to the Secretary, the State agency, and enrollees.

(B) CAUSES FOR TERMINATION.—In accordance with regulations establishing procedures for termination of PACE program agreements, the Secretary or a State administering agency may terminate a PACE program agreement with a PACE provider for, among other reasons, the fact that—

(i) the Secretary or State administering agency determines that—

(I) there are significant deficiencies in the quality of care provided to enrolled participants; or

(II) the provider has failed to comply substantially with conditions for a program or provider under this section or section 1934; and

(ii) the entity has failed to develop and successfully initiate, within 30 days of the date of the receipt of written notice of such a determination, a plan to cor-

rect the deficiencies, or has failed to continue implementation of such a plan.

(C) TERMINATION AND TRANSITION PROCEDURES.— An entity whose PACE provider agreement is terminated under this paragraph shall implement the transition procedures required under subsection (a)(2)(C).

(6) SECRETARY'S OVERSIGHT; ENFORCEMENT AUTHORITY.—

(A) IN GENERAL.—Under regulations, if the Secretary determines (after consultation with the State administering agency) that a PACE provider is failing substantially to comply with the requirements of this section and regulations, the Secretary (and the State administering agency) may take any or all of the following actions:

(i) Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.

(ii) Withhold some or all further payments under the PACE program agreement under this section or section 1934 with respect to PACE program services furnished by such provider until the deficiencies have been corrected.

(iii) Terminate such agreement.

(B) APPLICATION OF INTERMEDIATE SANCTIONS.— Under regulations, the Secretary may provide for the application against a PACE provider of remedies described in section 1857(g)(2) (or, for periods before January 1, 1999, section 1876(i)(6)(B)) or 1903(m)(5)(B) in the case of violations by the provider of the type described in section 1857(g)(1) (or section 1876(i)(6)(A) for such periods) or 1903(m)(5)(A), respectively (in relation to agreements, enrollees, and requirements under this section or section 1934, respectively).

(7) PROCEDURES FOR TERMINATION OR IMPOSITION OF SANCTIONS.—Under regulations, the provisions of section 1857(h) (or for periods before January 1, 1999, section 1876(i)(9)) shall apply to termination and sanctions respecting a PACE program agreement and PACE provider under this subsection in the same manner as they apply to a termination and sanctions with respect to a contract and a Medicare+Choice organization under part D (or for such periods an eligible organization under section 1876).

(8) TIMELY CONSIDERATION OF APPLICATIONS FOR PACE PROGRAM PROVIDER STATUS.—In considering an application for PACE provider program status, the application shall be deemed approved unless the Secretary, within 90 days after the date of the submission of the application to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information that is needed in order to make a final determination with respect to the application. After the date the Secretary receives such additional information, the application shall be deemed approved unless the Secretary, within 90 days of such date, denies such request.

(f) REGULATIONS.—

(1) IN GENERAL.—The Secretary shall issue interim final or final regulations to carry out this section and section 1934.

(2) USE OF PACE PROTOCOL.—

(A) IN GENERAL.—In issuing such regulations, the Secretary shall, to the extent consistent with the provisions of this section, incorporate the requirements applied to PACE demonstration waiver programs under the PACE protocol.

(B)[756] FLEXIBILITY.—In order to provide for reasonable flexibility in adapting the PACE service delivery model to the needs of particular organizations (such as those in rural areas or those that may determine it appropriate to use nonstaff physicians according to State licensing law requirements) under this section and section 1934, the Secretary (in close consultation with State administering agencies) may modify or waive provisions of the PACE protocol so long as any such modification or waiver is not inconsistent with and would not impair the essential elements, objectives, and requirements of this section, but may not modify or waive any of the following provisions:

(i) The focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility.

(ii) The delivery of comprehensive, integrated acute and long–term care services.

(iii) The interdisciplinary team approach to care management and service delivery.

(iv) Capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals.

(v) The assumption by the provider of full financial risk.

(C) CONTINUATION OF MODIFICATIONS OR WAIVERS OF OPERATIONAL REQUIREMENTS UNDER DEMONSTRATION STATUS.—If a PACE program operating under demonstration authority has contractual or other operating arrangements which are not otherwise recognized in regulation and which were in effect on July 1, 2000, the Secretary (in close consultation with, and with the concurrence of, the State administering agency) shall permit any such program to continue such arrangements so long as such arrangements are found by the Secretary and the State to be reasonably consistent with the objectives of the PACE program.

(3) APPLICATION OF CERTAIN ADDITIONAL BENEFICIARY AND PROGRAM PROTECTIONS.—

(A) IN GENERAL.—In issuing such regulations and subject to subparagraph (B), the Secretary may apply with respect to PACE programs, providers, and agreements such requirements of part D (or, for periods before January 1, 1999, section 1876) and sections 1903(m) and 1932 relating to protection of beneficiaries and program integrity as would apply to Medicare+Choice organizations under part D (or for such periods eligible organizations under risk–sharing contracts under section 1876) and to medicaid

[756] See Vol. II, P.L. 106–554, §1(a)(6)[903], with respect to flexibility in exercising waiver authority.

managed care organizations under prepaid capitation agreements under section 1903(m).

(B) CONSIDERATIONS.—In issuing such regulations, the Secretary shall—

(i) take into account the differences between populations served and benefits provided under this section and under part D (or, for periods before January 1, 1999, section 1876) and section 1903(m);

(ii) not include any requirement that conflicts with carrying out PACE programs under this section; and

(iii) not include any requirement restricting the proportion of enrollees who are eligible for benefits under this title or title XIX.

(4) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the Secretary from including in regulations provisions to ensure the health and safety of individuals enrolled in a PACE program under this section that are in addition to those otherwise provided under paragraphs (2) and (3).

(g) WAIVERS OF REQUIREMENTS.—With respect to carrying out a PACE program under this section, the following requirements of this title (and regulations relating to such requirements) are waived and shall not apply:

(1) Section 1812, insofar as it limits coverage of institutional services.

(2) Sections 1813, 1814, 1833, and 1886, insofar as such sections relate to rules for payment for benefits.

(3) Sections 1814(a)(2)(B), 1814(a)(2)(C), and 1835(a)(2)(A), insofar as they limit coverage of extended care services or home health services.

(4) Section 1861(i), insofar as it imposes a 3–day prior hospitalization requirement for coverage of extended care services.

(5) Paragraphs (1) and (9) of section 1862(a), insofar as they may prevent payment for PACE program services to individuals enrolled under PACE programs.

(h) DEMONSTRATION PROJECT FOR FOR–PROFIT ENTITIES.—

(1) IN GENERAL.—In order to demonstrate the operation of a PACE program by a private, for–profit entity, the Secretary (in close consultation with State administering agencies) shall grant waivers from the requirement under subsection (a)(3) that a PACE provider may not be a for–profit, private entity.

(2) SIMILAR TERMS AND CONDITIONS.—

(A) IN GENERAL.—Except as provided under subparagraph (B), and paragraph (1), the terms and conditions for operation of a PACE program by a provider under this subsection shall be the same as those for PACE providers that are nonprofit, private organizations.

(B) NUMERICAL LIMITATION.—The number of programs for which waivers are granted under this subsection shall not exceed 10. Programs with waivers granted under this subsection shall not be counted against the numerical limitation specified in subsection (e)(1)(B).

(i) MISCELLANEOUS PROVISIONS.—Nothing in this section or section 1934 shall be construed as preventing a PACE provider from entering into contracts with other governmental or nongovernmental payers for the care of PACE program eligible individuals

who are not eligible for benefits under part A, or enrolled under part B, or eligible for medical assistance under title XIX.

PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES [757]

SEC. 1895. [42 U.S.C. 1395fff] (a) IN GENERAL.—Notwithstanding section 1861(v), the Secretary shall provide, for portions of cost reporting periods occurring on or after October 1, 2000, for payments for home health services in accordance with a prospective payment system established by the Secretary under this section.

(b) SYSTEM OF PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES.—

(1) IN GENERAL.—The Secretary shall establish under this subsection a prospective payment system for payment for all costs of home health services. Under the system under this subsection all services covered and paid on a reasonable cost basis under the medicare home health benefit as of the date of the enactment of this section, including medical supplies, shall be paid for on the basis of a prospective payment amount determined under this subsection and applicable to the services involved. In implementing the system, the Secretary may provide for a transition (of not longer than 4 years) during which a portion of such payment is based on agency–specific costs, but only if such transition does not result in aggregate payments under this title that exceed the aggregate payments that would be made if such a transition did not occur.

(2) UNIT OF PAYMENT.—In defining a prospective payment amount under the system under this subsection, the Secretary shall consider an appropriate unit of service and the number, type, and duration of visits provided within that unit, potential changes in the mix of services provided within that unit and their cost, and a general system design that provides for continued access to quality services.

(3) PAYMENT BASIS.—

(A) INITIAL BASIS.—

(i) IN GENERAL.— Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts) as follows:

(I) Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be

[757] See Vol. II, P.L. 105–33, §4602(d), with respect to the development of a case mix system; §4602(c), with respect to submission of data for a case mix system; §4603(e), with respect to a contingency regarding the prospective payment system; and §4613 with respect to a study on definition of homebound.

See Vol. II, P.L. 106–113, §1000(a)(6)[301], with respect to an adjustment to reflect administrative costs and a GAO report on costs of compliance with OASIS data collection requirements; [302(c)], with respect to a report analyzing the need for the 15 percent reduction under 1895(b)(3)(A)(ii); and [307], with respect to a study and report to Congress regarding the exemption of rural agencies and populations from inclusion in the home health Prospective Payment Systems.

See Vol. II, P.L. 106–554, §1(a)(6)[502(b)], with respect to a special rule for payment for fiscal year 2001 based on adjusted prospective payment amounts; [503], with respect to a temporary two–month periodic interim payment; [508], with respect to a temporary increase for home health services furnished in a rural area; and [547(c)], with respect to clarification of application of temporary payment increases for 2001.

See Vol. II, P.L. 108–173, §421, with respect to a one-year increase for home health services furnished in a rural area; §703, with respect to a demonstration project for medical adult daycare services; §704, with respect to temporary suspension of OASIS requirement for collection of data on non-medicare and non-medicaid patients; and §705, with respect to a MEDPAC study on Medicare margins of home health agencies.

computed in a manner so that the total amounts payable under the system for the 12–period beginning on the date the Secretary implements the system shall be equal to the total amount that would have been made if the system had not been in effect and if section 1861(v)(1)(L)(ix) had not been enacted.

(II) For the 12–month period beginning after the period described in subclause (I), such amount (or amounts) shall be equal to the amount (or amounts) determined under subclause (I), updated under subparagraph (B).

(III) For periods beginning after the period described in subclause (II), such amount (or amounts) shall be equal to the amount (or amounts) that would have been determined under subclause (I) that would have been made for fiscal year 2001 if the system had not been in effect and if section 1861(v)(1)(L)(ix) had not been in effect but if the reduction in limits described in clause (ii) had been in effect, updated under subparagraph (B).

Each such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and area wage adjustments among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.

(ii) REDUCTION.—The reduction described in this clause is a reduction by 15 percent in the cost limits and per beneficiary limits described in section 1861(v)(1)(L), as those limits are in effect on September 30, 2000.

(B) ANNUAL UPDATE.—

(i) IN GENERAL.—The standard prospective payment amount (or amounts) shall be adjusted for fiscal year 2002 and for fiscal year 2003 and for each subsequent year (beginning with 2004)[758] in a prospective manner specified by the Secretary by the home health applicable increase percentage (as defined in clause (ii)) applicable to the fiscal year or year[759] involved.

(ii) HOME HEALTH APPLICABLE INCREASE PERCENTAGE.—For purposes of this subparagraph, the term "home health applicable increase percentage" means, with respect to—

(I) each of fiscal years 2002 and 2003, the home health market basket percentage increase (as

[758] P.L. 108-173, §701(a)(1)(A), struck out "each fiscal year (beginning with fiscal year 2002)", and substituted "fiscal year 2002 and for fiscal year 2003 and for each subsequent year (beginning with 2004)", effective December 8, 2003.

[759] P.L. 108-173, §701(a)(1)(B), inserted "or year" after "the fiscal year", effective December 8, 2003.

defined in clause (iii)) minus 1.1 percentage points;[760]

(II)[761] for the last calendar quarter of 2003 and the first calendar quarter of 2004, the home health market basket percentage increase;

(III)[762] the last 3 calendar quarters of 2004, and each of 2005 and 2006 the home health market basket percentage increase minus 0.8 percentage points; or

(IV)[763] 2007 any subsequent year[764], the home health market basket percentage increase.

(iii) HOME HEALTH MARKET BASKET PERCENTAGE INCREASE.—For purposes of this subsection, the term home health market basket percentage increase means, with respect to a fiscal year or year[765], a percentage (estimated by the Secretary before the beginning of the fiscal year or year[766]) determined and applied with respect to the mix of goods and services included in home health services in the same manner as the market basket percentage increase under section 1886(b)(3)(B)(iii) is determined and applied to the mix of goods and services comprising inpatient hospital services for the fiscal year or year[767].

(iv)[768] ADJUSTMENT FOR CASE MIX CHANGES.—Insofar as the Secretary determines that the adjustments under paragraph (4)(A)(i) for a previous fiscal year or year[769] (or estimates that such adjustments for a future fiscal year or year[770]) did (or are likely to) result in a change in aggregate payments under this subsection during the fiscal year or year[771] that are a result of changes in the coding or classification of different units of services that do not reflect real changes in case mix, the Secretary may adjust the standard prospective payment amount (or amounts) under paragraph (3) for subsequent fiscal years or years[772] so as to eliminate the effect of such coding or classification changes.

(C) ADJUSTMENT FOR OUTLIERS.—The Secretary shall reduce the standard prospective payment amount (or amounts) under this paragraph applicable to home health services furnished during a period by such proportion as will result in an aggregate reduction in payments for the

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[760] P.L. 108-173, §701(a)(2)(A), struck out "or".

[761] P.L. 108-173, §701(a)(2)(D), added subclause (II), effective December 8, 2003.

P.L. 108-173, §701(b)(1), struck out "or".

[762] P.L. 108-173, §701(b)(4), added subclause (III), effective December 8, 2003.

[763] P.L. 108-173, §701(a)(2)(B), redesignated the former subclause (II) as subclause (III).

P.L. 108-173, §701(b)(2), redesignated the former subclause (III) as subclause (IV).

[764] P.L. 108-173, §701(a)(2)(C), struck out "any subsequent fiscal year" and inserted "2004* and any subsequent year", effective December 8, 2003.

*P.L. 108-173, §701(b)(3), struck out "2004" and substituted "2007", effective December 8, 2003.

[765] P.L. 108-173, §701(a)(3), inserted "or year", effective December 8, 2003.

[766] P.L. 108-173, §701(a)(3), inserted "or year", effective December 8, 2003.

[767] P.L. 108-173, §701(a)(3), inserted "or year", effective December 8, 2003.

[768] P.L. 106-554, 501(c)(1), added clause (iv), applicable to episodes concluding on or after October 1, 2001.

[769] P.L. 108-173, §701(a)(4)(A), inserted "or year", effective December 8, 2003.

[770] P.L. 108-173, §701(a)(4)(A), inserted "or year", effective December 8, 2003.

[771] P.L. 108-173, §701(a)(4)(A), inserted "or year", effective December 8, 2003.

[772] P.L. 108-173, §701(a)(4)(B), inserted "or years", effective December 8, 2003.

period equal to the aggregate increase in payments resulting from the application of paragraph (5) (relating to outliers).

(4) PAYMENT COMPUTATION.—

(A) IN GENERAL.—The payment amount for a unit of home health services shall be the applicable standard prospective payment amount adjusted as follows:

(i) CASE MIX ADJUSTMENT.—The amount shall be adjusted by an appropriate case mix adjustment factor (established under subparagraph (B)).

(ii) AREA WAGE ADJUSTMENT.—The portion of such amount that the Secretary estimates to be attributable to wages and wage–related costs shall be adjusted for geographic differences in such costs by an area wage adjustment factor (established under subparagraph (C)) for the area in which the services are furnished or such other area as the Secretary may specify.

(B) ESTABLISHMENT OF CASE MIX ADJUSTMENT FACTORS.—The Secretary shall establish appropriate case mix adjustment factors for home health services in a manner that explains a significant amount of the variation in cost among different units of services.

(C) ESTABLISHMENT OF AREA WAGE ADJUSTMENT FACTORS.—The Secretary shall establish area wage adjustment factors that reflect the relative level of wages and wage–related costs applicable to the furnishing of home health services in a geographic area compared to the national average applicable level. Such factors may be the factors used by the Secretary for purposes of section 1886(d)(3)(E).

(5) OUTLIERS.—The Secretary may provide for an addition or adjustment to the payment amount otherwise made in the case of outliers because of unusual variations in the type or amount of medically necessary care. The total amount of the additional payments or payment adjustments made under this paragraph with respect to a fiscal year or year[773] may not exceed 5 percent of the total payments projected or estimated to be made based on the prospective payment system under this subsection in that year.

(6) PRORATION OF PROSPECTIVE PAYMENT AMOUNTS.—If a beneficiary elects to transfer to, or receive services from, another home health agency within the period covered by the prospective payment amount, the payment shall be prorated between the home health agencies involved.

(c) REQUIREMENTS FOR PAYMENT INFORMATION.—With respect to home health services furnished on or after October 1, 1998, no claim for such a service may be paid under this title unless—

(1) the claim has the unique identifier (provided under section 1842(r)) for the physician who prescribed the services or made the certification described in section 1814(a)(2) or 1835(a)(2)(A); and

(2) in the case of a service visit described in paragraph (1), (2), (3), or (4) of section 1861(m), the claim contains a code (or codes) specified by the Secretary that identifies the length of time of the service visit, as measured in 15 minute increments.

[773] P.L. 108-173, §701(a)(5), inserted "or year", effective December 8, 2003.

(d) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

(1) the establishment of a transition period under subsection (b)(1);

(2) the definition and application of payment units under subsection (b)(2);

(3) the computation of initial standard prospective payment amounts under subsection (b)(3)(A) (including the reduction described in clause (ii) of such subsection);

(4) the establishment of the adjustment for outliers under subsection (b)(3)(C);

(5) the establishment of case mix and area wage adjustments under subsection (b)(4); and

(6) the establishment of any adjustments for outliers under subsection (b)(5).

(e) CONSTRUCTION RELATED TO HOME HEALTH SERVICES.—

(1) TELECOMMUNICATIONS.—Nothing in this section shall be construed as preventing a home health agency furnishing a home health unit of service for which payment is made under the prospective payment system established by this section for such units of service from furnishing services via a telecommunication system if such services—

(A) do not substitute for in-person home health services ordered as part of a plan of care certified by a physician pursuant to section 1814(a)(2)(C) or 1835(a)(2)(A); and

(B) are not considered a home health visit for purposes of eligibility or payment under this title.

(2) PHYSICIAN CERTIFICATION.—Nothing in this section shall be construed as waiving the requirement for a physician certification under section 1814(a)(2)(C) or 1835(a)(2)(A) of such Act (42 U.S.C. 1395f(a)(2)(C), 1395n(a)(2)(A)) for the payment for home health services, whether or not furnished via a telecommunications system.

MEDICARE SUBVENTION FOR MILITARY RETIREES [774]

SEC. 1896. [42 U.S.C. 1395ggg] (a) DEFINITIONS.—In this section:

(1) ADMINISTERING SECRETARIES.—The term administering Secretaries means the Secretary and the Secretary of Defense acting jointly.

(2) DEMONSTRATION PROJECT; PROJECT.—The terms demonstration project and project mean the demonstration project carried out under this section.

(3) DESIGNATED PROVIDER.—The term designated provider has the meaning given that term in section 721(5) of the National Defense Authorization Act For Fiscal Year 1997 (Public Law 104–201; 110 Stat. 2593; 10 U.S.C. 1073 note).

(4) MEDICARE–ELIGIBLE MILITARY RETIREE OR DEPENDENT.—The term medicare–eligible military retiree or dependent means an individual described in section 1074(b) or 1076(b) of title 10, United States Code, who—

[774] See Vol. II, P.L. 105–33, §4015(b), with respect to an implementation plan for veterans subvention.

See Vol. II, P.L. 106–398, §1[712(f)], with respect to a conditional effective date, and [712(c)(2)], (c)(3), (d) an (e) with respect to the negotiations of an agreement under §1896(b)(4) and the effective date for that agreement.

(A) is eligible for health benefits under section 1086 of such title by reason of subsection (c)(1) of such section;

(B)(i) is entitled to benefits under part A of this title; and

(ii) if the individual was entitled to such benefits before July 1, 1997, received health care items or services from a health care facility of the uniformed services before that date, but after becoming entitled to benefits under part A of this title;

(C) is enrolled for benefits under part B of this title; and

(D) has attained age 65.

(5) MEDICARE HEALTH CARE SERVICES.—The term medicare health care services means items or services covered under part A or B of this title.

(6) MILITARY TREATMENT FACILITY.—The term military treatment facility means a facility referred to in section 1074(a) of title 10, United States Code.

(7) TRICARE.—The term TRICARE has the same meaning as the term TRICARE program under section 711 of the National Defense Authorization Act for Fiscal Year 1996 (10 U.S.C. 1073 note).

(8) TRUST FUNDS.—The term trust funds means the Federal Hospital Insurance Trust Fund established in section 1817 and the Federal Supplementary Medical Insurance Trust Fund established in section 1841.

(b) DEMONSTRATION PROJECT.—

(1) IN GENERAL.—

(A) ESTABLISHMENT.—The administering Secretaries are authorized to establish a demonstration project (under an agreement entered into by the administering Secretaries) under which the Secretary shall reimburse the Secretary of Defense, from the trust funds, for medicare health care services furnished to certain medicare–eligible military retirees or dependents in a military treatment facility or by a designated provider.

(B) AGREEMENT.—The agreement entered into under subparagraph (A) shall include at a minimum—

(i) a description of the benefits to be provided to the participants of the demonstration project established under this section;

(ii) a description of the eligibility rules for participation in the demonstration project, including any cost sharing requirements;

(iii) a description of how the demonstration project will satisfy the requirements under this title;

(iv) a description of the sites selected under paragraph (2);

(v) a description of how reimbursement requirements under subsection (i) and maintenance of effort requirements under subsection (j) will be implemented in the demonstration project;

(vi) a statement that the Secretary shall have access to all data of the Department of Defense that the Secretary determines is necessary to conduct independent estimates and audits of the maintenance of effort re-

quirement, the annual reconciliation, and related matters required under the demonstration project;

(vii) a description of any requirement that the Secretary waives pursuant to subsection (d); and

(viii) a certification, provided after review by the administering Secretaries, that any entity that is receiving payments by reason of the demonstration project has sufficient—

(I) resources and expertise to provide, consistent with payments under subsection (i), the full range of benefits required to be provided to beneficiaries under the project; and

(II) information and billing systems in place to ensure the accurate and timely submission of claims for benefits and to ensure that providers of services, physicians, and other health care professionals are reimbursed by the entity in a timely and accurate manner.

(2) NUMBER OF SITES.—The project established under this section shall be conducted in no more than 6 sites, designated jointly by the administering Secretaries after review of all TRICARE regions.

(3) RESTRICTION.—No new military treatment facilities will be built or expanded with funds from the demonstration project.

(4) DURATION.—The administering Secretaries shall conduct the demonstration project during the 4–year period beginning on January 1, 1998, except that the administering Secretaries may negotiate and (subject to section 712(f)[775] of the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001) enter into a new or revised agreement under paragraph (1)(A) to continue the project after the end of such period. If the project is so continued, the administering Secretaries may terminate the agreement under which the program operates after providing notice to Congress in accordance with subsection (k)(2)(B)(v).

(5) REPORT.—At least 60 days prior to the commencement of the demonstration project, the administering Secretaries shall submit a copy of the agreement entered into under paragraph (1) to the committees of jurisdiction under this title.

(c) CREDITING OF PAYMENTS.—A payment received by the Secretary of Defense under the demonstration project shall be credited to the applicable Department of Defense medical appropriation (and within that appropriation). Any such payment received during a fiscal year for services provided during a prior fiscal year may be obligated by the Secretary of Defense during the fiscal year during which the payment is received.

(d) WAIVER OF CERTAIN MEDICARE REQUIREMENTS.—

(1) AUTHORITY.—

(A) IN GENERAL.—Except as provided under subparagraph (B), the demonstration project shall meet all requirements of Medicare+Choice plans under part D of this title and regulations pertaining thereto, and other requirements for receiving medicare payments, except that the

[775] P.L. 108-173, §736(c)(8), struck out "701(f)" and inserted "712(f).

prohibition of payments to Federal providers of services under sections 1814(c) and 1835(d), and paragraphs (2) and (3) of section 1862(a) shall not apply.

(B) WAIVER.—Except as provided in paragraph (2), the Secretary is authorized to waive any requirement described under subparagraph (A), or approve equivalent or alternative ways of meeting such a requirement, but only if such waiver or approval—

(i) reflects the unique status of the Department of Defense as an agency of the Federal Government; and

(ii) is necessary to carry out the demonstration project.

(2) BENEFICIARY PROTECTIONS AND OTHER MATTERS.—The demonstration project shall comply with the requirements of part D of this title that relate to beneficiary protections and other matters, including such requirements relating to the following areas:

(A) Enrollment and disenrollment.

(B) Nondiscrimination.

(C) Information provided to beneficiaries.

(D) Cost–sharing limitations.

(E) Appeal and grievance procedures.

(F) Provider participation.

(G) Access to services.

(H) Quality assurance and external review.

(I) Advance directives.

(J) Other areas of beneficiary protections that the Secretary determines are applicable to such project.

(e) INSPECTOR GENERAL.—Nothing in the agreement entered into under subsection (b) shall limit the Inspector General of the Department of Health and Human Services from investigating any matters regarding the expenditure of funds under this title for the demonstration project, including compliance with the provisions of this title and all other relevant laws.

(f) VOLUNTARY PARTICIPATION.—Participation of medicare–eligible military retirees or dependents in the demonstration project shall be voluntary.

(g) TRICARE HEALTH CARE PLANS.—

(1) MODIFICATION OF TRICARE CONTRACTS.—In carrying out the demonstration project, the Secretary of Defense is authorized to amend existing TRICARE contracts (including contracts with designated providers) in order to provide the medicare health care services to the medicare–eligible military retirees and dependents enrolled in the demonstration project consistent with part D of this title.

(2) HEALTH CARE BENEFITS.—The administering Secretaries shall prescribe the minimum health care benefits to be provided under such a plan to medicare–eligible military retirees or dependents enrolled in the plan. Those benefits shall include at least all medicare health care services covered under this title.

(h) ADDITIONAL PLANS.—Notwithstanding any provisions of title 10, United States Code, the administering Secretaries may agree to include in the demonstration project any of the Medicare+Choice plans described in section 1851(a)(2)(A), and such agreement may include an agreement between the Secretary of Defense and the

Medicare+Choice organization offering such plan to provide medicare health care services to medicare–eligible military retirees or dependents and for such Secretary to receive payments from such organization for the provision of such services.

(i) PAYMENTS BASED ON REGULAR MEDICARE PAYMENT RATES.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall reimburse the Secretary of Defense for services provided under the demonstration project at a rate equal to 95 percent of the amount paid to a Medicare+Choice organization under part D of this title with respect to such an enrollee. In cases in which a payment amount may not otherwise be readily computed, the Secretary shall establish rules for computing equivalent or comparable payment amounts.

(2) EXCLUSION OF CERTAIN AMOUNTS.—In computing the amount of payment under paragraph (1), the following shall be excluded:

(A) SPECIAL PAYMENTS.—Any amount attributable to an adjustment under subparagraphs (B) and (F) of section 1886(d)(5) and subsection (h) of such section.

(B) PERCENTAGE OF CAPITAL PAYMENTS.—An amount determined by the administering Secretaries for amounts attributable to payments for capital–related costs under subsection (g) of such section.

(3) PERIODIC PAYMENTS FROM MEDICARE TRUST FUNDS.—Payments under this subsection shall be made—

(A) on a periodic basis consistent with the periodicity of payments under this title; and

(B) in appropriate part, as determined by the Secretary, from the trust funds.

(4) CAP ON AMOUNT.—The aggregate amount to be reimbursed under this subsection pursuant to the agreement entered into between the administering Secretaries under subsection (b) shall not exceed a total of—

(A) $50,000,000 for calendar year 1998;

(B) $60,000,000 for calendar year 1999;

(C) $65,000,000 for calendar year 2000;and

(D) $70,000,000 for calendar year 2001.

(j) MAINTENANCE OF EFFORT.—

(1) MONITORING EFFECT OF DEMONSTRATION PROGRAM ON COSTS TO MEDICARE PROGRAM.—

(A) IN GENERAL.—The administering Secretaries, in consultation with the Comptroller General, shall closely monitor the expenditures made under the medicare program for medicare–eligible military retirees or dependents during the period of the demonstration project compared to the expenditures that would have been made for such medicare– eligible military retirees or dependents during that period if the demonstration project had not been conducted. The agreement entered into by the administering Secretaries under subsection (b) shall require any participating military treatment facility to maintain the level of effort for space available care to medicare–eligible military retirees or dependents.

(B) ANNUAL REPORT BY THE COMPTROLLER GENERAL.—Not later than December 31 of each year during which the

demonstration project is conducted, the Comptroller General shall submit to the administering Secretaries and the appropriate committees of Congress a report on the extent, if any, to which the costs of the Secretary under the medicare program under this title increased during the preceding fiscal year as a result of the demonstration project.

(2) REQUIRED RESPONSE IN CASE OF INCREASE IN COSTS.—

(A) IN GENERAL.—If the administering Secretaries find, based on paragraph (1), that the expenditures under the medicare program under this title increased (or are expected to increase) during a fiscal year because of the demonstration project, the administering Secretaries shall take such steps as may be needed—

(i) to recoup for the medicare program the amount of such increase in expenditures; and

(ii) to prevent any such increase in the future.

(B) STEPS.—Such steps—

(i) under subparagraph (A)(i) shall include payment of the amount of such increased expenditures by the Secretary of Defense from the current medical care appropriation of the Department of Defense to the trust funds; and

(ii) under subparagraph (A)(ii) shall include suspending or terminating the demonstration project (in whole or in part) or lowering the amount of payment under subsection (i)(1).

(k) EVALUATION AND REPORTS.—

(1) INDEPENDENT EVALUATION.—The Comptroller General of the United States shall conduct an evaluation of the demonstration project, and shall submit annual reports on the demonstration project to the administering Secretaries and to the committees of jurisdiction in the Congress. The first report shall be submitted not later than 12 months after the date on which the demonstration project begins operation, and the final report not later than 3 ½ years after that date. The evaluation and reports shall include an assessment, based on the agreement entered into under subsection (b), of the following:

(A) Any savings or costs to the medicare program under this title resulting from the demonstration project.

(B) The cost to the Department of Defense of providing care to medicare–eligible military retirees and dependents under the demonstration project.

(C) A description of the effects of the demonstration project on military treatment facility readiness and training and the probable effects of the project on overall Department of Defense medical readiness and training.

(D) Any impact of the demonstration project on access to care for active duty military personnel and their dependents.

(E) An analysis of how the demonstration project affects the overall accessibility of the uniformed services treatment system and the amount of space available for point–of– service care, and a description of the unintended effects (if any) upon the normal treatment priority system.

(F) Compliance by the Department of Defense with the requirements under this title.

(G) The number of medicare–eligible military retirees and dependents opting to participate in the demonstration project instead of receiving health benefits through another health insurance plan (including benefits under this title).

(H) A list of the health insurance plans and programs that were the primary payers for medicare–eligible military retirees and dependents during the year prior to their participation in the demonstration project and the distribution of their previous enrollment in such plans and programs.

(I) Any impact of the demonstration project on private health care providers and beneficiaries under this title that are not enrolled in the demonstration project.

(J) An assessment of the access to care and quality of care for medicare–eligible military retirees and dependents under the demonstration project.

(K) An analysis of whether, and in what manner, easier access to the uniformed services treatment system affects the number of medicare–eligible military retirees and dependents receiving medicare health care services.

(L) Any impact of the demonstration project on the access to care for medicare–eligible military retirees and dependents who did not enroll in the demonstration project and for other individuals entitled to benefits under this title.

(M) A description of the difficulties (if any) experienced by the Department of Defense in managing the demonstration project and TRICARE contracts.

(N) Any additional elements specified in the agreement entered into under subsection (b).

(O) Any additional elements that the Comptroller General of the United States determines is appropriate to assess regarding the demonstration project.

(2) REPORT ON EXTENSION AND EXPANSION OF DEMONSTRATION PROJECT.—Not later than 6 months after the date of the submission of the final report by the Comptroller General of the United States under paragraph (1), the administering Secretaries shall submit to Congress a report containing their recommendation as to—

(A) whether there is a cost to the health care program under this title in conducting the demonstration project, and whether the demonstration project could be expanded without there being a cost to such health care program or to the Federal Government;

(B) whether to extend the demonstration project or make the project permanent; and

(C) whether the terms and conditions of the project should be continued (or modified) if the project is extended or expanded.

HEALTH CARE INFRASTRUCTURE IMPROVEMENT PROGRAM[776]

SEC. 1897. [42 U.S.C. 1395hhh] (a) ESTABLISHMENT.—The Secretary shall establish a loan program that provides loans to qualifying hospitals for payment of the capital costs of projects described in subsection (d).

(b) APPLICATION.—No loan may be provided under this section to a qualifying hospital except pursuant to an application that is submitted and approved in a time, manner, and form specified by the Secretary. A loan under this section shall be on such terms and conditions and meet such requirements as the Secretary determines appropriate.

(c) SELECTION CRITERIA.—

(1) IN GENERAL.—The Secretary shall establish criteria for selecting among qualifying hospitals that apply for a loan under this section. Such criteria shall consider the extent to which the project for which loan is sought is nationally or regionally significant, in terms of expanding or improving the health care infrastructure of the United States or the region or in terms of the medical benefit that the project will have.

(2) QUALIFYING HOSPITAL DEFINED.—For purposes of this section, the term "qualifying hospital" means a hospital that—

(A) is engaged in research in the causes, prevention, and treatment of cancer; and

(B) is designated as a cancer center for the National Cancer Institute or is designated by the State as the official cancer institute of the State.

(d) PROJECTS.—A project described in this subsection is a project of a qualifying hospital that is designed to improve the health care infrastructure of the hospital, including construction, renovation, or other capital improvements.

(e) STATE AND LOCAL PERMITS.——The provision of a loan under this section with respect to a project shall not—

(1) relieve any recipient of the loan of any obligation to obtain any required State or local permit or approval with respect to the project;

(2) limit the right of any unit of State or local government to approve or regulate any rate of return on private equity invested in the project; or

(3) otherwise supersede any State or local law (including any regulation) applicable to the construction or operation of the project.

(f) FORGIVENESS OF INDEBTEDNESS.—The Secretary may forgive a loan provided to a qualifying hospital under this section under terms and conditions that are analogous to the loan forgiveness provision for student loans under part D of title IV of the Higher Education Act of 1965 (20 U.S.C. 1087a et seq.), except that the Secretary shall condition such forgiveness on the establishment by the hospital of—

(A) an outreach program for cancer prevention, early diagnosis, and treatment that provides services to a substantial majority of the residents of a State or region, including residents of rural areas;

[776] P.L. 108-173, §1016, added §1897, effective December 8, 2003.

(B) an outreach program for cancer prevention, early diagnosis, and treatment that provides services to multiple Indian tribes; and

(C)(i) unique research resources (such as population databases); or

(ii) an affiliation with an entity that has unique research resources.

(g) FUNDING.—

(1) In general.—There are appropriated, out of amounts in the Treasury not otherwise appropriated, to carry out this section, $200,000,000, to remain available during the period beginning on July 1, 2004, and ending on September 30, 2008.

(2) ADMINISTRATIVE COSTS.—From funds made available under paragraph (1), the Secretary may use, for the administration of this section, not more than $2,000,000 for each of fiscal years 2004 through 2008.

(3) AVAILABILITY.—Amounts appropriated under this section shall be available for obligation on July 1, 2004.

(h) REPORT TO CONGRESS.—Not later than 4 years after the date of the enactment of this section, the Secretary shall submit to Congress a report on the projects for which loans are provided under this section and a recommendation as to whether the Congress should authorize the Secretary to continue loans under this section beyond fiscal year 2008.

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS [1]

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[1] Title XIX of the Social Security Act is administered by the Centers for Medicare and Medicaid Services.

Title XIX appears in the United States Code as §§1396–1396v, subchapter XIX, chapter 7, Title 42.

Regulations relating to Title XIX are contained in chapter IV, Title 42, and subtitle A, Title 45, Code of Federal Regulations.

See Vol. II, 31 U.S.C. 6504–6505 with respect to intergovernmental cooperation. See Vol. II, 31 U.S.C. 7501–7507 with respect to uniform audit requirements for State and local governments receiving Federal financial assistance.

See Vol. II, P.L. 78–410, §317A(a) and (d), with respect to coordination required in lead poisoning prevention; §353(i)(3) and (n), with respect to clinical laboratories; and §1301(c)(3), with respect to the requirement that health maintenance organizations enroll individuals entitled to medical assistance under Title XIX.

See Vol. II, P.L. 79–396, §17(p), with respect to proprietary title XIX center.

See Vol. II, P.L. 88–352, §601, for prohibition against discrimination in federally assisted programs.

See Vol. II, P.L. 89–73, §§203 and §306(c) with respect to agreements with other agencies.

See Vol. II, P.L. 94–566, §503, with respect to preservation of medicaid eligibility for individuals who cease to be eligible for supplemental security income benefits on account of cost-of-living increases in social security benefits.

See Vol. II, P.L. 95–521, §102(i), with respect to reporting of benefits received under the Social Security Act.

See Vol. II, P.L. 99–319, §105, with respect to requirements for a system established regarding the rights of individuals with mental illness.

See Vol. II, P.L. 100–203, §4211(j) with respect to technical assistance with respect to the development and implementation of reimbursement methods for nursing facilities.

See Vol. II, P.L. 100–204, §724(d), with respect to furnishing information to the United States Commission on Improving the Effectiveness of the United Nations; and §725(b), with respect to the detailing of Government personnel.

See Vol. II, P.L. 100–235, §§5–8, with respect to responsibilities of each Federal agency for computer systems security and privacy.

See Vol. II, P.L. 100–690, §2306(c)(4), with respect to services covered in the plan of Hawaii; and §5301(a)(1)(C) and (d)(1)(B), with respect to benefits of drug traffickers and possessors.

See Vol. II, P.L. 101–121, with respect to the amounts collected by the Secretary of Health and Human Services under the authority of title IV of the Indian Health Care Improvement Act.

See Vol. II, P.L. 101–239, §6507, with respect to research on infant mortality and medicaid services; §6509, with respect to a maternal and child health handbook.

See Vol. II, P.L. 101–508, §4401(d), with respect to an annual report on drug pricing; §13302, with respect to protection of OASDI Trust Funds in the House of Representatives.

[2] This table of contents does not appear in the law.

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APPROPRIATION

SEC. 1901. [42 U.S.C. 1396] For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.

STATE PLANS FOR MEDICAL ASSISTANCE[3]

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,[4] (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

[3] 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.

[4] 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.

207 or 208 of title 18, United States Code[5], 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[6] administration of the plan; and[7]

(B)[8] 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 and free or reduced price lunches under the Richard B. Russell National School Lunch Act, in accordance with section 9(b) of that Act, using data standards and formats established by the State agency;

(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,

[5] See Vol. II, Title 18.
[6] P.L. 108–265, §105(b)(1), struck out "connected with the" and substituted "connected with—(A) the", effective June 30, 2004.
[7] P.L. 108–265, §105(b)(2), added "and".
[8] P.L. 108–265, §105(b)(3), added subparagraph (B), effective June 30, 2004.

(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, and

(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);

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17) and (21) 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) with respect to whom supplemental security income benefits are being paid under title XVI (or were being paid as of the date of the enactment of section 211(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104–193)) and would continue to be paid but for the enactment of that section or who are qualified severely impaired individuals (as defined in section 1905(q)),

(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, or

(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;

(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) 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; or

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

(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 (but only for premiums payable with respect to months during the period beginning with January 1998, and ending with September 2005[9]) for medicare cost-sharing described[10] 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

[9] P.L. 108-173, §103(f)(1), struck out "ending with March 2004" and substituted "ending with September 2004*", effective December 8, 2003, applicable to calendar quarters beginning on or after April 1, 2004.

*P.L. 108-448, §1(a), struck out "2004" and substituted "2005", effective December 8, 2004.

[10] P.L. 108-89, §401(a)(2), struck out "ending with December 2002)—

(I) for medicare cost–sharing described" and substituted "ending with March 2004) for medicare cost-sharing described", effective October 1, 2003.

P.L. 108-89, §401(a)(1), struck out subclause (II), effective October 1, 2003. For subclause II as it formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L. 108-89.

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;[11]

(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, dura-

[11] P.L. 108-89, §401(a)(3), struck out ", and" and substituted a semicolon, effective October 1, 2003.

tion, 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)), and (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;

(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 [12];

(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; and

[12] See Vol. II, P.L. 89–642.

(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;

(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 (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)[13] or section 1603(a)(4)(A)(i) and (ii)[14] 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;

[13] 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.

[14] 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.

(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;

(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, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, and health maintenance organizations) 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 to the extent of such legal liability;

(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; and

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

(F) that in the case of any services covered under such plan which are provided to an individual on whose behalf child support enforcement is being carried out by the State agency under part D of title IV of this Act, the State shall—

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to any third-party liability for payment for such services, if such third-party liability is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by such agency, if payment has not been made by such third party within 30 days after such services are furnished;

(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, 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; and

(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 payment by any other party for such health care items or services;

(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); [15]

(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, 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 that whenever a provider of services or any other person is terminated, suspended, or otherwise sanctioned or prohibited from participating under the State plan, the State agency shall promptly notify the Secretary and, in the case of a physician and notwithstanding paragraph (7), the State medical licensing board of such action;

(42) provide that 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 nec-

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

essary to insure that proper payments are made under the plan;

(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

(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) 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;

(47) at the option of the State, provide 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;

(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 [16]), 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;

[16] See Vol. II, P.L. 89-642.

(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)[17], 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;

[17] Probably should be "1905(l)(2)(B)".

(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; [18]

(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; [19]

(66) [20] provide for making eligibility determinations under section 1935(a); and [21]

(67) [22] 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).

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

[18] P.L. 108-173, §103(a)(1)(A), struck out "and".

[19] P.L. 108-173, §103(a)(1)(B), struck out the period and substituted "; and".

P.L. 108-173, 236(b)(1)(A), struck out "and".

[20] P.L. 108-173, §103(a)(1)(C), added paragraph (66), effective December 8, 2003.

[21] P.L. 108-173, §236(b)(1)(B), struck out the period and substituted "; and".

[22] P.L. 108-173, §236(b)(1)(C), added paragraph (67), effective December 8, 2003, applicable to services furnished on or after January 1, 2004.

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[23] not been applicable to such individual.

The requirement of clause[24] (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

[23] See Vol. II, P.L. 92–336.

[24] As in original. Should be "subparagraph".

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)(A) Notwithstanding any other provision of this title, effective January 1, 1974, subject to subparagraph (B) each State plan approved under this title must provide that each family which was receiving aid pursuant to a plan of the State approved under part A of title IV in at least 3 of the 6 months immediately preceding the month in which such family became ineligible for such aid because of increased hours of, or increased income from, employment, shall, while a member of such family is employed, remain eligible for assistance under the plan approved under this title (as though the family was receiving aid under the plan approved under part A of title IV) for 4 calendar months beginning with the month in which such family became ineligible for aid under the plan approved under part A of title IV because of income and resources or hours of work limitations contained in such plan.

(B) Subparagraph (A) shall not apply with respect to families that cease to be eligible for aid under part A of title IV during the period beginning on April 1, 1990, and ending on September 30, 2003[25]. During such period, for provisions relating to extension of eligibility for medical assistance for certain families who have received aid pursuant to a State plan approved under part A of title IV and have earned income, see section 1925.

(2)(A) In the case of an individual who is enrolled with a medicaid managed care organization (as defined in section 1903(m)(1)(A)), with a primary care case manager (as defined in section 1905(t)), or with an eligible organization with a contract under section 1876 and who would (but for this paragraph) lose eligibility for benefits under this title before the end of the minimum enrollment period (defined in subparagraph (B)), the State plan may provide, notwithstanding any other provision of this title, that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum period, but, except for benefits furnished under section 1905(a)(4)(C), only with respect to such benefits provided to the individual as an enrollee of such organization or entity or by or through the case manager.[26]

[25] P.L. 108-40, §7(b), struck out "2002" and substituted "2003", effective July 1, 2003.

[26] 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.

(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 so long as the child is a member of the woman's household and the woman remains (or would remain if pregnant) eligible for such assistance. 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).

(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.

(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 dem-

onstrates 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) [Stricken. [27]]

(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,

[27] P.L. 103–66, §13611(d)(1)(C); 107 Stat. 627.

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[28]) 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[29], 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[30], 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

[28] See Vol. II, P.L. 97–35.
[29] July 1, 1988.
[30] December 19, 1989; P.L. 101–239, 103 Stat. 2106.

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 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[31]) 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

[31] See Vol. II, P.L. 97–35.

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 insection 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[32],

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,

[32] See Vol. II, Title 38, §1741.

(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[33]) 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[34].

(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.

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[33] See Vol. II, P.L. 97–35.

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

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

(v) A State plan may provide for the making of determinations of disability or blindness for the purpose of determining eligibility for medical assistance under the State plan by the single State agency or its designee, and make medical assistance available to individuals whom it finds to be blind or disabled and who are determined otherwise eligible for such assistance during the period of time prior to which a final determination of disability or blindness is made by the Social Security Administration with respect to such an individual. In making such determinations, the State must apply the definitions of disability and blindness found in section 1614(a) of the Social Security Act.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(x) The Secretary shall establish a system, for implementation by not later than July 1, 1991, which provides for a unique identifier for each physician who furnishes services for which payment may be made under a State plan approved under this title.[35]

(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—

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

(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.

PAYMENT TO STATES [36]

SEC. 1903. [42 U.S.C. 1396b] (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966—

(1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b), subject to subsections (g) and (j) of this section and subsection 1923(f)) of the total amount expended during such quarter as medical assistance under the State plan; plus

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

(B) notwithstanding paragraph (1) or subparagraph (A), with respect to amounts expended for nursing aide training and competency evaluation programs, and competency evaluation programs, described in section 1919(e)(1) (including the costs for nurse aides to complete such competency evaluation programs), regardless of whether the programs are provided in or outside nursing facilities or of

[36] See Vol. II, P.L. 108-173, §1001(c), with respect to a clarification regarding non-regulation of funds tranfers.

the skill of the personnel involved in such programs, an amount equal to 50 percent (or, for calendar quarters beginning on or after July 1, 1988, and before October 1, 1990, the lesser of 90 percent or the Federal medical assistance percentage plus 25 percentage points) of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to such programs; plus

(C) an amount equal to 75 percent of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to preadmission screening and resident review activities conducted by the State under section 1919(e)(7); plus

(D) for each calendar quarter during—

(i) fiscal year 1991, an amount equal to 90 percent,

(ii) fiscal year 1992, an amount equal to 85 percent,

(iii) fiscal year 1993, an amount equal to 80 percent, and

(iv) fiscal year 1994 and thereafter, an amount equal to 75 percent,

of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to State activities under section 1919(g); plus

(3) an amount equal to—

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

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

(B) 75 per centum of so much of the sums expended during such quarter as are attributable to the operation of systems (whether such systems are operated directly by the State or by another person under a contract with the State) of the type described in subparagraph (A)(i) (whether or not designed, developed, or installed with assistance under such subparagraph) which are approved by the Secretary and which include provision for prompt written notice to each individual who is furnished services covered by

the plan, or to each individual in a sample group of individuals who are furnished such services, of the specific services (other than confidential services) so covered, the name of the person or persons furnishing the services, the date or dates on which the services were furnished, and the amount of the payment or payments made under the plan on account of the services; and

(C)(i) 75 per centum of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to the performance of medical and utilization review by a utilization and quality control peer review organization or by an entity which meets the requirements of section 1152, as determined by the Secretary, under a contract entered into under section 1902(d); and

(ii) 75 percent of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to the performance of independent external reviews conducted under section 1932(c)(2); and

(D) 75 percent of so much of the sums expended by the State plan during a quarter in 1991, 1992, or 1993, as the Secretary determines is attributable to the statewide adoption of a drug use review program which conforms to the requirements of section 1927(g); and [37]

(E) [38] 50 percent of the sums expended with respect to costs incurred during such quarter as are attributable to providing—

(i) services to identify and educate individuals who are likely to be eligible for medical assistance under this title and who have Sickle Cell Disease or who are carriers of the sickle cell gene, including education regarding how to identify such individuals; or

(ii) education regarding the risks of stroke and other complications, as well as the prevention of stroke and other complications, in individuals who are likely to be eligible for medical assistance under this title and who have Sickle Cell Disease; plus

(4) an amount equal to 100 percent of the sums expended during the quarter which are attributable to the costs of the implementation and operation of the immigration status verification system described in section 1137(d); plus

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

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

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

[37] P.L. 108-357, §712(b)(1), struck out "plus" and substituted "and".

[38] P.L. 108-357, §712(b)(2), added subparagraph (E), effective October 22, 2004, applicable to medical assistance and services provided under title XIX on and after October 22, 2004.

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

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

(7) subject to section 1919(g)(3)(B), an amount equal to 50 per centum of the remainder of the amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

(b)(1) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State for any quarter beginning after December 31, 1969, shall not take into account any amounts expended as medical assistance with respect to individuals aged 65 or over and disabled individuals entitled to hospital insurance benefits under title XVIII which would not have been so expended if the individuals involved had been enrolled in the insurance program established by part B of title XVIII, other than amounts expended under provisions of the plan of such State required by section 1902(a)(34).

(2) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122.

(3) The amount of funds which the Secretary is otherwise obligated to pay a State during a quarter under subsection (a)(6) may not exceed the higher of—

(A) $125,000, or

(B) one-quarter of 1 per centum of the sums expended by the Federal, State, and local governments during the previous quarter in carrying out the State's plan under this title.

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

(A) The broker is independent of any such entity and of any health care providers (whether or not any such provider participates in the State plan under this title) that provide coverage of services in the same State in which the broker is conducting enrollment activities.

(B) No person who is an owner, employee, consultant, or has a contract with the broker either has any direct or indirect financial interest with such an entity or health care provider or has been excluded from participation in the program under this title or title XVIII or debarred by any Federal agency, or subject to a civil money penalty under this Act.

(5) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State shall be decreased in a quarter by the amount of any health

care related taxes (described in section 1902(w)(3)(A)) that are imposed on a hospital described in subsection (w)(3)(F) in that quarter.

(c) Nothing in this title shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict, payment under subsection (a) for medical assistance for covered services furnished to a child with a disability because such services are included in the child's individualized education program established pursuant to part B of the Individuals with Disabilities Education Act[39] or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan adopted pursuant to part C[40] of such Act.

(d)(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsections (a) and (b) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsections, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

(2)(A) The Secretary shall then pay to the State, in such installments as he may determine, the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

(B) Expenditures for which payments were made to the State under subsection (a) shall be treated as an overpayment to the extent that the State or local agency administering such plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan in compliance with section 1902(a)(25).

(C) For purposes of this subsection, when an overpayment is discovered, which was made by a State to a person or other entity, the State shall have a period of 60 days in which to recover or attempt to recover such overpayment before adjustment is made in the Federal payment to such State on account of such overpayment. Except as otherwise provided in subparagraph (D), the adjustment in the Federal payment shall be made at the end of the 60 days, whether or not recovery was made.

(D) In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity on account of such debt having been discharged in bankruptcy or otherwise being uncollectable, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof).

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[39] See Vol. II, P.L. 91–230.

[40] P.L. 108-446, Title III, §305(j)(1), struck out "part H" and substituted "part C".

(3)(A) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.

(B)(i) Subparagraph (A) and paragraph (2)(B) shall not apply to any amount recovered or paid to a State as part of the comprehensive settlement of November 1998 between manufacturers of tobacco products, as defined in section 5702(d) of the Internal Revenue Code of 1986, and State Attorneys General, or as part of any individual State settlement or judgment reached in litigation initiated or pursued by a State against one or more such manufacturers.

(ii) Except as provided in subsection (i)(19), a State may use amounts recovered or paid to the State as part of a comprehensive or individual settlement, or a judgment, described in clause (i) for any expenditures determined appropriate by the State.

(4) Upon the making of any estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

(5) In any case in which the Secretary estimates that there has been an overpayment under this section to a State on the basis of a claim by such State that has been disallowed by the Secretary under section 1116(d), and such State disputes such disallowance, the amount of the Federal payment in controversy shall, at the option of the State, be retained by such State or recovered by the Secretary pending a final determination with respect to such payment amount. If such final determination is to the effect that any amount was properly disallowed, and the State chose to retain payment of the amount in controversy, the Secretary shall offset, from any subsequent payments made to such State under this title, an amount equal to the proper amount of the disallowance plus interest on such amount disallowed for the period beginning on the date such amount was disallowed and ending on the date of such final determination at a rate (determined by the Secretary) based on the average of the bond equivalent of the weekly 90-day treasury bill auction rates during such period.

(6)(A) Each State (as defined in subsection (w)(7)(D)) shall include, in the first report submitted under paragraph (1) after the end of each fiscal year, information related to—

(i) provider-related donations made to the State or units of local government during such fiscal year, and

(ii) health care related taxes collected by the State or such units during such fiscal year.

(B) Each State shall include, in the first report submitted under paragraph (1) after the end of each fiscal year, information related to the total amount of payment adjustments made, and the amount of payment adjustments made to individual providers (by provider), under section 1923(c) during such fiscal year.

(e) A State plan approved under this title may include, as a cost with respect to hospital services under the plan under this title,

periodic expenditures made to reflect transitional allowances established with respect to a hospital closure or conversion under section 1884.

(f)(1)(A) Except as provided in paragraph (4), payment under the preceding provisions of this section shall not be made with respect to any amount expended as medical assistance in a calendar quarter, in any State, for any member of a family the annual income of which exceeds the applicable income limitation determined under this paragraph.

(B)(i) Except as provided in clause (ii) of this subparagraph, the applicable income limitation with respect to any family is the amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to 133 ⅓ percent of the highest amount which would ordinarily be paid to a family of the same size without any income or resources, in the form of money payments, under the plan of the State approved under part A of title IV of this Act.

(ii) If the Secretary finds that the operation of a uniform maximum limits payments to families of more than one size, he may adjust the amount otherwise determined under clause (i) to take account of families of different sizes.[41]

(C) The total amount of any applicable income limitation determined under subparagraph (B) shall, if it is not a multiple of $100 or such other amount as the Secretary may prescribe, be rounded to the next higher multiple of $100 or such other amount, as the case may be.

(2)(A) In computing a family's income for purposes of paragraph (1), there shall be excluded any costs (whether in the form of insurance premiums or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof) incurred by such family for medical care or for any other type of remedial care recognized under State law or, (B) notwithstanding section 1916 at State option, an amount paid by such family, at the family's option, to the State, provided that the amount, when combined with costs incurred in prior months, is sufficient when excluded from the family's income to reduce such family's income below the applicable income limitation described in paragraph (1). The amount of State expenditures for which medical assistance is available under subsection (a)(1) will be reduced by amounts paid to the State pursuant to this subparagraph.

(3) For purposes of paragraph (1)(B), in the case of a family consisting of only one individual, the "highest amount which would ordinarily be paid" to such family under the State's plan approved under part A of title IV of this Act shall be the amount determined by the State agency (on the basis of reasonable relationship to the amounts payable under such plan to families consisting of two or more persons) to be the amount of the aid which would ordinarily be payable under such plan

[41] See Vol. II, P.L. 100–203, §4106, with respect to medically needy income levels for certain two-member couples in California.

See Vol. II, P.L. 101–508, §4718, with respect to medically needy income levels for certain one-member families.

to a family (without any income or resources) consisting of one person if such plan provided for aid to such a family.

(4) The limitations on payment imposed by the preceding provisions of this subsection shall not apply with respect to any amount expended by a State as medical assistance for any individual described in section 1902(a)(10)(A)(i)(III), 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(V), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII),1902(a)(10)(A)(ii)(IX),1902(a)(10)(A)(ii)(X), 1902(a)(10)(A)(ii)(XIII), 1902(a)(10)(A)(ii)(XIV), 1902(a)(10)(A)(ii)(XV), 1902(a)(10)(A)(ii)(XVI), 1902(a)(10)(A)(ii)(XVII), 1902(a)(10)(A)(ii)(XVIII), or 1905(p)(1) or for any individual—

(A) who is receiving aid or assistance under any plan of the State approved under title I, X, XIV or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or

(B) who is not receiving such aid or assistance, and with respect to whom such benefits are not being paid, but (i) is eligible to receive such aid or assistance, or to have such benefits paid with respect to him, or (ii) would be eligible to receive such aid or assistance, or to have such benefits paid with respect to him if he were not in a medical institution, or

(C) with respect to whom there is being paid, or who is eligible, or would be eligible if he were not in a medical institution, to have paid with respect to him, a State supplementary payment and is eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A), or who is a PACE program eligible individual enrolled in a PACE program under section 1934, but only if the income of such individual (as determined under section 1612, but without regard to subsection (b) thereof) does not exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1),

at the time of the provision of the medical assistance giving rise to such expenditure.

(g)(1) Subject to paragraph (3), with respect to amounts paid for the following services furnished under the State plan after June 30, 1973 (other than services furnished pursuant to a contract with a health maintenance organization as defined in section 1876 or which is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act[42])), the Federal medical assistance percentage shall be decreased as follows: After an individual has received inpatient hospital services or services in an intermediate care facility for the mentally retarded for 60 days or inpatient mental hospital services for 90 days (whether or not such days are consecutive), during any fiscal year, the Federal medical assistance percentage with respect to amounts paid for any such care furnished thereafter to such individual shall be decreased by a per centum thereof (determined under paragraph (5)) unless the State agency responsible for the administration of the plan makes a showing satisfactory to the Secretary that, with respect to each calendar quarter for which the State submits a request for

[42] See Vol. II, P.L. 78–410.

payment at the full Federal medical assistance percentage for amounts paid for inpatient hospital services or services in an intermediate care facility for the mentally retarded furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), such State has an effective program of medical review of the care of patients in mental hospitals and intermediate care facilities for the mentally retarded pursuant to paragraphs (26) and (31) of section 1902(a) whereby the professional management of each case is reviewed and evaluated at least annually by independent professional review teams. In determining the number of days on which an individual has received services described in this subsection, there shall not be counted any days with respect to which such individual is entitled to have payments made (in whole or in part) on his behalf under section 1812.

(2) The Secretary shall, as part of his validation procedures under this subsection, conduct timely sample onsite surveys of private and public institutions in which recipients of medical assistance may receive care and services under a State plan approved under this title, and his findings with respect to such surveys (as well as the showings of the State agency required under this subsection) shall be made available for public inspection.

(3)(A) No reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under this subsection shall take effect—

(i) if such reduction is due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning before January 1, 1977;

(ii) before January 1, 1978;

(iii) unless a notice of such reduction has been provided to the State at least 30 days before the date such reduction takes effect; or

(iv) due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning after September 30, 1977, unless notice of such reduction has been provided to the State no later than the first day of the fourth calendar quarter following the calendar quarter with respect to which such showing was made.

(B) The Secretary shall waive application of any reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under paragraph (1) because a showing by the State, made under such paragraph with respect to a calendar quarter ending after January 1, 1977, and before January 1, 1978, is determined to be either unsatisfactory under such paragraph or invalid under paragraph (2), if the Secretary determines that the State's showing made under paragraph (1) with respect to any calendar quarter ending on or before December 31, 1978, is satisfactory under such paragraph and is valid under paragraph (2).

(4)(A) The Secretary may not find the showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory if the showing is submitted to the Secretary later than the 30th day after the last day of the calendar quarter,

unless the State demonstrates to the satisfaction of the Secretary good cause for not meeting such deadline.

(B) The Secretary shall find a showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory under such paragraph with respect to the requirement that the State conduct annual onsite inspections in mental hospitals and intermediate care facilities for the mentally retarded under paragraphs (26) and (31) of section 1902(a), if the showing demonstrates that the State has conducted such an onsite inspection during the 12-month period ending on the last date of the calendar quarter—

(i) in each of not less than 98 per centum of the number of such hospitals and facilities requiring such inspection, and

(ii) in every such hospital or facility which has 200 or more beds,

and that, with respect to such hospitals and facilities not inspected within such period, the State has exercised good faith and due diligence in attempting to conduct such inspection, or if the State demonstrates to the satisfaction of the Secretary that it would have made such a showing but for failings of a technical nature only.

(5) In the case of a State's unsatisfactory or invalid showing made with respect to a type of facility or institutional services in a calendar quarter, the per centum amount of the reduction of the State's Federal medical assistance percentage for that type of services under paragraph (1) is equal to 33 ⅓ per centum multiplied by a fraction, the denominator of which is equal to the total number of patients receiving that type of services in that quarter under the State plan in facilities or institutions for which a showing was required to be made under this subsection, and the numerator of which is equal to the number of such patients receiving such type of services in that quarter in those facilities or institutions for which a satisfactory and valid showing was not made for that calendar quarter.

(6)(A) Recertifications required under section 1902(a)(44) shall be conducted at least every 60 days in the case of inpatient hospital services.

(B) Such recertifications in the case of services in an intermediate care facility for the mentally retarded shall be conducted at least—

(i) 60 days after the date of the initial certification,

(ii) 180 days after the date of the initial certification,

(iii) 12 months after the date of the initial certification,

(iv) 18 months after the date of the initial certification,

(v) 24 months after the date of the initial certification, and

(vi) every 12 months thereafter.

(C) For purposes of determining compliance with the schedule established by this paragraph, a recertification shall be considered to have been done on a timely basis if it was performed not later than 10 days after the date the recertification was otherwise required and the State estab-

lishes good cause why the physician or other person making such recertification did not meet such schedule.

(h) **[** Stricken.[43]**]**

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

(1) for organ transplant procedures unless the State plan provides for written standards respecting the coverage of such procedures and unless such standards provide that—

(A) similarly situated individuals are treated alike; and

(B) any restriction, on the facilities or practitioners which may provide such procedures, is consistent with the accessibility of high quality care to individuals eligible for the procedures under the State plan; or

(2) with respect to any amount expended for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished—

(A) under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, or 1842(j)(2), or

(B) at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person); or

(3) with respect to any amount expended for inpatient hospital services furnished under the plan (other than amounts attributable to the special situation of a hospital which serves a disproportionate number of low income patients with special needs) to the extent that such amount exceeds the hospital's customary charges with respect to such services or (if such services are furnished under the plan by a public institution free of charge or at nominal charges to the public) exceeds an amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such payment which the Secretary finds will provide fair compensation to such institution for such services; or

(4) with respect to any amount expended for care or services furnished under the plan by a hospital unless such hospital has in effect a utilization review plan which meets the requirements imposed by section 1861(k) for purposes of title XVIII; and if such hospital has in effect such a utilization review plan for purposes of title XVIII, such plan shall serve as the plan required by this subsection (with the same standards and procedures and the same review committee or group) as a condition of payment under this title; the Secretary is authorized to waive the requirements of this paragraph if the State agency demonstrates to his satisfaction that it has in operation utilization review procedures which are superior in their effectiveness to the procedures required under section 1861(k); or

[43] P.L. 100–203, §4211(g)(1); 101 Stat. 1330–205.

(5) with respect to any amount expended for any drug product for which payment may not be made under part B of title XVIII because of section 1862(c); or

(6) with respect to any amount expended for inpatient hospital tests (other than in emergency situations) not specifically ordered by the attending physician or other responsible practitioner; or

(7) with respect to any amount expended for clinical diagnostic laboratory tests performed by a physician, independent laboratory, or hospital, to the extent such amount exceeds the amount that would be recognized under section 1833(h) for such tests performed for an individual enrolled under part B of title XVIII; or

(8) with respect to any amount expended for medical assistance (A) for nursing facility services to reimburse (or otherwise compensate) a nursing facility for payment of a civil money penalty imposed under section 1919(h) or (B) for home and community care to reimburse (or otherwise compensate) a provider of such care for payment of a civil money penalty imposed under this title or title XI or for legal expenses in defense of an exclusion or civil money penalty under this title or title XI if there is no reasonable legal ground for the provider's case; or

(9) **[** Stricken.[44]**]**

(10)(A) with respect to covered outpatient drugs unless there is a rebate agreement in effect under section 1927 with respect to such drugs or unless section 1927(a)(3) applies, and

(B) with respect to any amount expended for an innovator multiple source drug (as defined in section 1927(k)) dispensed on or after July 1, 1991, if, under applicable State law, a less expensive multiple source drug could have been dispensed, but only to the extent that such amount exceeds the upper payment limit for such multiple source drug; or

(11) with respect to any amount expended for physicians' services furnished on or after the first day of the first quarter beginning more than 60 days after the date of establishment of the physician identifier system under section 1902(x), unless the claim for the services includes the unique physician identifier provided under such system; or

(12) **[** Stricken.[45]**]**

(13) with respect to any amount expended to reimburse (or otherwise compensate) a nursing facility for payment of legal expenses associated with any action initiated by the facility that is dismissed on the basis that no reasonable legal ground existed for the institution of such action; or

(14) with respect to any amount expended on administrative costs to carry out the program under section 1928; or

(15) with respect to any amount expended for a single-antigen vaccine and its administration in any case in which the administration of a combined–antigen vaccine was medically appropriate (as determined by the Secretary); or

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[44] P.L. 104–193, §114(d)(2); 110 Stat. 2180.

[45] P.L. 105–33, §4724(a); 111 Stat. 516.

(16) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997[46]; or

(17) with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under a State plan under this title; or

(18) with respect to any amount expended for home health care services provided by an agency or organization unless the agency or organization provides the State agency on a continuing basis a surety bond in a form specified by the Secretary under paragraph (7) of section 1861(o) and in an amount that is not less than $50,000 or such comparable surety bond as the Secretary may permit under the last sentence of such section; or

(19) with respect to any amount expended on administrative costs to initiate or pursue litigation described in subsection (d)(3)(B).

(20) with respect to amounts expended for medical assistance provided to an individual described in subclause (XV) or (XVI) of section 1902(a)(10)(A)(ii) for a fiscal year unless the State demonstrates to the satisfaction of the Secretary that the level of State funds expended for such fiscal year for programs to enable working individuals with disabilities to work (other than for such medical assistance) is not less than the level expended for such programs during the most recent State fiscal year ending before the date of the enactment of this paragraph.

Nothing in paragraph (1) shall be construed as permitting a State to provide services under its plan under this title that are not reasonable in amount, duration, and scope to achieve their purpose. Paragraphs (1), (2), (16), (17), and (18) shall apply with respect to items or services furnished and amounts expended by or through a managed care entity (as defined in section 1932(a)(1)(B)) in the same manner as such paragraphs apply to items or services furnished and amounts expended directly by the State.

(j) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State for any quarter shall be adjusted in accordance with section 1914.

(k) The Secretary is authorized to provide at the request of any State (and without cost to such State) such technical and actuarial assistance as may be necessary to assist such State to contract with any medicaid managed care organization which meets the requirements of subsection (m) of this section for the purpose of providing medical care and services to individuals who are entitled to medical assistance under this title.

(l) **[** Repealed.[47]**]**

(m)(1)(A) The term "medicaid managed care organization" means a health maintenance organization, an eligible organization with a contract under section 1876 or a Medicare+Choice organization with a contract under part C of title XVIII, a provider sponsored organization, or any other public or private organization, which meets the requirement of section 1902(w) and—

(i) makes services it provides to individuals eligible for benefits under this title accessible to such individ-

[46] P.L. 105–12; 111 Stat. 23.
[47] P.L. 94–552, §1; 90 Stat. 2540.

uals, within the area served by the organization, to the same extent as such services are made accessible to individuals (eligible for medical assistance under the State plan) not enrolled with the organization, and

(ii) has made adequate provision against the risk of insolvency, which provision is satisfactory to the State, meets the requirements of subparagraph (C)(i) (if applicable), and which assures that individuals eligible for benefits under this title are in no case held liable for debts of the organization in case of the organization's insolvency.

An organization that is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) is deemed to meet the requirements of clauses (i) and (ii).

(B) The duties and functions of the Secretary, insofar as they involve making determinations as to whether an organization is a medicaid managed care organization within the meaning of subparagraph (A), shall be integrated with the administration of section 1312 (a) and (b) of the Public Health Service Act.

(C)(i) Subject to clause (ii), a provision meets the requirements of this subparagraph for an organization if the organization meets solvency standards established by the State for private health maintenance organizations or is licensed or certified by the State as a risk–bearing entity.

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

(I) the organization is not responsible for the provision (directly or through arrangements with providers of services) of inpatient hospital services and physicians' services;

(II) the organization is a public entity;

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

(IV) the organization is (or is controlled by) one or more Federally–qualified health centers and meets solvency standards established by the State for such an organization.

For purposes of subclause (IV), the term "control" means the possession, whether direct or indirect, of the power to direct or cause the direction of the management and policies of the organization through membership, board representation, or an ownership interest equal to or greater than 50.1 percent.

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

(i) the Secretary has determined that the entity is a medicaid managed care organization as defined in paragraph (1);

(ii) [Stricken.[48]]

(iii) such services are provided for the benefit of individuals eligible for benefits under this title in accordance with a contract between the State and the entity under which prepaid payments to the entity are made on an actuarially sound basis and under which the Secretary must provide prior approval for contracts providing for expenditures in excess of $1,000,000 for 1998 and, for a subsequent year, the amount established under this clause for the previous year increased by the percentage increase in the consumer price index for all urban consumers over the previous year;

(iv) such contract provides that the Secretary and the State (or any person or organization designated by either) shall have the right to audit and inspect any books and records of the entity (and of any subcontractor) that pertain (I) to the ability of the entity to bear the risk of potential financial losses, or (II) to services performed or determinations of amounts payable under the contract;

(v) such contract provides that in the entity's enrollment, reenrollment, or disenrollment of individuals who are eligible for benefits under this title and eligible to enroll, reenroll, or disenroll with the entity pursuant to the contract, the entity will not discriminate among such individuals on the basis of their health status or requirements for health care services;

(vi) such contract (I) permits individuals who have elected under the plan to enroll with the entity for provision of such benefits to terminate such enrollment in accordance with section 1932(a)(4), and (II) provides for notification in accordance with such section of each such individual, at the time of the individual's enrollment, of such right to terminate such enrollment;

(vii) such contract provides that, in the case of medically necessary services which were provided (I) to an individual enrolled with the entity under the contract and entitled to benefits with respect to such services under the State's plan and (II) other than through the organization because the services were immediately required due to an unforeseen illness, injury, or condition, either the entity or the State provides for reimbursement with respect to those services,

(viii) such contract provides for disclosure of information in accordance with section 1124 and paragraph (4) of this subsection;

(ix) such contract provides, in the case of an entity that has entered into a contract for the provision of services with a Federally–qualified health center or a rural health clinic, that the entity shall provide payment that is not less than the level and amount of payment which the entity would make for the services

[48] P.L. 105–33, §4703(a); 111 Stat. 495.

if the services were furnished by a provider which is not a Federally–qualified health center or a rural health clinic;

(x) any physician incentive plan that it operates meets the requirements described in section 1876(i)(8);

(xi) such contract provides for maintenance of sufficient patient encounter data to identify the physician who delivers services to patients[49]; and

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

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

(i)(I) received a grant of at least $100,000 in the fiscal year ending June 30, 1976, under section 329(d)(1)(A) or 330(d)(1) of the Public Health Service Act[50], and for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this title has been the recipient of a grant under either such section; and

(II) provides to its enrollees, on a prepaid capitation risk basis or on any other risk basis, all of the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905(a) and, to the extent required by section 1902(a)(10)(D) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1905(a); or

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

(I) which received in the fiscal year ending June 30, 1976, at least $100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965[51], and

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

(iii) which has contracted with the single State agency for the provision of services (but not including

[49] See Vol. II, P.L. 99–272, §9517(c)(2)(C), with respect to the Hartford Health Network, Inc.; §9517(c)(2)(D), with respect to health maintenance organization laws of a State and §9517(c)(2)(A) and (3) [as amended by P.L. 101–508, §4734], with respect to certain county–operated health insuring organizations.

[50] See Vol. II, P.L. 78–410.

[51] P.L. 89–4; see 40 U.S.C. App. 214, 303.

inpatient hospital services) to persons eligible under this title on a prepaid risk basis prior to 1970.

(C)–(F) [Stricken.[52]]

(G) In the case of an entity which is receiving (and has received during the previous two years) a grant of at least $100,000 under section 329(d)(1)(A) or 330(d)(1) of the Public Health Service Act or is receiving (and has received during the previous two years) at least $100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965[53], clause (i) of subparagraph (A) shall not apply.

(H) In the case of an individual who—

(i) in a month is eligible for benefits under this title and enrolled with a medicaid managed care organization with a contract under this paragraph or with a primary care case manager with a contract described in section 1905(t)(3),

(ii) in the next month (or in the next 2 months) is not eligible for such benefits, but

(iii) in the succeeding month is again eligible for such benefits,

the State plan, subject to subparagraph (A)(vi), may enroll the individual for that succeeding month with the organization described in clause (i) if the organization continues to have a contract under this paragraph with the State or with the manager described in such clause if the manager continues to have a contract described in section 1905(t)(3) with the State.

(3) [Stricken.[54]]

(4)(A) Each medicaid managed care organization which is not a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act[55]) must report to the State and, upon request, to the Secretary, the Inspector General of the Department of Health and Human Services, and the Comptroller General a description of transactions between the organization and a party in interest (as defined in section 1318(b) of such Act), including the following transactions:

(i) Any sale or exchange, or leasing of any property between the organization and such a party.

(ii) Any furnishing for consideration of goods, services (including management services), or facilities between the organization and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.

(iii) Any lending of money or other extension of credit between the organization and such a party.

The State or Secretary may require that information reported respecting an organization which controls, or is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

(B) Each organization shall make the information reported pursuant to subparagraph (A) available to its enrollees upon reasonable request.

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[52] P.L. 105–33, §4701(d)(2)(B) and §4703(b)(1)(A); 111 Stat. 494 - 495.
[53] P.L. 89–4; see 40 U.S.C. App. 214, 303.
[54] P.L. 101–508, §4732(d)(2); 104 Stat. 1388–196.
[55] P.L. 78–410.

(5)(A) If the Secretary determines that an entity with a contract under this subsection—

(i) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

(ii) imposes premiums on individuals enrolled under this subsection in excess of the premiums permitted under this title;

(iii) acts to discriminate among individuals in violation of the provision of paragraph (2)(A)(v), including expulsion or refusal to re-enroll an individual or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this subsection) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

(iv) misrepresents or falsifies information that is furnished—

(I) to the Secretary or the State under this subsection, or

(II) to an individual or to any other entity under this subsection, or

(v) fails to comply with the requirements of section 1876(i)(8),

the Secretary may provide, in addition to any other remedies available under law, for any of the remedies described in subparagraph (B).

(B) The remedies described in this subparagraph are—

(i) civil money penalties of not more than $25,000 for each determination under subparagraph (A), or, with respect to a determination under clause (iii) or (iv)(I) of such subparagraph, of not more than $100,000 for each such determination, plus, with respect to a determination under subparagraph (A)(ii), double the excess amount charged in violation of such subparagraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under subparagraph (A)(iii), $15,000 for each individual not enrolled as a result of a practice described in such subparagraph, or

(ii) denial of payment to the State for medical assistance furnished under the contract under this subsection for individuals enrolled after the date the Secretary notifies the organization of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(6)(A) For purposes of this subsection and section 1902(e)(2)(A), in the case of the State of New Jersey, the term "contract" shall be deemed to include an undertaking by the State agency, in the State plan under this title, to operate a program meeting all requirements of this subsection.

(B) The undertaking described in subparagraph (A) must provide—

(i) for the establishment of a separate entity responsible for the operation of a program meeting the requirements of this subsection, which entity may be a subdivision of the State agency administering the State plan under this title;

(ii) for separate accounting for the funds used to operate such program; and

(iii) for setting the capitation rates and any other payment rates for services provided in accordance with this subsection using a methodology satisfactory to the Secretary designed to ensure that total Federal matching payments under this title for such services will be lower than the matching payments that would be made for the same services, if provided under the State plan on a fee for service basis to an actuarially equivalent population.

(C) The undertaking described in subparagraph (A) shall be subject to approval (and annual re-approval) by the Secretary in the same manner as a contract under this subsection.

(D) The undertaking described in subparagraph (A) shall not be eligible for a waiver under section 1915(b).

(n) **[** Repealed.[56] **]**

(o) Notwithstanding the preceding provisions of this section, no payment shall be made to a State under the preceding provisions of this section for expenditures for medical assistance provided for an individual under its State plan approved under this title to the extent that a private insurer (as defined by the Secretary by regulation and including a group health plan (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), a service benefit plan, and a health maintenance organization) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided medical assistance under the plan.

(p)(1) When a political subdivision of a State makes, for the State of which it is a political subdivision, or one State makes, for another State, the enforcement and collection of rights of support or payment assigned under section 1912, pursuant to a cooperative arrangement under such section (either within or outside of such State), there shall be paid to such political subdivision or such other State from amounts which would otherwise represent the Federal share of payments for medical assistance provided to the eligible individuals on whose behalf such enforcement and collection was made, an amount equal to 15 percent of any amount collected which is attributable to such rights of support or payment.

[56] P.L. 100-93, §8(h)(1); 101 Stat. 694.

(2) Where more than one jurisdiction is involved in such enforcement or collection, the amount of the incentive payment determined under paragraph (1) shall be allocated among the jurisdictions in a manner to be prescribed by the Secretary.

(q) For the purposes of this section, the term "State medicaid fraud control unit" means a single identifiable entity of the State government which the Secretary certifies (and annually recertifies) as meeting the following requirements:

(1) The entity (A) is a unit of the office of the State Attorney General or of another department of State government which possesses statewide authority to prosecute individuals for criminal violations, (B) is in a State the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority and has formal procedures, approved by the Secretary, that (i) assure its referral of suspected criminal violations relating to the program under this title to the appropriate authority or authorities in the State for prosecution and (ii) assure its assistance of, and coordination with, such authority or authorities in such prosecutions, or (C) has a formal working relationship with the office of the State Attorney General and has formal procedures (including procedures for its referral of suspected criminal violations to such office) which are approved by the Secretary and which provide effective coordination of activities between the entity and such office with respect to the detection, investigation, and prosecution of suspected criminal violations relating to the program under this title.

(2) The entity is separate and distinct from the single State agency that administers or supervises the administration of the State plan under this title.

(3) The entity's function is conducting a statewide program for the investigation and prosecution of violations of all applicable State laws regarding any and all aspects of fraud in connection with (A) any aspect of the provision of medical assistance and the activities of providers of such assistance under the State plan under this title; and (B) upon the approval of the Inspector General of the relevant Federal agency, any aspect of the provision of health care services and activities of providers of such services under any Federal health care program (as defined in section 1128B(f)(1)), if the suspected fraud or violation of law in such case or investigation is primarily related to the State plan under this title.

(4)(A) The entity has—

(i) procedures for reviewing complaints of abuse or neglect of patients in health care facilities which receive payments under the State plan under this title;

(ii) at the option of the entity, procedures for reviewing complaints of abuse or neglect of patients residing in board and care facilities; and

(iii) procedures for acting upon such complaints under the criminal laws of the State or for referring such complaints to other State agencies for action.

(B) For purposes of this paragraph, the term "board and care facility" means a residential setting which receives payment (regardless of whether such payment is made under the State plan under this title) from or on behalf of

two or more unrelated adults who reside in such facility, and for whom one or both of the following is provided:

(i) Nursing care services provided by, or under the supervision of, a registered nurse, licensed practical nurse, or licensed nursing assistant.

(ii) A substantial amount of personal care services that assist residents with the activities of daily living, including personal hygiene, dressing, bathing, eating, toileting, ambulation, transfer, positioning, self-medication, body care, travel to medical services, essential shopping, meal preparation, laundry, and housework.

(5) The entity provides for the collection, or referral for collection to a single State agency, of overpayments that are made under the State plan or under any Federal Health care program (as so defined) to health care facilities and that are discovered by the entity in carrying out its activities. All funds collected in accordance with this paragraph shall be credited exclusively to, and available for expenditure under, the Federal health care program (including the State plan under this title) that was subject to the activity that was the basis for the collection.

(6) The entity employs such auditors, attorneys, investigators, and other necessary personnel and is organized in such a manner as is necessary to promote the effective and efficient conduct of the entity's activities.

(7) The entity submits to the Secretary an application and annual reports containing such information as the Secretary determines, by regulation, to be necessary to determine whether the entity meets the other requirements of this subsection.

(r)(1) In order to receive payments under subsection (a) for use of automated data systems in administration of the State plan under this title, a State must have in operation mechanized claims processing and information retrieval systems that meet the requirements of this subsection and that the Secretary has found—

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

(B) are compatible with the claims processing and information retrieval systems used in the administration of title XVIII, and for this purpose—

(i) have a uniform identification coding system for providers, other payees, and beneficiaries under this title or title XVIII;

(ii) provide liaison between States and carriers and intermediaries with agreements under title XVIII to facilitate timely exchange of appropriate data; and

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

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

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

(E) are designed to receive provider claims in standard formats to the extent specified by the Secretary; and

(F) effective for claims filed on or after January 1, 1999, provide for electronic transmission of claims data in the format specified by the Secretary and consistent with the

Medicaid Statistical Information System (MSIS) (including detailed individual enrollee encounter data and other information that the Secretary may find necessary).

(2) In order to meet the requirements of this paragraph, mechanized claims processing and information retrieval systems must meet the following requirements:

(A) The systems must be capable of developing provider, physician, and patient profiles which are sufficient to provide specific information as to the use of covered types of services and items, including prescribed drugs.

(B) The State must provide that information on probable fraud or abuse which is obtained from, or developed by, the systems, is made available to the State's medicaid fraud control unit (if any) certified under subsection (q) of this section.

(C) The systems must meet all performance standards and other requirements for initial approval developed by the Secretary.

(s) Notwithstanding the preceding provisions of this section, no payment shall be made to a State under this section for expenditures for medical assistance under the State plan consisting of a designated health service (as defined in subsection (h)(6) of section 1877) furnished to an individual on the basis of a referral that would result in the denial of payment for the service under title XVIII if such title provided for coverage of such service to the same extent and under the same terms and conditions as under the State plan, and subsections (f) and (g)(5) of such section shall apply to a provider of such a designated health service for which payment may be made under this title in the same manner as such subsections apply to a provider of such a service for which payment may be made under such title.

(t) [Repealed.[57]]

(u)(1)(A) Notwithstanding subsection (a)(1), if the ratio of a State's erroneous excess payments for medical assistance (as defined in subparagraph (D)) to its total expenditures for medical assistance under the State plan approved under this title exceeds 0.03, for the period consisting of the third and fourth quarters of fiscal year 1983, or for any full fiscal year thereafter, then the Secretary shall make no payment for such period or fiscal year with respect to so much of such erroneous excess payments as exceeds such allowable error rate of 0.03.

(B) The Secretary may waive, in certain limited cases, all or part of the reduction required under subparagraph (A) with respect to any State if such State is unable to reach the allowable error rate for a period or fiscal year despite a good faith effort by such State.

(C) In estimating the amount to be paid to a State under subsection (d), the Secretary shall take into consideration the limitation on Federal financial participation imposed by subparagraph (A) and shall reduce the estimate he makes under subsection (d)(1), for purposes of payment to the State under subsection (d)(3), in light of any expected erroneous excess payments for medical assistance (estimated in accordance with such criteria, including sampling

[57] P.L. 97–35, §2161(c)(2); 95 Stat. 805.

procedures, as he may prescribe and subject to subsequent adjustment, if necessary, under subsection (d)(2)).

(D)(i) For purposes of this subsection, the term "erroneous excess payments for medical assistance" means the total of—

(I) payments under the State plan with respect to ineligible individuals and families, and

(II) overpayments on behalf of eligible individuals and families by reason of error in determining the amount of expenditures for medical care required of an individual or family as a condition of eligibility.

(ii) In determining the amount of erroneous excess payments for medical assistance to an ineligible individual or family under clause (i)(I), if such ineligibility is the result of an error in determining the amount of the resources of such individual or family, the amount of the erroneous excess payment shall be the smaller of (I) the amount of the payment with respect to such individual or family, or (II) the difference between the actual amount of such resources and the allowable resource level established under the State plan.

(iii) In determining the amount of erroneous excess payments for medical assistance to an individual or family under clause (i)(II), the amount of the erroneous excess payment shall be the smaller of (I) the amount of the payment on behalf of the individual or family, or (II) the difference between the actual amount incurred for medical care by the individual or family and the amount which should have been incurred in order to establish eligibility for medical assistance.

(iv) In determining the amount of erroneous excess payments, there shall not be included any error resulting from a failure of an individual to cooperate or give correct information with respect to third-party liability as required under section 1912(a)(1)(C) or 402(a)(26)(C) or with respect to payments made in violation of section 1906.

(v) In determining the amount of erroneous excess payments, there shall not be included any erroneous payments made for ambulatory prenatal care provided during a presumptive eligibility period (as defined in section 1920(b)(1)), for items and services described in subsection (a) of section 1920A provided to a child during a presumptive eligibility period under such section or for medical assistance provided to an individual described in subsection (a) of section 1920(B) during a presumptive eligibility period under such section.

(E) For purposes of subparagraph (D), there shall be excluded, in determining both erroneous excess payments for medical assistance and total expenditures for medical assistance—

(i) payments with respect to any individual whose eligibility therefor was determined exclusively by the Secretary under an agreement pursuant to section

1634 and such other classes of individuals as the Secretary may by regulation prescribe whose eligibility was determined in part under such an agreement; and

(ii) payments made as the result of a technical error.

(2) The State agency administering the plan approved under this title shall, at such times and in such form as the Secretary may specify, provide information on the rates of erroneous excess payments made (or expected, with respect to future periods specified by the Secretary) in connection with its administration of such plan, together with any other data he requests that are reasonably necessary for him to carry out the provisions of this subsection.

(3)(A) If a State fails to cooperate with the Secretary in providing information necessary to carry out this subsection, the Secretary, directly or through contractual or such other arrangements as he may find appropriate, shall establish the error rates for that State on the basis of the best data reasonably available to him and in accordance with such techniques for sampling and estimating as he finds appropriate.

(B) In any case in which it is necessary for the Secretary to exercise his authority under subparagraph (A) to determine a State's error rates for a fiscal year, the amount that would otherwise be payable to such State under this title for quarters in such year shall be reduced by the costs incurred by the Secretary in making (directly or otherwise) such determination.

(4) This subsection shall not apply with respect to Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, or American Samoa.

(v)(1) Notwithstanding the preceding provisions of this section, except as provided in paragraph (2), no payment may be made to a State under this section for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

(2) Payment shall be made under this section for care and services that are furnished to an alien described in paragraph (1) only if—

(A) such care and services are necessary for the treatment of an emergency medical condition of the alien,

(B) such alien otherwise meets the eligibility requirements for medical assistance under the State plan approved under this title (other than the requirement of the receipt of aid or assistance under title IV, supplemental security income benefits under title XVI, or a State supplementary payment), and

(C) such care and services are not related to an organ transplant procedure.

(3) For purposes of this subsection, the term "emergency medical condition" means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(A) placing the patient's health in serious jeopardy,

(B) serious impairment to bodily functions, or

(C) serious dysfunction of any bodily organ or part.

(w)(1)(A) Notwithstanding the previous provisions of this section, for purposes of determining the amount to be paid to a State (as defined in paragraph (7)(D)) under subsection (a)(1) for quarters in any fiscal year, the total amount expended during such fiscal year as medical assistance under the State plan (as determined without regard to this subsection) shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during the fiscal year—

(i) from provider-related donations (as defined in paragraph (2)(A)), other than—

(I) bona fide provider-related donations (as defined in paragraph (2)(B)), and

(II) donations described in paragraph (2)(C);

(ii) from health care related taxes (as defined in paragraph (3)(A)), other than broad-based health care related taxes (as defined in paragraph (3)(B));

(iii) from a broad-based health care related tax, if there is in effect a hold harmless provision (described in paragraph (4)) with respect to the tax; or

(iv) only with respect to State fiscal years (or portions thereof) occurring on or after January 1, 1992, and before October 1, 1995, from broad-based health care related taxes to the extent the amount of such taxes collected exceeds the limit established under paragraph (5).

(B) Notwithstanding the previous provisions of this section, for purposes of determining the amount to be paid to a State under subsection (a)(7) for all quarters in a Federal fiscal year (beginning with fiscal year 1993), the total amount expended during the fiscal year for administrative expenditures under the State plan (as determined without regard to this subsection) shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during such quarters from donations described in paragraph (2)(C), to the extent the amount of such donations exceeds 10 percent of the amounts expended under the State plan under this title during the fiscal year for purposes described in paragraphs (2), (3), (4), (6), and (7) of subsection (a).

(C)(i) Except as otherwise provided in clause (ii), subparagraph (A)(i) shall apply to donations received on or after January 1, 1992.

(ii) Subject to the limits described in clause (iii) and subparagraph (E), subparagraph (A)(i) shall not apply to donations received before the effective date specified in subparagraph (F) if such donations are received under programs in effect or as described in State plan amendments or related documents submitted to the Secretary by September 30, 1991, and applicable to State fiscal year 1992, as demonstrated by State plan amendments, written agreements, State budget documentation, or other documentary evidence in existence on that date.

(iii) In applying clause (ii) in the case of donations received in State fiscal year 1993, the maximum

amount of such donations to which such clause may be applied may not exceed the total amount of such donations received in the corresponding period in State fiscal year 1992 (or not later than 5 days after the last day of the corresponding period).

(D)(i) Except as otherwise provided in clause (ii), subparagraphs (A)(ii) and (A)(iii) shall apply to taxes received on or after January 1, 1992.

(ii) Subparagraphs (A)(ii) and (A)(iii) shall not apply to impermissible taxes (as defined in clause (iii)) received before the effective date specified in subparagraph (F) to the extent the taxes (including the tax rate or base) were in effect, or the legislation or regulations imposing such taxes were enacted or adopted, as of November 22, 1991.

(iii) In this subparagraph and subparagraph (E), the term "impermissible tax" means a health care related tax for which a reduction may be made under clause (ii) or (iii) of subparagraph (A).

(E)(i) In no case may the total amount of donations and taxes permitted under the exception provided in subparagraphs (C)(ii) and (D)(ii) for the portion of State fiscal year 1992 occurring during calendar year 1992 exceed the limit under paragraph (5) minus the total amount of broad-based health care related taxes received in the portion of that fiscal year.

(ii) In no case may the total amount of donations and taxes permitted under the exception provided in subparagraphs (C)(ii) and (D)(ii) for State fiscal year 1993 exceed the limit under paragraph (5) minus the total amount of broad-based health care related taxes received in that fiscal year.

(F) In this paragraph in the case of a State—

(i) except as provided in clause (iii), with a State fiscal year beginning on or before July 1, the effective date is October 1, 1992,

(ii) except as provided in clause (iii), with a State fiscal year that begins after July 1, the effective date is January 1, 1993, or

(iii) with a State legislature which is not scheduled to have a regular legislative session in 1992, with a State legislature which is not scheduled to have a regular legislative session in 1993, or with a provider-specific tax enacted on November 4, 1991, the effective date is July 1, 1993.

(2)(A) In this subsection (except as provided in paragraph (6)), the term "provider-related donation" means any donation or other voluntary payment (whether in cash or in kind) made (directly or indirectly) to a State or unit of local government by—

(i) a health care provider (as defined in paragraph (7)(B)),

(ii) an entity related to a health care provider (as defined in paragraph (7)(C)), or

(iii) an entity providing goods or services under the State plan for which payment is made to the State

under paragraph (2), (3), (4), (6), or (7) of subsection (a).

(B) For purposes of paragraph (1)(A)(i)(I), the term "bona fide provider-related donation" means a provider-related donation that has no direct or indirect relationship (as determined by the Secretary) to payments made under this title to that provider, to providers furnishing the same class of items and services as that provider, or to any related entity, as established by the State to the satisfaction of the Secretary. The Secretary may by regulation specify types of provider-related donations described in the previous sentence that will be considered to be bona fide provider-related donations.

(C) For purposes of paragraph (1)(A)(i)(II), donations described in this subparagraph are funds expended by a hospital, clinic, or similar entity for the direct cost (including costs of training and of preparing and distributing outreach materials) of State or local agency personnel who are stationed at the hospital, clinic, or entity to determine the eligibility of individuals for medical assistance under this title and to provide outreach services to eligible or potentially eligible individuals.

(3)(A) In this subsection (except as provided in paragraph (6)), the term "health care related tax" means a tax (as defined in paragraph (7)(F)) that—

(i) is related to health care items or services, or to the provision of, the authority to provide, or payment for, such items or services, or

(ii) is not limited to such items or services but provides for treatment of individuals or entities that are providing or paying for such items or services that is different from the treatment provided to other individuals or entities.

In applying clause (i), a tax is considered to relate to health care items or services if at least 85 percent of the burden of such tax falls on health care providers.

(B) In this subsection, the term "broad-based health care related tax" means a health care related tax which is imposed with respect to a class of health care items or services (as described in paragraph (7)(A)) or with respect to providers of such items or services and which, except as provided in subparagraphs (D), (E), and (F)—

(i) is imposed at least with respect to all items or services in the class furnished by all non-Federal, nonpublic providers in the State (or, in the case of a tax imposed by a unit of local government, the area over which the unit has jurisdiction) or is imposed with respect to all non-Federal, nonpublic providers in the class; and

(ii) is imposed uniformly (in accordance with subparagraph (C)).

(C)(i) Subject to clause (ii), for purposes of subparagraph (B)(ii), a tax is considered to be imposed uniformly if—

(I) in the case of a tax consisting of a licensing fee or similar tax on a class of health care items or services (or providers of such items or services),

the amount of the tax imposed is the same for every provider providing items or services within the class;

(II) in the case of a tax consisting of a licensing fee or similar tax imposed on a class of health care items or services (or providers of such services) on the basis of the number of beds (licensed or otherwise) of the provider, the amount of the tax is the same for each bed of each provider of such items or services in the class;

(III) in the case of a tax based on revenues or receipts with respect to a class of items or services (or providers of items or services) the tax is imposed at a uniform rate for all items and services (or providers of such items of services) in the class on all the gross revenues or receipts, or net operating revenues, relating to the provision of all such items or services (or all such providers) in the State (or, in the case of a tax imposed by a unit of local government within the State, in the area over which the unit has jurisdiction); or

(IV) in the case of any other tax, the State establishes to the satisfaction of the Secretary that the tax is imposed uniformly.

(ii) Subject to subparagraphs (D) and (E), a tax imposed with respect to a class of health care items and services is not considered to be imposed uniformly if the tax provides for any credits, exclusions, or deductions which have as their purpose or effect the return to providers of all or a portion of the tax paid in a manner that is inconsistent with subclauses (I) and (II) of subparagraph (E)(ii) or provides for a hold harmless provision described in paragraph (4).

(D) A tax imposed with respect to a class of health care items and services is considered to be imposed uniformly—

(i) notwithstanding that the tax is not imposed with respect to items or services (or the providers thereof) for which payment is made under a State plan under this title or title XVIII, or

(ii) in the case of a tax described in subparagraph (C)(i)(III), notwithstanding that the tax provides for exclusion (in whole or in part) of revenues or receipts from a State plan under this title or title XVIII.

(E)(i) A State may submit an application to the Secretary requesting that the Secretary treat a tax as a broad-based health care related tax, notwithstanding that the tax does not apply to all health care items or services in class (or all providers of such items and services), provides for a credit, deduction, or exclusion, is not applied uniformly, or otherwise does not meet the requirements of subparagraph (B) or (C). Permissible waivers may include exemptions for rural or sole-community providers.

(ii) The Secretary shall approve such an application if the State establishes to the satisfaction of the Secretary that—

(I) the net impact of the tax and associated expenditures under this title as proposed by the State is generally redistributive in nature, and

(II) the amount of the tax is not directly correlated to payments under this title for items or services with respect to which the tax is imposed.

The Secretary shall by regulation specify types of credits, exclusions, and deductions that will be considered to meet the requirements of this subparagraph.

(F) In no case shall a tax not qualify as a broad–based health care related tax under this paragraph because it does not apply to a hospital that is described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from taxation under section 501(a) of such Code and that does not accept payment under the State plan under this title or under title XVIII.

(4) For purposes of paragraph (1)(A)(iii), there is in effect a hold harmless provision with respect to a broad-based health care related tax imposed with respect to a class of items or services if the Secretary determines that any of the following applies:

(A) The State or other unit of government imposing the tax provides (directly or indirectly) for a payment (other than under this title) to taxpayers and the amount of such payment is positively correlated either to the amount of such tax or to the difference between the amount of the tax and the amount of payment under the State plan.

(B) All or any portion of the payment made under this title to the taxpayer varies based only upon the amount of the total tax paid.

(C) The State or other unit of government imposing the tax provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax.

The provisions of this paragraph shall not prevent use of the tax to reimburse health care providers in a class for expenditures under this title nor preclude States from relying on such reimbursement to justify or explain the tax in the legislative process.

(5)(A) For purposes of this subsection, the limit under this subparagraph with respect to a State is an amount equal to 25 percent (or, if greater, the State base percentage, as defined in subparagraph (B)) of the non-Federal share of the total amount expended under the State plan during a State fiscal year (or portion thereof), as it would be determined pursuant to paragraph (1)(A) without regard to paragraph (1)(A)(iv).

(B)(i) In subparagraph (A), the term "State base percentage" means, with respect to a State, an amount (expressed as a percentage) equal to—

(I) the total of the amount of health care related taxes (whether or not broad-based) and the amount of provider-related donations (whether or not bona fide) projected to be collected (in accordance with clause (ii)) during State fiscal year 1992, divided by

(II) the non-Federal share of the total amount estimated to be expended under the State plan during such State fiscal year.

(ii) For purposes of clause (i)(I), in the case of a tax that is not in effect throughout State fiscal year 1992 or the rate (or base) of which is increased during such fiscal year, the Secretary shall project the amount to be collected during such fiscal year as if the tax (or increase) were in effect during the entire State fiscal year.

(C)(i) The total amount of health care related taxes under subparagraph (B)(i)(I) shall be determined by the Secretary based on only those taxes (including the tax rate or base) which were in effect, or for which legislation or regulations imposing such taxes were enacted or adopted, as of November 22, 1991.

(ii) The amount of provider-related donations under subparagraph (B)(i)(I) shall be determined by the Secretary based on programs in effect on September 30, 1991, and applicable to State fiscal year 1992, as demonstrated by State plan amendments, written agreements, State budget documentation, or other documentary evidence in existence on that date.

(iii) The amount of expenditures described in subparagraph (B)(i)(II) shall be determined by the Secretary based on the best data available as of the date of the enactment of this subsection.

(6)(A) Notwithstanding the provisions of this subsection, the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider, except as provided in section 1902(a)(2), unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.

(B) For purposes of this subsection, funds the use of which the Secretary may not restrict under subparagraph (A) shall not be considered to be a provider-related donation or a health care related tax.

(7) For purposes of this subsection:

(A) Each of the following shall be considered a separate class of health care items and services:

(i) Inpatient hospital services.

(ii) Outpatient hospital services.

(iii) Nursing facility services (other than services of intermediate care facilities for the mentally retarded).

(iv) Services of intermediate care facilities for the mentally retarded.

(v) Physicians' services.

(vi) Home health care services.

(vii) Outpatient prescription drugs.

(viii) Services of a medicaid managed care organization with a contract under section 1903(m).

(ix) Such other classification of health care items and services consistent with this subparagraph as the Secretary may establish by regulation.

(B) The term "health care provider" means an individual or person that receives payments for the provision of health care items or services.

(C) An entity is considered to be "related" to a health care provider if the entity—

(i) is an organization, association, corporation or partnership formed by or on behalf of health care providers;

(ii) is a person with an ownership or control interest (as defined in section 1124(a)(3)) in the provider;

(iii) is the employee, spouse, parent, child, or sibling of the provider (or of a person described in clause (ii)); or

(iv) has a similar, close relationship (as defined in regulations) to the provider.

(D) The term "State" means only the 50 States and the District of Columbia but does not include any State whose entire program under this title is operated under a waiver granted under section 1115.

(E) The "State fiscal year" means, with respect to a specified year, a State fiscal year ending in that specified year.

(F) The term "tax" includes any licensing fee, assessment, or other mandatory payment, but does not include payment of a criminal or civil fine or penalty (other than a fine or penalty imposed in lieu of or instead of a fee, assessment, or other mandatory payment).

(G) The term "unit of local government" means, with respect to a State, a city, county, special purpose district, or other governmental unit in the State.

OPERATION OF STATE PLANS

SEC. 1904. [42 U.S.C. 1396c] If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this title, finds—

(1) that the plan has been so changed that it no longer complies with the provisions of section 1902; or

(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

DEFINITIONS[58]

SEC. 1905. [42 U.S.C. 1396d] For purposes of this title— (a) The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of medicare cost-sharing with respect to a qualified medicare beneficiary described in subsection (p)(1), if provided after the month in which the individual becomes such a beneficiary) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A)) not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, who are—

(i) under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose,

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

(iii) 65 years of age or older,

(iv) blind, with respect to States eligible to participate in the State plan program established under title XVI,

(v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under title XVI,

(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under title I, X, XIV, or XVI,

(vii) blind or disabled as defined in section 1614, with respect to States not eligible to participate in the State plan program established under title XVI,

(viii) pregnant women,

(ix) individuals provided extended benefits under section 1925,

(x) individuals described in section 1902(u)(1),

(xi) individuals described in section 1902(z)(1),

(xii) employed individuals with a medically improve disability (as defined in subsection (v)), or

(xiii) individuals described in section 1902(aa),

but whose income and resources are insufficient to meet all of such cost—

(1) inpatient hospital services (other than services in an institution for mental diseases);

(2)(A) outpatient hospital services, (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (l)(1)) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (l)(1)) and which are otherwise included in the plan,

[58] See Vol. II, P.L. 108–27, §401, with respect to temporary state fiscal relief.

and (C) Federally-qualified health center services (as defined in subsection (l)(2)) and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan;

(3) other laboratory and X-ray services;

(4)(A) nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older; (B) early and periodic screening, diagnostic, and treatment services (as defined in subsection (r)) for individuals who are eligible under the plan and are under the age of 21; and (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies;

(5)(A) physicians' services furnished by a physician (as defined in section 1861(r)(1)), whether furnished in the office, the patient's home, a hospital, or a nursing facility, or elsewhere, and (B) medical and surgical services furnished by a dentist (described in section 1861(r)(2)) to the extent such services may be performed under State law either by a doctor of medicine or by a doctor of dental surgery or dental medicine and would be described in clause (A) if furnished by a physician (as defined in section 1861(r)(1));

(6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;

(7) home health care services;

(8) private duty nursing services;

(9) clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician, including such services furnished outside the clinic by clinic personnel to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address;

(10) dental services;

(11) physical therapy and related services;

(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(13) other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;

(14) inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases;

(15) services in an intermediate care facility for the mentally retarded (other than in an institution for mental diseases) for individuals who are determined, in accordance with section 1902(a)(31), to be in need of such care;

(16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h);

(17) services furnished by a nurse-midwife (as defined in section 1861(gg)) which the nurse-midwife is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider, and without regard to whether or not the services are performed in the area of management of the care of mothers and babies throughout the maternity cycle;

(18) hospice care (as defined in subsection (o));

(19) case management services (as defined in section 1915(g)(2)) and TB-related services described in section 1902(z)(2)(F);

(20) respiratory care services (as defined in section 1902(e)(9)(C));

(21) services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner (as defined by the Secretary) which the certified pediatric nurse practitioner or certified family nurse practitioner is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the certified pediatric nurse practitioner or certified family nurse practitioner is under the supervision of, or associated with, a physician or other health care provider;

(22) home and community care (to the extent allowed and as defined in section 1929) for functionally disabled elderly individuals;

(23) community supported living arrangements services (to the extent allowed and as defined in section 1930);

(24) personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home or other location;

(25) primary care case management services (as defined in subsection (t));

(26) services furnished under a PACE program under section 1934 to PACE program eligible individuals enrolled under the program under such section;[59]

(27)[60] subject to subsection (x), primary and secondary medical strategies and treatment and services for individuals who have Sickle Cell Disease; and

[59] P.L. 108–357, §712(a)(1)(A)(i), struck out "and".

[60] P.L. 108–357, §712(a)(1)(A)(iii), added this subparagraph (27), effective October 22, 2004, applicable to medical assistance and services provided under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) on or after October 22, 2004.

See Vol. II, P.L. 108-357, with respect to a rule of construction.

(28)[61] any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary.

except as otherwise provided in paragraph (16), such term does not include—

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases.

For purposes of clause (vi) of the preceding sentence, a person shall be considered essential to another individual if such person is the spouse of and is living with such individual, the needs of such person are taken into account in determining the amount of aid or assistance furnished to such individual (under a State plan approved under title I, X, XIV, or XVI), and such person is determined, under such a State plan, to be essential to the well-being of such individual. The payment described in the first sentence may include expenditures for medicare cost-sharing and for premiums under part B of title XVIII for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A), and, except in the case of individuals 65 years of age or older and disabled individuals entitled to health insurance benefits under title XVIII who are not enrolled under part B of title XVIII, other insurance premiums for medical or any other type of remedial care or the cost thereof. No service (including counseling) shall be excluded from the definition of "medical assistance" solely because it is provided as a treatment service for alcoholism or drug dependency.

(b) Subject to section 1933(d), the term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 50 per centum.[62] The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of section 1101(a)(8)(B). Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian

[61] P.L. 108–357, §712(a)(1)(A)(ii), redesignated the former paragraph (27) as paragraph (28).
[62] See Vol. II, P.L. 106–554, §706, with respect to the Alaska FMAP.

tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act[63]). Notwithstanding the first sentence of this subsection, in the case of a State plan that meets the condition described in subsection (u)(1), with respect to expenditures (other than expenditures under section 1923) described in subsection (u)(2)(A) or subsection (u)(3) for the State for a fiscal year, and that do not exceed the amount of the State's available allotment under section 2104, the Federal medical assistance percentage is equal to the enhanced FMAP described in section 2105(b), for purposes of this title and title XXI, the Federal medical assistance percentage for the District of Columbia shall be 70 percent and (4) the Federal medical assistance percentage shall be equal to the enhanced FMAP described in section 2105(b) with respect to medical assistance provided to individuals who are eligible for such assistance only on the basis of section 1902(a)(10)(A)(ii)(XVIII).

(c) For definition of the term "nursing facility", see section 1919(a).

(d) The term "intermediate care facility for the mentally retarded" means an institution (or distinct part thereof) for the mentally retarded or persons with related conditions if—

(1) the primary purpose of such institution (or distinct part thereof) is to provide health or rehabilitative services for mentally retarded individuals and the institution meets such standards as may be prescribed by the Secretary;

(2) the mentally retarded individual with respect to whom a request for payment is made under a plan approved under this title is receiving active treatment under such a program; and

(3) in the case of a public institution, the State or political subdivision responsible for the operation of such institution has agreed that the non-Federal expenditures in any calendar quarter prior to January 1, 1975, with respect to services furnished to patients in such institution (or distinct part thereof) in the State will not, because of payments made under this title, be reduced below the average amount expended for such services in such institution in the four quarters immediately preceding the quarter in which the State in which such institution is located elected to make such services available under its plan approved under this title.

(e) In the case of any State the State plan of which (as approved under this title)—

(1) does not provide for the payment of services (other than services covered under section 1902(a)(12)) provided by an optometrist; but

(2) at a prior period did provide for the payment of services referred to in paragraph (1);

the term "physicians' services" (as used in subsection (a)(5)) shall include services of the type which an optometrist is legally authorized to perform where the State plan specifically provides that the term "physicians' services", as employed in such plan, includes services of the type which an optometrist is legally authorized to perform, and shall be reimbursed whether furnished by a physician or an optometrist.

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[63] See Vol. II, P.L. 94–437.

(f) For purposes of this title, the term "nursing facility services" means services which are or were required to be given an individual who needs or needed on a daily basis nursing care (provided directly by or requiring the supervision of nursing personnel) or other rehabilitation services which as a practical matter can only be provided in a nursing facility on an inpatient basis.

(g) If the State plan includes provision of chiropractors' services, such services include only—

(1) services provided by a chiropractor (A) who is licensed as such by the State and (B) who meets uniform minimum standards promulgated by the Secretary under section 1861(r)(5); and

(2) services which consist of treatment by means of manual manipulation of the spine which the chiropractor is legally authorized to perform by the State.

(h)(1) For purposes of paragraph (16) of subsection (a), the term "inpatient psychiatric hospital services for individuals under age 21" includes only—

(A) inpatient services which are provided in an institution (or distinct part thereof) which is a psychiatric hospital as defined in section 1861(f) or in another inpatient setting that the Secretary has specified in regulations;

(B) inpatient services which, in the case of any individual (i) involve active treatment which meets such standards as may be prescribed in regulations by the Secretary, and (ii) a team, consisting of physicians and other personnel qualified to make determinations with respect to mental health conditions and the treatment thereof, has determined are necessary on an inpatient basis and can reasonably be expected to improve the condition, by reason of which such services are necessary, to the extent that eventually such services will no longer be necessary; and

(C) inpatient services which, in the case of any individual, are provided prior to (i) the date such individual attains age 21, or (ii) in the case of an individual who was receiving such services in the period immediately preceding the date on which he attained age 21, (I) the date such individual no longer requires such services, or (II) if earlier, the date such individual attains age 22;

(2) Such term does not include services provided during any calendar quarter under the State plan of any State if the total amount of the funds expended, during such quarter, by the State (and the political subdivisions thereof) from non-Federal funds for inpatient services included under paragraph (1), and for active psychiatric care and treatment provided on an outpatient basis for eligible mentally ill children, is less than the average quarterly amount of the funds expended, during the 4-quarter period ending December 31, 1971, by the State (and the political subdivisions thereof) from non-Federal funds for such services.

(i) The term "institution for mental diseases" means a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

(j) The term "State supplementary payment" means any cash payment made by a State on a regular basis to an individual who

is receiving supplemental security income benefits under title XVI or who would but for his income be eligible to receive such benefits, as assistance based on need in supplementation of such benefits (as determined by the Commissioner of Social Security), but only to the extent that such payments are made with respect to an individual with respect to whom supplemental security income benefits are payable under title XVI, or would but for his income be payable under that title.

(k) Increased supplemental security income benefits payable pursuant to section 211 of Public Law 93–66[64] shall not be considered supplemental security income benefits payable under title XVI.

(l)(1) The terms "rural health clinic services" and "rural health clinic" have the meanings given such terms in section 1861(aa), except that (A) clause (ii) of section 1861(aa)(2) shall not apply to such terms, and (B) the physician arrangement required under section 1861(aa)(2)(B) shall only apply with respect to rural health clinic services and, with respect to other ambulatory care services, the physician arrangement required shall be only such as may be required under the State plan for those services.

(2)(A) The term "Federally-qualified health center services" means services of the type described in subparagraphs (A) through (C) of section 1861(aa)(1) when furnished to an individual as an[65] patient of a Federally-qualified health center and, for this purpose, any reference to a rural health clinic or a physician described in section 1861(aa)(2)(B) is deemed a reference to a Federally-qualified health center or a physician at the center, respectively.

(B) The term "Federally-qualified health center" means a entity which—

(i) is receiving a grant under section 330 of the Public Health Service Act[66],

(ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and

(II) meets the requirements to receive a grant under section 330 of such Act,

(iii) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant, including requirements of the Secretary that an entity may not be owned, controlled, or operated by another entity, or

(iv) was treated by the Secretary, for purposes of part B of title XVIII, as a comprehensive Federally funded health center as of January 1, 1990;

and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93–638) or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act for the provision of primary health services. In applying clause (ii), the Secretary may waive any requirement referred to in such clause for up to 2 years for good cause shown.

(m)(1) Subject to paragraph (2), the term "qualified family member" means an individual (other than a qualified pregnant woman or child, as defined in subsection (n)) who is a member of a family

[64] See Vol. II, P.L. 93–66.
[65] As in original. Should read "a patient".
[66] See Vol. II, P.L. 78–410.

that would be receiving aid under the State plan under part A of title IV pursuant to section 407 if the State had not exercised the option under section 407(b)(2)(B)(i).

(2) No individual shall be a qualified family member for any period after September 30, 1998.

(n) The term "qualified pregnant woman or child" means—

(1) a pregnant woman who—

(A) would be eligible for aid to families with dependent children under part A of title IV (or would be eligible for such aid if coverage under the State plan under part A of title IV included aid to families with dependent children of unemployed parents pursuant to section 407) if her child had been born and was living with her in the month such aid would be paid, and such pregnancy has been medically verified;

(B) is a member of a family which would be eligible for aid under the State plan under part A of title IV pursuant to section 407 if the plan required the payment of aid pursuant to such section; or

(C) otherwise meets the income and resources requirements of a State plan under part A of title IV; and

(2) a child who has not attained the age of 19, who was born after September 30, 1983 (or such earlier date as the State may designate), and who meets the income and resources requirements of the State plan under part A of title IV.

(o)(1)(A) Subject to subparagraph (B), the term "hospice care" means the care described in section 1861(dd)(1) furnished by a hospice program (as defined in section 1861(dd)(2)) to a terminally ill individual who has voluntarily elected (in accordance with paragraph (2)) to have payment made for hospice care instead of having payment made for certain benefits described in section 1812(d)(2)(A) and for which payment may otherwise be made under title XVIII and intermediate care facility services under the plan. For purposes of such election, hospice care may be provided to an individual while such individual is a resident of a skilled nursing facility or intermediate care facility, but the only payment made under the State plan shall be for the hospice care.

(B) For purposes of this title, with respect to the definition of hospice program under section 1861(dd)(2), the Secretary may allow an agency or organization to make the assurance under subparagraph (A)(iii) of such section without taking into account any individual who is afflicted with acquired immune deficiency syndrome (AIDS).

(2) An individual's voluntary election under this subsection—

(A) shall be made in accordance with procedures that are established by the State and that are consistent with the procedures established under section 1812(d)(2);

(B) shall be for such a period or periods (which need not be the same periods described in section 1812(d)(1)) as the State may establish; and

(C) may be revoked at any time without a showing of cause and may be modified so as to change the hospice program with respect to which a previous election was made.

(3) In the case of an individual—

(A) who is residing in a nursing facility or intermediate care facility for the mentally retarded and is receiving medical assistance for services in such facility under the plan,

(B) who is entitled to benefits under part A of title XVIII and has elected, under section 1812(d), to receive hospice care under such part, and

(C) with respect to whom the hospice program under such title and the nursing facility or intermediate care facility for the mentally retarded have entered into a written agreement under which the program takes full responsibility for the professional management of the individual's hospice care and the facility agrees to provide room and board to the individual,

instead of any payment otherwise made under the plan with respect to the facility's services, the State shall provide for payment to the hospice program of an amount equal to the additional amount determined in section 1902(a)(13)(B) and, if the individual is an individual described in section 1902(a)(10)(A), shall provide for payment of any coinsurance amounts imposed under section 1813(a)(4).

(p)(1) The term "qualified medicare beneficiary" means an individual—

(A) who is entitled to hospital insurance benefits under part A of title XVIII (including an individual entitled to such benefits pursuant to an enrollment under section 1818, but not including an individual entitled to such benefits only pursuant to an enrollment under section 1818A),

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

(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.

(2)(A) The income level established under paragraph (1)(B) shall be at least the percent provided under subparagraph (B) (but 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[67]) applicable to a family of the size involved.

(B) Except as provided in subparagraph (C), the percent provided under this clause, with respect to eligibility for medical assistance on or after—

(i) January 1, 1989, is 85 percent,

(ii) January 1, 1990, is 90 percent, and

(iii) January 1, 1991, is 100 percent.

(C) In the case of a State which has elected treatment under section 1902(f) and which, as of January 1, 1987, used an income standard for individuals age 65 or older which was more restrictive than the income standard established under the supplemental security income program under title XVI, the percent provided under subparagraph (B), with respect to eligibility for medical assistance on or after—

(i) January 1, 1989, is 80 percent,

[67] See Vol. II, P.L. 97–35.

(ii) January 1, 1990, is 85 percent,

(iii) January 1, 1991, is 95 percent, and

(iv) January 1, 1992, is 100 percent.

(D)(i) In determining under this subsection the income of an individual who is entitled to monthly insurance benefits under title II for a transition month (as defined in clause (ii)) in a year, such income shall not include any amounts attributable to an increase in the level of monthly insurance benefits payable under such title which have occurred pursuant to section 215(i) for benefits payable for months beginning with December of the previous year.

(ii) For purposes of clause (i), the term "transition month" means each month in a year through the month following the month in which the annual revision of the official poverty line, referred to in subparagraph (A), is published.

(3) The term "medicare cost-sharing" means (subject to section 1902(n)(2)) the following costs incurred with respect to a qualified medicare beneficiary, without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan:

(A)(i) premiums under section 1818 or 1818A, and

(ii) premiums under section 1839,

(B) Coinsurance under title XVIII (including coinsurance described in section 1813).[68]

(C) Deductibles established under title XVIII (including those described in section 1813 and section 1833(b)).[69]

(D) The difference between the amount that is paid under section 1833(a) and the amount that would be paid under such section if any reference to "80 percent" therein were deemed a reference to "100 percent".

Such term also may include, at the option of a State, premiums for enrollment of a qualified medicare beneficiary with an eligible organization under section 1876.

(4) Notwithstanding any other provision of this title, in the case of a State (other than the 50 States and the District of Columbia)—

(A) the requirement stated in section 1902(a)(10)(E) shall be optional, and

(B) for purposes of paragraph (2), the State may substitute for the percent provided under subparagraph (B) of such paragraph or 1902(a)(10)(E)(iii) any percent.

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 meet the requirement of section 1902(a)(10)(E) in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title.

(5)(A) The Secretary shall develop and distribute to States a simplified application form for use by individuals (including both qualified medicare beneficiaries and specified low–income medicare beneficiaries) in applying for medical assistance for medicare cost–sharing under this title in the States which elect to use such form. Such form shall be easily readable by applicants and uniform nationally.

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[68] Punctuation as in original.

[69] Punctuation as in original.

(B) In developing such form, the Secretary shall consult with beneficiary groups and the States.

(6) For provisions relating to outreach efforts to increase awareness of the availability of medicare cost-sharing, see section 1144.

(q) The term "qualified severely impaired individual" means an individual under age 65—

(1) who for the month preceding the first month to which this subsection applies to such individual—

(A) received (i) a payment of supplemental security income benefits under section 1611(b) on the basis of blindness or disability, (ii) a supplementary payment under section 1616 of this Act or under section 212 of Public Law 93–66 [70] on such basis, (iii) a payment of monthly benefits under section 1619(a), or (iv) a supplementary payment under section 1616(c)(3), and

(B) was eligible for medical assistance under the State plan approved under this title; and

(2) with respect to whom the Commissioner of Social Security determines that—

(A) the individual continues to be blind or continues to have the disabling physical or mental impairment on the basis of which he was found to be under a disability and, except for his earnings, continues to meet all non-disability-related requirements for eligibility for benefits under title XVI,

(B) the income of such individual would not, except for his earnings, be equal to or in excess of the amount which would cause him to be ineligible for payments under section 1611(b) (if he were otherwise eligible for such payments),

(C) the lack of eligibility for benefits under this title would seriously inhibit his ability to continue or obtain employment, and

(D) the individual's earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the benefits under title XVI (including any federally administered State supplementary payments), this title, and publicly funded attendant care services (including personal care assistance) that would be available to him in the absence of such earnings.

In the case of an individual who is eligible for medical assistance pursuant to section 1619(b) in June, 1987, the individual shall be a qualified severely impaired individual for so long as such individual meets the requirements of paragraph (2).

(r) The term "early and periodic screening, diagnostic, and treatment services" means the following items and services:

(1) Screening services—

(A) which are provided—

(i) at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care and, with respect to immunizations under subparagraph

[70] See Vol. II, P.L. 93–66.

(B)(iii), in accordance with the schedule referred to in section
1928(c)(2)(B)(i) for pediatric vaccines, and
(ii) at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions; and
(B) which shall at a minimum include—
(i) a comprehensive health and developmental history (including assessment of both physical and mental health development),
(ii) a comprehensive unclothed physical exam,
(iii) appropriate immunizations (according to the schedule referred to in section 1928(c)(2)(B)(i) for pediatric vaccines) according to age and health history,
(iv) laboratory tests (including lead blood level assessment appropriate for age and risk factors), and
(v) health education (including anticipatory guidance).
(2) Vision services—
(A) which are provided—
(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and
(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and
(B) which shall at a minimum include diagnosis and treatment for defects in vision, including eyeglasses.
(3) Dental services—
(A) which are provided—
(i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and
(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and
(B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.
(4) Hearing services—
(A) which are provided—
(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and
(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and
(B) which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.
(5) Such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses

and conditions discovered by the screening services, whether or not such services are covered under the State plan.

Nothing in this title shall be construed as limiting providers of early and periodic screening, diagnostic, and treatment services to providers who are qualified to provide all of the items and services described in the previous sentence or as preventing a provider that is qualified under the plan to furnish one or more (but not all) of such items or services from being qualified to provide such items and services as part of early and periodic screening, diagnostic, and treatment services. The Secretary shall, not later than July 1, 1990, and every 12 months thereafter, develop and set annual participation goals for each State for participation of individuals who are covered under the State plan under this title in early and periodic screening, diagnostic, and treatment services.

(s) The term "qualified disabled and working individual" means an individual—

(1) who is entitled to enroll for hospital insurance benefits under part A of title XVIII under section 1818A (as added by 6012 of the Omnibus Budget Reconciliation Act of 1989 [71]);

(2) whose income (as determined under section 1612 for purposes of the supplemental security income program) does not exceed 200 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 [72]) applicable to a family of the size involved;

(3) 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 or a couple (in the case of an individual with a spouse) may have and obtain benefits for supplemental security income benefits under title XVI; and

(4) who is not otherwise eligible for medical assistance

(t)(1) The term "primary care case management services" means case–management related services (including locating, coordinating, and monitoring of health care services) provided by a primary care case manager under a primary care case management contract.

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

(A) A physician, a physician group practice, or an entity employing or having other arrangements with physicians to provide such services.

(B) At State option—

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

(ii) a certified nurse–midwife (as defined in section 1861(gg)); or

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

(3) The term "primary care case management contract" means a contract between a primary care case manager and a

[71] P.L. 101–239.
[72] See Vol. II, P.L. 97–35.

State under which the manager undertakes to locate, coordinate, and monitor covered primary care (and such other covered services as may be specified under the contract) to all individuals enrolled with the manager, and which—

(A) provides for reasonable and adequate hours of operation, including 24–hour availability of information, referral, and treatment with respect to medical emergencies;

(B) restricts enrollment to individuals residing sufficiently near a service delivery site of the manager to be able to reach that site within a reasonable time using available and affordable modes of transportation;

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

(D) prohibits discrimination on the basis of health status or requirements for health care services in enrollment, disenrollment, or reenrollment of individuals eligible for medical assistance under this title;

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

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

(4) For purposes of this subsection, the term "primary care" includes all health care services customarily provided in accordance with State licensure and certification laws and regulations, and all laboratory services customarily provided by or through, a general practitioner, family medicine physician, internal medicine physician, obstetrician/gynecologist, or pediatrician.

(u)(1) The conditions described in this paragraph for a State plan are as follows:

(A) The State is complying with the requirement of section 2105(d)(1).

(B) The plan provides for such reporting of information about expenditures and payments attributable to the operation of this subsection as the Secretary deems necessary in order to carry out the fourth sentence of subsection (b).

(2)(A) For purposes of subsection (b), the expenditures described in this subparagraph are expenditures for medical assistance for optional targeted low–income children described in subparagraph (B).

(B) For purposes of this paragraph, the term "optional targeted low-income child" means a targeted low-income child as defined in section 2110(b)(1) (determined without regard to that portion of subparagraph (C) of such section concerning eligibility for medical assistance under this title) who would not qualify for medical assistance under the State plan under this title as in effect on March 31, 1997 (but taking into account the expansion of age of eligibility effected through the operation of section 1902(l)(1)(D)).

(3) For purposes of subsection (b), the expenditures described in this paragraph are expenditures for medical assistance for children who are born before October 1, 1983, and who would be described in section 1902(l)(1)(D) if they had been born on or after such date, and who are not eligible for such assistance under the State plan

under this title based on such State plan as in effect as of March 31, 1997.

(4) The limitations on payment under subsections (f) and (g) of section 1108 shall not apply to Federal payments made under section 1903(a)(1) based on an enhanced FMAP described in section 2105(b).

(v)(1) The term "employed individual with a medically improved disability" means an individual who—

(A) is at least 16, but less than 65, years of age;

(B) is employed (as defined in paragraph (2));

(C) ceases to be eligible for medical assistance under section 1902(a)(10)(A)(ii)(XV) because the individual, by reason of medical improvement, is determined at the time of a regularly scheduled continuing disability review to no longer be eligible for benefits under section 223(d) or 1614(a)(3); and

(D) continues to have a severe medically determinable impairment, as determined under regulations of the Secretary.

(2) For purposes of paragraph (1), an individual is considered to be "employed" if the individual—

(A) is earning at least the applicable minimum wage requirement under section 6 of the Fair Labor Standards Act (29 U.S.C. 206) and working at least 40 hours per month; or

(B) is engaged in a work effort that meets substantial and reasonable threshold criteria for hours of work, wages, or other measures, as defined by the State and approved by the Secretary.

(w)(1) For purposes of this title, the term "independent foster care adolescent" means an individual—

(A) who is under 21 years of age;

(B) who, on the individual's 18th birthday, was in foster care under the responsibility of a State; and

(C) whose assets, resources, and income do not exceed such levels (if any) as the State may establish consistent with paragraph (2).

(2) The levels established by a State under paragraph (1)(C) may not be less than the corresponding levels applied by the State under section 1931(b).

(3) A State may limit the eligibility of independent foster care adolescents under section 1902(a)(10)(A)(ii)(XVII) to those individuals with respect to whom foster care maintenance payments or independent living services were furnished under a program funded under part E of title IV before the date the individuals attained 18 years of age.

(x)[73] For purposes of subsection (a)(27), the strategies, treatment, and services described in that subsection include the following:

(1) Chronic blood transfusion (with deferoxamine chelation) to prevent stroke in individuals with Sickle Cell Disease who have been identified as being at high risk for stroke.

(2) Genetic counseling and testing for individuals with Sickle Cell Disease or the sickle cell trait to allow health care professionals to treat such individuals and to prevent symptoms of Sickle Cell Disease.

[73] P.L. 108–357, §712(a)(1)(B), added subsection (x), effective October 22, 2004, applicable to medical assistance and services provided under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) on or after October 22, 2004. See Vol. II, P.L. 108-357, §712(a)(2), with respect to a rule of construction.

(3) Other treatment and services to prevent individuals who have Sickle Cell Disease and who have had a stroke from having another stroke.

ENROLLMENT OF INDIVIDUALS UNDER GROUP HEALTH PLANS

SEC. 1906. [42 U.S.C. 1396e] (a) Each State plan—

(1) may implement guidelines established by the Secretary, consistent with subsection (b), to identify those cases in which enrollment of an individual otherwise entitled to medical assistance under this title in a group health plan (in which the individual is otherwise eligible to be enrolled) is cost-effective (as defined in subsection (e)(2));

(2) may require, in case of an individual so identified and as a condition of the individual being or remaining eligible for medical assistance under this title and subject to subsection (b)(2), notwithstanding any other provision of this title, that the individual (or in the case of a child, the child's parent) apply for enrollment in the group health plan; and

(3) in the case of such enrollment (except as provided in subsection (c)(1)(B)), shall provide for payment of all enrollee premiums for such enrollment and all deductibles, coinsurance, and other cost-sharing obligations for items and services otherwise covered under the State plan under this title (exceeding the amount otherwise permitted under section 1916), and shall treat coverage under the group health plan as a third party liability (under section 1902(a)(25)).

(b)(1) In establishing guidelines under subsection (a)(1), the Secretary shall take into account that an individual may only be eligible to enroll in group health plans at limited times and only if other individuals (not entitled to medical assistance under the plan) are also enrolled in the plan simultaneously.

(2) If a parent of a child fails to enroll the child in a group health plan in accordance with subsection (a)(2), such failure shall not affect the child's eligibility for benefits under this title.

(c)(1)(A) In the case of payments of premiums, deductibles, coinsurance, and other cost-sharing obligations under this section shall be considered, for purposes of section 1903(a), to be payments for medical assistance.

(B) If all members of a family are not eligible for medical assistance under this title and enrollment of the members so eligible in a group health plan is not possible without also enrolling members not so eligible—

(i) payment of premiums for enrollment of such other members shall be treated as payments for medical assistance for eligible individuals, if it would be cost-effective (taking into account payment of all such premiums), but

(ii) payment of deductibles, coinsurance, and other cost-sharing obligations for such other members shall not be treated as payments for medical assistance for eligible individuals.

(2) The fact that an individual is enrolled in a group health plan under this section shall not change the individual's eligibility for benefits under the State plan, except insofar as section 1902(a)(25) provides that payment for such benefits shall first be made by such plan.

(d) [Stricken.[74]]

(e) In this section:

(1) The term "group health plan" has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986[75], and includes the provision of continuation coverage by such a plan 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[76] .

(2) The term "cost-effective" means, as established by the Secretary, that the reduction in expenditures under this title with respect to an individual who is enrolled in a group health plan is likely to be greater than the additional expenditures for premiums and cost-sharing required under this section with respect to such enrollment.

OBSERVANCE OF RELIGIOUS BELIEFS

SEC. 1907. [42 U.S.C. 1396f] Nothing in this title shall be construed to require any State which has a plan approved under this title to compel any person to undergo any medical screening, examination, diagnosis, or treatment or to accept any other health care or services provided under such plan for any purpose (other than for the purpose of discovering and preventing the spread of infection or contagious disease or for the purpose of protecting environmental health), if such person objects (or, in case such person is a child, his parent or guardian objects) thereto on religious grounds.

STATE PROGRAMS FOR LICENSING OF ADMINISTRATORS OF NURSING HOMES[77]

SEC. 1908. [42 U.S.C. 1396g] (a) For purposes of section 1902(a)(29), a "State program for the licensing of administrators of nursing homes" is a program which provides that no nursing home within the State may operate except under the supervision of an administrator licensed in the manner provided in this section.

(b) Licensing of nursing home administrators shall be carried out by the agency of the State responsible for licensing under the healing arts licensing act of the State, or, on the absence of such act or such an agency, a board representative of the professions and institutions concerned with care of chronically ill and inform aged patients and established to carry out the purposes of this section.

(c) It shall be the function and duty of such agency or board to—

(1) develop, impose, and enforce standards which must be met by individuals in order to receive a license as a nursing home administrator, which standards shall be designed to insure that nursing home administrators will be individuals who are of good character and are otherwise suitable, and who, by training or experience in the field of institutional administration, are qualified to serve as nursing home administrators;

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[74] P.L. 105–33, §4741(b)(2); 111 Stat. 523.

[75] See Vol. II, P.L. 83–591.

[76] P.L. 78–410, Title XXII, P.L. 83–591, §4980B, and P.L. 93–406, Title VI.

[77] P.L. 101–508, §4801(e)(11)(B), repealed this section, effective on the date on which the Secretary promulgates standards regarding the qualifications of nursing facility administrators under §1919(f)(4). The Secretary has not, to date, promulgated such standards and is not expected to promulgate them in the near future.

(2) develop and apply appropriate techniques, including examinations and investigations, for determining whether an individual meets such standards;

(3) issue licenses to individuals determined, after the application of such techniques, to meet such standards, and revoke or suspend licenses previously issued by the board in any case where the individual holding any such license is determined substantially to have failed to conform to the requirements of such standards;

(4) establish and carry out procedures designed to insure that individuals licensed as nursing home administrators will, during any period that they serve as such, comply with the requirements of such standards;

(5) receive, investigate, and take appropriate action with respect to, any charge or complaint filed with the board to the effect that any individual licensed as a nursing home administrator has failed to comply with the requirements of such standards; and

(6) conduct a continuing study and investigation of nursing homes and administrators of nursing homes within the State with a view to the improvement of the standards imposed for the licensing of such administrators and of procedures and methods for the enforcement of such standards with respect to administrators of nursing homes who have been licensed as such.

(d) No State shall be considered to have failed to comply with the provisions of section 1902(a)(29) because the agency or board of such State (established pursuant to subsection (b)) shall have granted any waiver, with respect to any individual who, during all of the three calendar years immediately preceding the calendar year in which the requirements prescribed in section 1902(a)(29) are first met by the State, has served as a nursing home administrator, of any of the standards developed, imposed, and enforced by such agency or board pursuant to subsection (c).

(e) As used in this section, the term—

(1) "nursing home" means any institution or facility defined as such for licensing purposes under State law, or, if State law does not employ the term nursing home, the equivalent term or terms as determined by the Secretary, but a religious nonmedical health care institution (as defined in section 1861(ss)(1)).

(2) "nursing home administrator" means any individual who is charged with the general administration of a nursing home whether or not such individual has an ownership interest in such home and whether or not his functions and duties are shared with one or more other individuals.

REQUIRED LAWS RELATING TO MEDICAL CHILD SUPPORT

SEC. 1908A. [42 U.S.C. 1396g–1] (a) IN GENERAL.—The laws relating to medical child support, which a State is required to have in effect under section 1902(a)(60), are as follows:

(1) A law that prohibits an insurer from denying enrollment of a child under the health coverage of the child's parent on the ground that—

(A) the child was born out of wedlock,

(B) the child is not claimed as a dependent on the parent's Federal income tax return, or

(C) the child does not reside with the parent or in the insurer's service area.

(2) In any case in which a parent is required by a court or administrative order to provide health coverage for a child and the parent is eligible for family health coverage through an insurer, a law that requires such insurer—

(A) to permit such parent to enroll under such family coverage any such child who is otherwise eligible for such coverage (without regard to any enrollment season restrictions);

(B) if such a parent is enrolled but fails to make application to obtain coverage of such child, to enroll such child under such family coverage upon application by the child's other parent or by the State agency administering the program under this title or part D of title IV; and

(C) not to disenroll (or eliminate coverage of) such a child unless the insurer is provided satisfactory written evidence that—

(i) such court or administrative order is no longer in effect, or

(ii) the child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the effective date of such disenrollment.

(3) In any case in which a parent is required by a court or administrative order to provide health coverage for a child and the parent is eligible for family health coverage through an employer doing business in the State, a law that requires such employer—

(A) to permit such parent to enroll under such family coverage any such child who is otherwise eligible for such coverage (without regard to any enrollment season restrictions);

(B) if such a parent is enrolled but fails to make application to obtain coverage of such child, to enroll such child under such family coverage upon application by the child's other parent or by the State agency administering the program under this title or part D of title IV; and

(C) not to disenroll (or eliminate coverage of) any such child unless—

(i) the employer is provided satisfactory written evidence that—

(I) such court or administrative order is no longer in effect, or

(II) the child is or will be enrolled in comparable health coverage which will take effect not later than the effective date of such disenrollment, or

(ii) the employer has eliminated family health coverage for all of its employees; and

(D) to withhold from such employee's compensation the employee's share (if any) of premiums for health coverage (except that the amount so withheld may not exceed the maximum amount permitted to be withheld under section

303(b) of the Consumer Credit Protection Act[78]), and to pay such share of premiums to the insurer, except that the Secretary may provide by regulation for appropriate circumstances under which an employer may withhold less than such employee's share of such premiums.

(4) A law that prohibits an insurer from imposing requirements on a State agency, which has been assigned the rights of an individual eligible for medical assistance under this title and covered for health benefits from the insurer, that are different from requirements applicable to an agent or assignee of any other individual so covered.

(5) A law that requires an insurer, in any case in which a child has health coverage through the insurer of a noncustodial parent—

(A) to provide such information to the custodial parent as may be necessary for the child to obtain benefits through such coverage;

(B) to permit the custodial parent (or provider, with the custodial parent's approval) to submit claims for covered services without the approval of the noncustodial parent; and

(C) to make payment on claims submitted in accordance with subparagraph (B) directly to such custodial parent, the provider, or the State agency.

(6) A law that permits the State agency under this title to garnish the wages, salary, or other employment income of, and requires withholding amounts from State tax refunds to, any person who—

(A) is required by court or administrative order to provide coverage of the costs of health services to a child who is eligible for medical assistance under this title,

(B) has received payment from a third party for the costs of such services to such child, but

(C) has not used such payments to reimburse, as appropriate, either the other parent or guardian of such child or the provider of such services,

to the extent necessary to reimburse the State agency for expenditures for such costs under its plan under this title, but any claims for current or past-due child support shall take priority over any such claims for the costs of such services.

(b) DEFINITION.—For purposes of this section, the term "insurer" includes a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, a health maintenance organization, and an entity offering a service benefit plan.

SEC. 1909. **[**Redesignated.[79]**]**

CERTIFICATION AND APPROVAL OF RURAL HEALTH CLINICS AND INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED[80]

SEC. 1910. **[**42 U.S.C. 1396i**]** (a)(1) Whenever the Secretary certifies a facility in a State to be qualified as a rural health clinic under title XVIII, such facility shall be deemed to meet the stand-

[78] See Vol. II, P.L. 90–321.
[79] P.L. 100–93, §4(d); 101 Stat. 689 redesignated §1909 as §1128B.
[80] See Vol. II, P.L. 95–210, §1(e), with respect to a definition of rural health clinics.

ards for certification as a rural health clinic for purposes of providing rural health clinic services under this title.

(2) The Secretary shall notify the State agency administering the medical assistance plan of his approval or disapproval of any facility in that State which has applied for certification by him as a qualified rural health clinic.

(b)(1) The Secretary may cancel approval of any intermediate care facility for the mentally retarded at any time if he finds on the basis of a determination made by him as provided in section 1902(a)(33)(B) that a facility fails to meet the requirements contained in section 1902(a)(31) or section 1905(d), or if he finds grounds for termination of his agreement with the facility pursuant to section 1866(b). In that event the Secretary shall notify the State agency and the intermediate care facility for the mentally retarded that approval of eligibility of the facility to participate in the programs established by this title and title XVIII shall be terminated at a time specified by the Secretary. The approval of eligibility of any such facility to participate in such programs may not be reinstated unless the Secretary finds that the reason for termination has been removed and there is reasonable assurance that it will not recur.

(2) Any intermediate care facility for the mentally retarded which is dissatisfied with a determination by the Secretary that it no longer qualifies as a[81] intermediate care facility for the mentally retarded for purposes of this title, shall be entitled to a hearing by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g), except that, in so applying such sections and in applying section 205(l) thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively[82]Any agreement between such facility and the State agency shall remain in effect until the period for filing a request for a hearing has expired or, if a request has been filed, until a decision has been made by the Secretary; except that the agreement shall not be extended if the Secretary makes a written determination, specifying the reasons therefor, that the continuation of provider status constitutes an immediate and serious threat to the health and safety of patients, and the Secretary certifies that the facility has been notified of its deficiencies and has failed to correct them.

INDIAN HEALTH SERVICE FACILITIES[83]

SEC. 1911. [42 U.S.C. 1396j] (a) A facility of the Indian Health Service (including a hospital, nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan), whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section

[81] As in original; should be "an".
[82] As in original; period missing.
[83] See Vol. II, P.L. 94–437, §402(c)(d), with respect to a special fund for Indian Health Service facilities.
See Vol. II, P.L. 100–713, §712, with respect to the provision of services in Montana.

4 of the Indian Health Care Improvement Act[84]), shall be eligible for reimbursement for medical assistance provided under a State plan if and for so long as it meets all of the conditions and requirements which are applicable generally to such facilities under this title.

(b) Notwithstanding subsection (a), a facility of the Indian Health Service (including a hospital, nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan) which does not meet all of the conditions and requirements of this title which are applicable generally to such facility, but which submits to the Secretary within six months after the date of the enactment of this section[85] an acceptable plan for achieving compliance with such conditions and requirements, shall be deemed to meet such conditions and requirements (and to be eligible for reimbursement under this title), without regard to the extent of its actual compliance with such conditions and requirements, during the first twelve months after the month in which such plan is submitted.

(c) The Secretary is authorized to enter into agreements with the State agency for the purpose of reimbursing such agency for health care and services provided in Indian Health Service facilities to Indians who are eligible for medical assistance under the State plan.

(d) For provisions relating to the authority of certain Indian tribes, tribal organizations, and Alaska Native health organizations to elect to directly bill for, and receive payment for, health care services provided by a hospital or clinic of such tribes or organizations and for which payment may be made under this title, see section 405 of the Indian Health Care Improvement Act (25 U.S.C. 1645).

ASSIGNMENT OF RIGHTS OF PAYMENT

SEC. 1912. [42 U.S.C. 1396k] (a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan approved under this title, a State plan for medical assistance shall—

(1) provide that, as a condition of eligibility for medical assistance under the State plan to an individual who has the legal capacity to execute an assignment for himself, the individual is required—

(A) to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under this title and on whose behalf the individual has the legal authority to execute an assignment of such rights, to support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party;

(B) to cooperate with the State (i) in establishing the paternity of such person (referred to in subparagraph (A)) if the person is a child born out of wedlock, and (ii) in obtaining support and payments (described in subparagraph (A)) for himself and for such person, unless (in either case) the individual is described in section 1902(l)(1)(A) or the indi-

[84] See Vol. II, P.L. 94–437.
[85] September 30, 1976 [P.L. 94–437; 90 Stat. 1400].

vidual is found to have good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and

(C) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan, unless such individual has good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and

(2) provide for entering into cooperative arrangements (including financial arrangements), with any appropriate agency of any State (including, with respect to the enforcement and collection of rights of payment for medical care by or through a parent, with a State's agency established or designated under section 454(3)) and with appropriate courts and law enforcement officials, to assist the agency or agencies administering the State plan with respect to (A) the enforcement and collection of rights to support or payment assigned under this section and (B) any other matters of common concern.

(b) Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

HOSPITAL PROVIDERS OF NURSING FACILITY SERVICES

SEC. 1913. [42 U.S.C. 1396l] (a) Notwithstanding any other provision of this title, payment may be made, in accordance with this section, under a State plan approved under this title for nursing facility services furnished by a hospital which has in effect an agreement under section 1883 and which, with respect to the provision of such services, meets the requirements of subsections (b) through (d) of section 1919.

(b)(1) Except as provided in paragraph (3), payment to any such hospital, for any nursing facility services furnished pursuant to subsection (a), shall be at a rate equal to the average rate per patient-day paid for routine services during the previous calendar year under the State plan to nursing facilities, respectively, located in the State in which the hospital is located. The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

(2) With respect to any period for which a hospital has an agreement under section 1883, in order to allocate routine costs between hospital and long-term care services, the total reimbursement for routine services due from all classes of long-term care patients (including title XVIII, title XIX, and private pay patients) shall be subtracted from the hospital total rou-

tine costs before calculations are made to determine reimbursement for routine hospital services under the State plan.

(3) Payment to all such hospitals, for any nursing facility services furnished pursuant to subsection (a), may be made at a payment rate established by the State in accordance with the requirements of section 1902(a)(13)(A).

WITHHOLDING OF FEDERAL SHARE OF PAYMENTS FOR CERTAIN MEDICARE PROVIDERS

SEC. 1914. [42 U.S.C. 1396m] (a) The Secretary may adjust, in accordance with this section, the Federal matching payment to a State with respect to expenditures for medical assistance for care or services furnished in any quarter by—

(1) an institution (A) which has or previously had in effect an agreement with the Secretary under section 1866; and (B)(i) from which the Secretary has been unable to recover overpayments made under title XVIII, or (ii) from which the Secretary has been unable to collect the information necessary to enable him to determine the amount (if any) of the overpayments made to such institution under title XVIII; and

(2) any person (A) who (i) has previously accepted payment on the basis of an assignment under section 1842(b)(3)(B)(ii), and (ii) during the annual period immediately preceding such quarter submitted no claims for payment under title XVIII, or submitted claims for payment under title XVIII which aggregated less than the amount of overpayments made to him, and (B)(i) from whom the Secretary has been unable to recover overpayments received in violation of the terms of such assignment, or (ii) from whom the Secretary has been unable to collect the information necessary to enable him to determine the amount (if any) of the overpayments made to such person under title XVIII.

(b) The Secretary may (subject to the remaining provisions of this section) reduce payment to a State under this title for any quarter by an amount equal to the lesser of the Federal matching share of payments to any institution or person specified in subsection (a), or the total overpayments to such institution or person under title XVIII, and may require the State to reduce its payment to such institution or person by such amount.

(c) The Secretary shall not make any adjustment in the payment to a State, nor require any adjustment in the payment to an institution or person, pursuant to subsection (b) until after he has provided adequate notice (which shall be not less than 60 days) to the State agency and the institution or person.

(d) The Secretary shall by regulation provide procedures for implementation of this section, which procedures shall (1) determine the amount of the Federal payment to which the institution or person would otherwise be entitled under this section which shall be treated as a setoff against overpayments under title XVIII, and (2) assure the restoration to the institution or person of amounts withheld under this section which are ultimately determined to be in excess of overpayments under title XVIII and to which the institution or person would otherwise be entitled under this title.

(e) The Secretary shall restore to the trust funds established under sections 1817 and 1841, as appropriate, amounts recovered

under this section as setoffs against overpayments under title XVIII.

(f) Notwithstanding any other provision of this title, an institution or person shall not be entitled to recover from any State any amount in payment for medical care and services under this title which is withheld by the State agency pursuant to an order by the Secretary under subsection (b).

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).[86]

(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.

[86] See Vol. II, P.L. 99–272, §9524, with respect to the Wisconsin health maintenance organization waiver.

(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 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 Indviduals with Disabilities Education Act[87] (20 U.S.C. 1401))[88] 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[89] (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

[87] See Vol. II, P.L. 91–230.

[88] P.L. 108-446, §305(j)(2), struck out "(as defined in section 602(16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401(16), (17))" and substituted "(as such terms are defined in section 602 of the Indviduals with Disabilities Education Act (20 U.S.C. 1401))".

[89] See Vol. II, P.L. 93–112.

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 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.

(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) No waiver under this section (other than a waiver under subsection (c), (d), or (e)) 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.

USE OF ENROLLMENT FEES, PREMIUMS, DEDUCTIONS, COST SHARING, AND SIMILAR CHARGES

SEC. 1916. [42 U.S.C. 1396o] (a) Subject to subsection (g), the State plan shall provide that in the case of individuals described in subparagraph (A) or (E)(i) of section 1902(a)(10) who are eligible under the plan—

(1) no enrollment fee, premium, or similar charge will be imposed under the plan (except for a premium imposed under subsection (c));

(2) no deduction, cost sharing or similar charge will be imposed under the plan with respect to—

(A) services furnished to individuals under 18 years of age (and, at the option of the State, individuals under 21, 20, or 19 years of age, or any reasonable category of individuals 18 years of age or over),

(B) services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy (or, at the option of the State, any services furnished to pregnant women),

(C) services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs,

(D) emergency services (as defined by the Secretary), family planning services and supplies described in section 1905(a)(4)(C), or

(E) services furnished to an individual who is receiving hospice care (as defined in section 1905(o)); and

(3) any deduction, cost sharing, or similar charge imposed under the plan with respect to other such individuals or other care and services will be nominal in amount (as determined by the Secretary in regulations which shall, if the definition of "nominal" under the regulations in effect on July 1, 1982 is

changed, take into account the level of cash assistance provided in such State and such other criteria as the Secretary determines to be appropriate); except that a deduction, cost-sharing, or similar charge of up to twice the nominal amount established for outpatient services may be imposed by a State under a waiver granted by the Secretary for services received at a hospital emergency room if the services are not emergency services (referred to in paragraph (2)(D)) and the State has established to the satisfaction of the Secretary that individuals eligible for services under the plan have actually available and accessible to them alternative sources of nonemergency, outpatient services.

(b) The State plan shall provide that in the case of individuals other than those described in subparagraph (A) or (E) of section 1902(a)(10) who are eligible under the plan—

(1) there may be imposed an enrollment fee, premium, or similar charge, which (as determined in accordance with standards prescribed by the Secretary) is related to the individual's income,

(2) no deduction, cost sharing, or similar charge will be imposed under the plan with respect to—

(A) services furnished to individuals under 18 years of age (and, at the option of the State, individuals under 21, 20, or 19 years of age, or any reasonable category of individuals 18 years of age or over),

(B) services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy (or, at the option of the State, any services furnished to pregnant women),

(C) services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs,

(D) emergency services (as defined by the Secretary), family planning services and supplies described in section 1905(a)(4)(C), or (at the option of the State) services furnished to such an individual by a health maintenance organization (as defined in section 1903(m)) in which he is enrolled, or

(E) services furnished to an individual who is receiving hospice care (as defined in section 1905(o)); and

(3) any deduction, cost sharing, or similar charge imposed under the plan with respect to other such individuals or other care and services will be nominal in amount (as determined by the Secretary in regulations which shall, if the definition of "nominal" under the regulations in effect on July 1, 1982 is changed, take into account the level of cash assistance provided in such State and such other criteria as the Secretary determines to be appropriate); except that a deduction, cost-sharing, or similar charge of up to twice the nominal amount established for outpatient services may be imposed by a State under a waiver granted by the Secretary for services received at a hospital emergency room if the services are not emergency

services (referred to in paragraph (2)(D)) and the State has established to the satisfaction of the Secretary that individuals eligible for services under the plan have actually available and accessible to them alternative sources of nonemergency, outpatient services.

(c)(1) The State plan of a State may at the option of the State provide for imposing a monthly premium (in an amount that does not exceed the limit established under paragraph (2)) with respect to an individual described in subparagraph (A) or (B) of section 1902(l)(1) who is receiving medical assistance on the basis of section 1902(a)(10)(A)(ii)(IX) and whose family income (as determined in accordance with the methodology specified in section 1902(l)(3)) equals or exceeds 150 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[90]) applicable to a family of the size involved.

(2) In no case may the amount of any premium imposed under paragraph (1) exceed 10 percent of the amount by which the family income (less expenses for the care of a dependent child) of an individual exceeds 150 percent of the line described in paragraph (1).

(3) A State shall not require prepayment of a premium imposed pursuant to paragraph (1) and shall not terminate eligibility of an individual for medical assistance under this title on the basis of failure to pay any such premium until such failure continues for a period of not less than 60 days. The State may waive payment of any such premium in any case where the State determines that requiring such payment would create an undue hardship.

(4) A State may permit State or local funds available under other programs to be used for payment of a premium imposed under paragraph (1). Payment of a premium with such funds shall not be counted as income to the individual with respect to whom such payment is made.

(d) With respect to a qualified disabled and working individual described in section 1905(s) whose income (as determined under paragraph (3) of that section) exceeds 150 percent of the official poverty line referred to in that paragraph, the State plan of a State may provide for the charging of a premium (expressed as a percentage of the medicare cost-sharing described in section 1905(p)(3)(A)(i) provided with respect to the individual) according to a sliding scale under which such percentage increases from 0 percent to 100 percent, in reasonable increments (as determined by the Secretary), as the individual's income increases from 150 percent of such poverty line to 200 percent of such poverty line.

(e) The State plan shall require that no provider participating under the State plan may deny care or services to an individual eligible for such care or services under the plan on account of such individual's inability to pay a deduction, cost sharing, or similar charge. The requirements of this subsection shall not extinguish the liability of the individual to whom the care or services were furnished for payment of the deduction, cost sharing, or similar charge.

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[90] See Vol. II, P.L. 97–35.

(f) No deduction, cost sharing, or similar charge may be imposed under any waiver authority of the Secretary, except as provided in subsections (a)(3) and (b)(3), unless such waiver is for a demonstration project which the Secretary finds after public notice and opportunity for comment—

(1) will test a unique and previously untested use of copayments,

(2) is limited to a period of not more than two years,

(3) will provide benefits to recipients of medical assistance which can reasonably be expected to be equivalent to the risks to the recipients,

(4) is based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area, and

(5) is voluntary, or makes provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation.

(g) With respect to individuals provided medical assistance only under subclause (XV) or (XVI) of section 1902(a)(10)(A)(ii)—

(1) a State may (in a uniform manner for individuals described in either such subclause)—

(A) require such individuals to pay premiums or other cost-sharing charges set on a sliding scale based on income that the State may determine; and

(B) require payment of 100 percent of such premiums for such year in the case of such an individual who has income for a year that exceeds 250 percent of the income official poverty line (referred to in subsection (c)(1)) applicable to a family of the size involved, except that in the case of such an individual who has income for a year that does not exceed 450 percent of such poverty line, such requirement may only apply to the extent such premiums do not exceed 7.5 percent of such income; and

(2) such State shall require payment of 100 percent of such premiums for a year by such an individual whose adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986) for such year exceeds $75,000, except that a State may choose to subsidize such premiums by using State funds which may not be federally matched under this title.

In the case of any calendar year beginning after 2000, the dollar amount specified in paragraph (2) shall be increased in accordance with the provisions of section 215(i)(2)(A)(ii).

LIENS, ADJUSTMENTS AND RECOVERIES, AND TRANSFERS OF ASSETS

SEC. 1917. [42 U.S.C. 1396p] (a)(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except—

(A) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

(B) in the case of the real property of an individual—

(i) who is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of

receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs, and

(ii) with respect to whom the State determines, after notice and opportunity for a hearing (in accordance with procedures established by the State), that he cannot reasonably be expected to be discharged from the medical institution and to return home,

except as provided in paragraph (2).

(2) No lien may be imposed under paragraph (1)(B) on such individual's home if—

(A) the spouse of such individual,

(B) 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 (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614, or

(C) a sibling of such individual (who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution),

is lawfully residing in such home.

(3) Any lien imposed with respect to an individual pursuant to paragraph (1)(B) shall dissolve upon that individual's discharge from the medical institution and return home.

(b)(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except that the State shall seek adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan in the case of the following individuals:

(A) In the case of an individual described in subsection (a)(1)(B), the State shall seek adjustment or recovery from the individual's estate or upon sale of the property subject to a lien imposed on account of medical assistance paid on behalf of the individual.

(B) In the case of an individual who was 55 years of age or older when the individual received such medical assistance, the State shall seek adjustment or recovery from the individual's estate, but only for medical assistance consisting of—

(i) nursing facility services, home and community-based services, and related hospital and prescription drug services, or

(ii) at the option of the State, any items or services under the State plan.

(C)(i) In the case of an individual who has received (or is entitled to receive) benefits under a long-term care insurance policy in connection with which assets or resources are disregarded in the manner described in clause (ii), except as provided in such clause, the State shall seek adjustment or recovery from the individual's estate on account of medical assistance paid on behalf of the individual for nursing facility and other long-term care services.

(ii) Clause (i) shall not apply in the case of an individual who received medical assistance under a State plan of a State which had a State plan amendment approved as of May 14, 1993, which provided for the disregard of any assets or resources—

(I) to the extent that payments are made under a long-term care insurance policy; or

(II) because an individual has received (or is entitled to receive) benefits under a long-term care insurance policy.

(2) Any adjustment or recovery under paragraph (1) may be made only after the death of the individual's surviving spouse, if any, and only at a time—

(A) when he has no surviving 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 (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614; and

(B) in the case of a lien on an individual's home under subsection (a)(1)(B), when—

(i) no sibling of the individual (who was residing in the individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution), and

(ii) no son or daughter of the individual (who was residing in the individual's home for a period of at least two years immediately before the date of the individual's admission to the medical institution, and who establishes to the satisfaction of the State that he or she provided care to such individual which permitted such individual to reside at home rather than in an institution),

is lawfully residing in such home who has lawfully resided in such home on a continuous basis since the date of the individual's admission to the medical institution.

(3) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency shall waive the application of this subsection (other than paragraph (1)(C)) if such application would work an undue hardship as determined on the basis of criteria established by the Secretary.

(4) For purposes of this subsection, the term "estate", with respect to a deceased individual—

(A) shall include all real and personal property and other assets included within the individual's estate, as defined for purposes of State probate law; and

(B) may include, at the option of the State (and shall include, in the case of an individual to whom paragraph (1)(C)(i) applies), any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

(c)(1)(A) In order to meet the requirements of this subsection for purposes of section 1902(a)(18), the State plan must provide that if an institutionalized individual or the spouse of such an individual (or, at the option of a State, a noninstitutionalized individual or the spouse of such an individual) disposes of assets for less than fair market value on or after the look-back date specified in subparagraph (B)(i), the individual is ineligible for medical assistance for services described in subparagraph (C)(i) (or, in the case of a noninstitutionalized individual, for the services described in subparagraph (C)(ii)) during the period beginning on the date specified in subparagraph (D) and equal to the number of months specified in subparagraph (E).

(B)(i) The look-back date specified in this subparagraph is a date that is 36 months (or, in the case of payments from a trust or portions of a trust that are treated as assets disposed of by the individual pursuant to paragraph (3)(A)(iii) or (3)(B)(ii) of subsection (d), 60 months) before the date specified in clause (ii).

(ii) The date specified in this clause, with respect to—

(I) an institutionalized individual is the first date as of which the individual both is an institutionalized individual and has applied for medical assistance under the State plan, or

(II) a noninstitutionalized individual is the date on which the individual applies for medical assistance under the State plan or, if later, the date on which the individual disposes of assets for less than fair market value.

(C)(i) The services described in this subparagraph with respect to an institutionalized individual are the following:

(I) Nursing facility services.

(II) A level of care in any institution equivalent to that of nursing facility services.

(III) Home or community-based services furnished under a waiver granted under subsection (c) or (d) of section 1915.

(ii) The services described in this subparagraph with respect to a noninstitutionalized individual are services (not including any services described in clause (i)) that are described in paragraph (7), (22), or (24) of section 1905(a), and, at the option of a State, other long-term care services for which medical assistance is otherwise available under the State plan to individuals requiring long-term care.

(D) The date specified in this subparagraph is the first day of the first month during or after which assets have been transferred for less than fair market value and which does not occur in any other periods of ineligibility under this subsection.

(E)(i) With respect to an institutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall be equal to—

(I) the total, cumulative uncompensated value of all assets transferred by the individual (or

individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by

(II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.

(ii) With respect to a noninstitutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall not be greater than a number equal to—

(I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by

(II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.

(iii) The number of months of ineligibility otherwise determined under clause (i) or (ii) with respect to the disposal of an asset shall be reduced—

(I) in the case of periods of ineligibility determined under clause (i), by the number of months of ineligibility applicable to the individual under clause (ii) as a result of such disposal, and

(II) in the case of periods of ineligibility determined under clause (ii), by the number of months of ineligibility applicable to the individual under clause (i) as a result of such disposal.

(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that—

(A) the assets transferred were a home and title to the home was transferred to—

(i) the spouse of such individual;

(ii) a child of such individual who (I) is under age 21, or (II) (with respect to States eligible to participate in the State program established under title XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614;

(iii) a sibling of such individual who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date the individual becomes an institutionalized individual; or

(iv) a son or daughter of such individual (other than a child described in clause (ii)) who was residing in such individual's home for a period of at least two years immediately before the date the individual becomes an institutionalized individual, and who (as determined by the State) provided care to such individual which permitted such individual to reside at home rather than in such an institution or facility;

(B) the assets—

(i) were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse,

(ii) were transferred from the individual's spouse to another for the sole benefit of the individual's spouse,

(iii) were transferred to, or to a trust (including a trust described in subsection (d)(4)) established solely for the benefit of, the individual's child described in subparagraph (A)(ii)(II), or

(iv) were transferred to a trust (including a trust described in subsection (d)(4)) established solely for the benefit of an individual under 65 years of age who is disabled (as defined in section 1614(a)(3));

(C) a satisfactory showing is made to the State (in accordance with regulations promulgated by the Secretary) that (i) the individual intended to dispose of the assets either at fair market value, or for other valuable consideration, (ii) the assets were transferred exclusively for a purpose other than to qualify for medical assistance, or (iii) all assets transferred for less than fair market value have been returned to the individual; or

(D) the State determines, under procedures established by the State (in accordance with standards specified by the Secretary), that the denial of eligibility would work an undue hardship as determined on the basis of criteria established by the Secretary;

(3) For purposes of this subsection, in the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset (or the affected portion of such asset) shall be considered to be transferred by such individual when any action is taken, either by such individual or by any other person, that reduces or eliminates such individual's ownership or control of such asset.

(4) A State (including a State which has elected treatment under section 1902(f)) may not provide for any period of ineligibility for an individual due to transfer of resources for less than fair market value except in accordance with this subsection. In the case of a transfer by the spouse of an individual which results in a period of ineligibility for medical assistance under a State plan for such individual, a State shall, using a reasonable methodology (as specified by the Secretary), apportion such period of ineligibility (or any portion of such period) among the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the State plan.

(5) In this subsection, the term "resources" has the meaning given such term in section 1613, without regard to the exclusion described in subsection (a)(1) thereof.

(d)(1) For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this title, subject to paragraph (4), the rules specified in paragraph (3) shall apply to a trust established by such individual.

(2)(A) For purposes of this subsection, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus

of the trust and if any of the following individuals established such trust other than by will:

(i) The individual.

(ii) The individual's spouse.

(iii) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.

(iv) A person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(B) In the case of a trust the corpus of which includes assets of an individual (as determined under subparagraph (A)) and assets of any other person or persons, the provisions of this subsection shall apply to the portion of the trust attributable to the assets of the individual.

(C) Subject to paragraph (4), this subsection shall apply without regard to—

(i) the purposes for which a trust is established,

(ii) whether the trustees have or exercise any discretion under the trust,

(iii) any restrictions on when or whether distributions may be made from the trust, or

(iv) any restrictions on the use of distributions from the trust.

(3)(A) In the case of a revocable trust—

(i) the corpus of the trust shall be considered resources available to the individual,

(ii) payments from the trust to or for the benefit of the individual shall be considered income of the individual, and

(iii) any other payments from the trust shall be considered assets disposed of by the individual for purposes of subsection (c).

(B) In the case of an irrevocable trust—

(i) if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual, and payments from that portion of the corpus or income—

(I) to or for the benefit of the individual, shall be considered income of the individual, and

(II) for any other purpose, shall be considered a transfer of assets by the individual subject to subsection (c); and

(ii) any portion of the trust from which, or any income on the corpus from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of subsection (c), and the value of the trust shall be determined for purposes of such subsection by including the amount of any pay-

ments made from such portion of the trust after such date.

(4) This subsection shall not apply to any of the following trusts:

(A) A trust containing the assets of an individual under age 65 who is disabled (as defined in section 1614(a)(3)) and which is established for the benefit of such individual by a parent, grandparent, legal guardian of the individual, or a court if the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this title.

(B) A trust established in a State for the benefit of an individual if—

(i) the trust is composed only of pension, Social Security, and other income to the individual (and accumulated income in the trust),

(ii) the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this title, and

(iii) the State makes medical assistance available to individuals described in section 1902(a)(10)(A)(ii)(V), but does not make such assistance available to individuals for nursing facility services under section 1902(a)(10)(C).

(C) A trust containing the assets of an individual who is disabled (as defined in section 1614(a)(3)) that meets the following conditions:

(i) The trust is established and managed by a nonprofit association.

(ii) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.

(iii) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in section 1614(a)(3)) by the parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court.

(iv) To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the State plan under this title.

(5) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency waives the application of this subsection with respect to an individual if the individual establishes that such application would work an undue hardship on the individual as determined on the basis of criteria established by the Secretary.

(6) The term "trust" includes any legal instrument or device that is similar to a trust but includes an annuity only to such extent and in such manner as the Secretary specifies.

(e) In this section, the following definitions shall apply:

(1) The term "assets", with respect to an individual, includes all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action—

(A) by the individual or such individual's spouse,

(B) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse, or

(C) by any person, including any court or administrative body, acting at the direction or upon the request of the individual or such individual's spouse.

(2) The term "income" has the meaning given such term in section 1612.

(3) The term "institutionalized individual" means an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility, or who is described in section 1902(a)(10)(A)(ii)(VI).

(4) The term "noninstitutionalized individual" means an individual receiving any of the services specified in subsection (c)(1)(C)(ii).

(5) The term "resources" has the meaning given such term in section 1613, without regard (in the case of an institutionalized individual) to the exclusion described in subsection (a)(1) of such section.

APPLICATION OF PROVISIONS OF TITLE II RELATING TO SUBPOENAS

SEC. 1918. [42 U.S.C. 1396q] The provisions of subsections (d) and (e) of section 205 of this Act shall apply with respect to this title to the same extent as they are applicable with respect to title II, except that, in so applying such subsections, and in applying section 205(l) thereto, with respect to this title, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

REQUIREMENTS FOR NURSING FACILITIES[91]

SEC. 1919. [42 U.S.C. 1396r] (a) NURSING FACILITY DEFINED.—In this title, the term "nursing facility" means an institution (or a distinct part of an institution) which—

(1) is primarily engaged in providing to residents—

(A) skilled nursing care and related services for residents who require medical or nursing care,

(B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or

(C) on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room

[91] See Vol. II, P.L. 100–203, §4215, with respect to a report to Congress.

and board) which can be made available to them only through institutional facilities,

and is not primarily for the care and treatment of mental diseases;

(2) has in effect a transfer agreement (meeting the requirements of section 1861(l)) with one or more hospitals having agreements in effect under section 1866; and

(3) meets the requirements for a nursing facility described in subsections (b), (c), and (d) of this section.

Such term also includes any facility which is located in a State on an Indian reservation and is certified by the Secretary as meeting the requirements of paragraph (1) and subsections (b), (c), and (d).

(b) REQUIREMENTS RELATING TO PROVISION OF SERVICES.—

(1) QUALITY OF LIFE.—

(A) IN GENERAL.—A nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

(B) QUALITY ASSESSMENT AND ASSURANCE.—A nursing facility must maintain a quality assessment and assurance committee, consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff, which (i) meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and (ii) develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this subparagraph.

(2) SCOPE OF SERVICES AND ACTIVITIES UNDER PLAN OF CARE.—A nursing facility must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care which—

(A) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met;

(B) is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending physician and a registered professional nurse with responsibility for the resident; and

(C) is periodically reviewed and revised by such team after each assessment under paragraph (3).

(3) RESIDENTS' ASSESSMENT.—

(A) REQUIREMENT.—A nursing facility must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, which assessment—

(i) describes the resident's capability to perform daily life functions and significant impairments in functional capacity;

(ii) is based on a uniform minimum data set specified by the Secretary under subsection (f)(6)(A);

(iii) uses an instrument which is specified by the State under subsection (e)(5); and

(iv) includes the identification of medical problems.

(B) CERTIFICATION.—

(i) IN GENERAL.—Each such assessment must be conducted or coordinated (with the appropriate participation of health professionals) by a registered professional nurse who signs and certifies the completion of the assessment. Each individual who completes a portion of such an assessment shall sign and certify as to the accuracy of that portion of the assessment.

(ii) PENALTY FOR FALSIFICATION.—

(I) An individual who willfully and knowingly certifies under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 with respect to each assessment.

(II) An individual who willfully and knowingly causes another individual to certify under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 with respect to each assessment.

(III) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this clause in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(iii) USE OF INDEPENDENT ASSESSORS.—If a State determines, under a survey under subsection (g) or otherwise, that there has been a knowing and willful certification of false assessments under this paragraph, the State may require (for a period specified by the State) that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the State.

(C) FREQUENCY.—

(i) IN GENERAL.—Such an assessment must be conducted—

(I) promptly upon (but no later than not later than 14 days after the date of) admission for each individual admitted on or after October 1, 1990, and by not later than October 1, 1991, for each resident of the facility on that date;

(II) promptly after a significant change in the resident's physical or mental condition; and

(III) in no case less often than once every 12 months.

(ii) RESIDENT REVIEW.—The nursing facility must examine each resident no less frequently than once every 3 months and, as appropriate, revise the resident's assessment to assure the continuing accuracy of the assessment.

(D) USE.—The results of such an assessment shall be used in developing, reviewing, and revising the resident's plan of care under paragraph (2).

(E) COORDINATION.—Such assessments shall be coordinated with any State-required preadmission screening program to the maximum extent practicable in order to avoid duplicative testing and effort. In addition, a nursing facility shall notify the State mental health authority or State mental retardation or developmental disability authority, as applicable, promptly after a significant change in the physical or mental condition of a resident who is mentally ill or mentally retarded.

(F) REQUIREMENTS RELATING TO PREADMISSION SCREENING FOR MENTALLY ILL AND MENTALLY RETARDED INDIVIDUALS.—Except as provided in clauses (ii) and (iii) of subsection (e)(7)(A), a nursing facility must not admit, on or after January 1, 1989, any new resident who—

(i) is mentally ill (as defined in subsection (e)(7)(G)(i)) unless the State mental health authority has determined (based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority) prior to admission that, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and, if the individual requires such level of services, whether the individual requires specialized services for mental illness, or

(ii) is mentally retarded (as defined in subsection (e)(7)(G)(ii)) unless the State mental retardation or developmental disability authority has determined prior to admission that, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and, if the individual requires such level of services, whether the individual requires specialized services for mental retardation.

A State mental health authority and a State mental retardation or developmental disability authority may not delegate (by subcontract or otherwise) their responsibilities under this subparagraph to a nursing facility (or to an entity that has a direct or indirect affiliation or relationship with such a facility).

(4) PROVISION OF SERVICES AND ACTIVITIES.—

(A) IN GENERAL.—To the extent needed to fulfill all plans of care described in paragraph (2), a nursing facility must provide (or arrange for the provision of)—

(i) nursing and related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

(ii) medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

(iii) pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispens-

ing, and administering of all drugs and biologicals) to meet the needs of each resident;

(iv) dietary services that assure that the meals meet the daily nutritional and special dietary needs of each resident;

(v) an on-going program, directed by a qualified professional, of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident;

(vi) routine dental services (to the extent covered under the State plan) and emergency dental services to meet the needs of each resident; and

(vii) treatment and services required by mentally ill and mentally retarded residents not otherwise provided or arranged for (or required to be provided or arranged for) by the State.

The services provided or arranged by the facility must meet professional standards of quality.

(B) QUALIFIED PERSONS PROVIDING SERVICES.—Services described in clauses (i), (ii), (iii), (iv), and (vi) of subparagraph (A) must be provided by qualified persons in accordance with each resident's written plan of care.

(C) REQUIRED NURSING CARE; FACILITY WAIVERS.—

(i) GENERAL REQUIREMENTS.—With respect to nursing facility services provided on or after October 1, 1990, a nursing facility—

(I) except as provided in clause (ii), must provide 24-hour licensed nursing services which are sufficient to meet the nursing needs of its residents, and

(II) except as provided in clause (ii), must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week.

(ii) WAIVER BY STATE.—To the extent that a facility is unable to meet the requirements of clause (i), a State may waive such requirements with respect to the facility if—

(I) the facility demonstrates to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel,

(II) the State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility,

(III) the State finds that, for any such periods in which licensed nursing services are not available, a registered professional nurse or a physician is obligated to respond immediately to telephone calls from the facility,

(IV) the State agency granting a waiver of such requirements provides notice of the waiver to the State long-term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy

system in the State for the mentally ill and the mentally retarded, and

(V) the nursing facility that is granted such a waiver by a State notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.

A waiver under this clause shall be subject to annual review and to the review of the Secretary and subject to clause (iii) shall be accepted by the Secretary for purposes of this title to the same extent as is the State's certification of the facility. In granting or renewing a waiver, a State may require the facility to use other qualified, licensed personnel.

(iii) ASSUMPTION OF WAIVER AUTHORITY BY SECRETARY.—If the Secretary determines that a State has shown a clear pattern and practice of allowing waivers in the absence of diligent efforts by facilities to meet the staffing requirements, the Secretary shall assume and exercise the authority of the State to grant waivers.

(5) REQUIRED TRAINING OF NURSE AIDES.—

(A) IN GENERAL.—(i) Except as provided in clause (ii), a nursing facility must not use on a full-time basis any individual as a nurse aide in the facility on or after October 1, 1990, for more than 4 months unless the individual—

(I) has completed a training and competency evaluation program, or a competency evaluation program, approved by the State under subsection (e)(1)(A), and

(II) is competent to provide nursing or nursing-related services.

(ii) A nursing facility must not use on a temporary, per diem, leased, or on any other basis other than as a permanent employee any individual as a nurse aide in the facility on or after January 1, 1991, unless the individual meets the requirements described in clause (i).

(B) OFFERING COMPETENCY EVALUATION PROGRAMS FOR CURRENT EMPLOYEES.—A nursing facility must provide, for individuals used as a nurse aide by the facility as of January 1, 1990, for a competency evaluation program approved by the State under subsection (e)(1) and such preparation as may be necessary for the individual to complete such a program by 0ctober 1, 1990.

(C) COMPETENCY.—The nursing facility must not permit an individual, other than in a training and competency evaluation program approved by the State, to serve as a nurse aide or provide services of a type for which the individual has not demonstrated competency and must not use such an individual as a nurse aide unless the facility has inquired of any State registry established under subsection (e)(2)(A) that the facility believes will include information concerning the individual.

(D) RE-TRAINING REQUIRED.—For purposes of subparagraph (A), if, since an individual's most recent completion

of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual performed nursing or nursing-related services for monetary compensation, such individual shall complete a new training and competency evaluation program, or a new competency evaluation program.

(E) REGULAR IN-SERVICE EDUCATION.—The nursing facility must provide such regular performance review and regular in-service education as assures that individuals used as nurse aides are competent to perform services as nurse aides, including training for individuals providing nursing and nursing-related services to residents with cognitive impairments.

(F) NURSE AIDE DEFINED.—In this paragraph, the term "nurse aide" means any individual providing nursing or nursing-related services to residents in a nursing facility, but does not include an individual—

(i) who is a licensed health professional (as defined in subparagraph (G)) or a registered dietician, or

(ii) who volunteers to provide such services without monetary compensation.

(G) LICENSED HEALTH PROFESSIONAL DEFINED.—In this paragraph, the term "licensed health professional" means a physician, physician assistant, nurse practitioner, physical, speech, or occupational therapist, physical or occupational therapy assistant, registered professional nurse, licensed practical nurse, or licensed or certified social worker.

(6) PHYSICIAN SUPERVISION AND CLINICAL RECORDS.—A nursing facility must—

(A) require that the health care of every resident be provided under the supervision of a physician (or, at the option of a State, under the supervision of a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician);

(B) provide for having a physician available to furnish necessary medical care in case of emergency; and

(C) maintain clinical records on all residents, which records include the plans of care (described in paragraph (2)) and the residents' assessments (described in paragraph (3)), as well as the results of any pre-admission screening conducted under subsection (e)(7).

(7) REQUIRED SOCIAL SERVICES.—In the case of a nursing facility with more than 120 beds, the facility must have at least one social worker (with at least a bachelor's degree in social work or similar professional qualifications) employed full-time to provide or assure the provision of social services.

(8) INFORMATION ON NURSE STAFFING.—

(A) IN GENERAL.—A nursing facility shall post daily for each shift the current number of licensed and unlicensed nursing staff directly responsible for resident care in the facility. The information shall be displayed in a uniform manner (as specified by the Secretary) and in a clearly visible place.

(B) PUBLICATION OF DATA.—A nursing facility shall, upon request, make available to the public the nursing staff data described in subparagraph (A).

(c) REQUIREMENTS RELATING TO RESIDENTS' RIGHTS.—

(1) GENERAL RIGHTS.—

(A) SPECIFIED RIGHTS.—A nursing facility must protect and promote the rights of each resident, including each of the following rights:

(i) FREE CHOICE. The right to choose a personal attending physician, to be fully informed in advance about care and treatment, to be fully informed in advance of any changes in care or treatment that may affect the resident's well-being, and (except with respect to a resident adjudged incompetent) to participate in planning care and treatment or changes in care and treatment.

(ii) FREE FROM RESTRAINTS.—The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed—

(I) to ensure the physical safety of the resident or other residents, and

(II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary until such an order could reasonably be obtained).

(iii) PRIVACY.—The right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of resident groups.

(iv) CONFIDENTIALITY.—The right to confidentiality of personal and clinical records and to access to current clinical records of the resident upon request by the resident or the resident's legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

(v) ACCOMMODATION OF NEEDS.—The right—

(I) to reside and receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered, and

(II) to receive notice before the room or roommate of the resident in the facility is changed.

(vi) GRIEVANCES.—The right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances and the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

(vii) PARTICIPATION IN RESIDENT AND FAMILY GROUPS.—The right of the resident to organize and participate in resident groups in the facility and the right of the resident's family to meet in the facility with the families of other residents in the facility.

(viii) PARTICIPATION IN OTHER ACTIVITIES.—The right of the resident to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

(ix) EXAMINATION OF SURVEY RESULTS.—The right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the Secretary or a State with respect to the facility and any plan of correction in effect with respect to the facility.

(x) refusal of certain transfers.—The right to refuse a transfer to another room within the facility, if a purposes of the transfer is to relocate the resident from a portion of the facility that is not a skilled nursing facility (for purposes of title XVIII) to a portion of the facility that is such a skilled nursing facility.

(xi) OTHER RIGHTS.—Any other right established by the Secretary.

Clause (iii) shall not be construed as requiring the provision of a private room. A resident's exercise of a right to refuse transfer under clause (x) shall not affect the resident's eligibility or entitlement to medical assistance under this title or a State's entitlement to Federal medical assistance under this title with respect to services furnished to such a resident.

(B) NOTICE OF RIGHTS.—A nursing facility must—

(i) inform each resident, orally and in writing at the time of admission to the facility, of the resident's legal rights during the stay at the facility and of the requirements and procedures for establishing eligibility for medical assistance under this title, including the right to request an assessment under section 1924(c)(1)(B);

(ii) make available to each resident, upon reasonable request, a written statement of such rights (which statement is updated upon changes in such rights) including the notice (if any) of the State developed under subsection (e)(6);

(iii) inform each resident who is entitled to medical assistance under this title—

(I) at the time of admission to the facility or, if later, at the time the resident becomes eligible for such assistance, of the items and services (including those specified under section 1902(a)(28)(B)) that are included in nursing facility services under the State plan and for which the resident may not be charged (except as permitted in section 1916), and of those other items and services that the facility offers and for which the resident may be charged and the

amount of the charges for such items and services, and

(II) of changes in the items and services described in subclause (I) and of changes in the charges imposed for items and services described in that subclause; and

(iv) inform each other resident, in writing before or at the time of admission and periodically during the resident's stay, of services available in the facility and of related charges for such services, including any charges for services not covered under title XVIII or by the facility's basic per diem charge.

The written description of legal rights under this subparagraph shall include a description of the protection of personal funds under paragraph (6) and a statement that a resident may file a complaint with a State survey and certification agency respecting resident abuse and neglect and misappropriation of resident property in the facility.

(C) Rights of incompetent residents.—In the case of a resident adjudged incompetent under the laws of a State, the rights of the resident under this title shall devolve upon, and, to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the resident's behalf.

(D) USE OF PSYCHOPHARMACOLOGIC DRUGS.—Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the written plan of care described in paragraph (2)) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually an independent, external consultant reviews the appropriateness of the drug plan of each resident receiving such drugs.

(2) TRANSFER AND DISCHARGE RIGHTS.—

(A) IN GENERAL.—A nursing facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless—

(i) the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;

(ii) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(iii) the safety of individuals in the facility is endangered;

(iv) the health of individuals in the facility would otherwise be endangered;

(v) the resident has failed, after reasonable and appropriate notice, to pay (or to have paid under this title or title XVIII on the resident's behalf) for a stay at the facility; or

(vi) the facility ceases to operate.

In each of the cases described in clauses (i) through (iv), the basis for the transfer or discharge must be documented in the resident's clinical record. In the cases described in

clauses (i) and (ii), the documentation must be made by the resident's physician, and in the case described in clause (iv) the documentation must be made by a physician. For purposes of clause (v), in the case of a resident who becomes eligible for assistance under this title after admission to the facility, only charges which may be imposed under this title shall be considered to be allowable.

(B) Pre-transfer and pre-discharge notice.—

(i) IN GENERAL.—Before effecting a transfer or discharge of a resident, a nursing facility must—

(I) notify the resident (and, if known, an immediate family member of the resident or legal representative) of the transfer or discharge and the reasons therefor,

(II) record the reasons in the resident's clinical record (including any documentation required under subparagraph (A)), and

(III) include in the notice the items described in clause (iii).

(ii) TIMING OF NOTICE.—The notice under clause (i)(I) must be made at least 30 days in advance of the resident's transfer or discharge except—

(I) in a case described in clause (iii) or (iv) of subparagraph (A);

(II) in a case described in clause (ii) of subparagraph (A), where the resident's health improves sufficiently to allow a more immediate transfer or discharge;

(III) in a case described in clause (i) of subparagraph (A), where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs; or

(IV) in a case where a resident has not resided in the facility for 30 days.

In the case of such exceptions, notice must be given as many days before the date of the transfer or discharge as is practicable.

(iii) ITEMS INCLUDED IN NOTICE.—Each notice under clause (i) must include—

(I) for transfers or discharges effected on or after October 1, 1989, notice of the resident's right to appeal the transfer or discharge under the State process established under subsection (e)(3);

(II) the name, mailing address, and telephone number of the State long-term care ombudsman (established under title III or VII of the Older Americans Act of 1965 [92] in accordance with section 712 of the Act);

(III) in the case of residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy system for developmentally disabled individuals established

[92] See Vol. II, P.L. 89–73.

under subtitle C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000[93] ; and

(IV) in the case of mentally ill residents (as defined in subsection (e)(7)(G)(i)), the mailing address and telephone number of the agency responsible for the protection and advocacy system for mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act[94].

(C) Orientation.—A nursing facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(D) NOTICE ON BED-HOLD POLICY AND READMISSION.—

(i) NOTICE BEFORE TRANSFER.—Before a resident of a nursing facility is transferred for hospitalization or therapeutic leave, a nursing facility must provide written information to the resident and an immediate family member or legal representative concerning—

(I) the provisions of the State plan under this title regarding the period (if any) during which the resident will be permitted under the State plan to return and resume residence in the facility, and

(II) the policies of the facility regarding such a period, which policies must be consistent with clause (iii).

(ii) Notice upon transfer.—At the time of transfer of a resident to a hospital or for therapeutic leave, a nursing facility must provide written notice to the resident and an immediate family member or legal representative of the duration of any period described in clause (i).

(iii) PERMITTING RESIDENT TO RETURN.—A nursing facility must establish and follow a written policy under which a resident—

(I) who is eligible for medical assistance for nursing facility services under a State plan,

(II) who is transferred from the facility for hospitalization or therapeutic leave, and

(III) whose hospitalization or therapeutic leave exceeds a period paid for under the State plan for the holding of a bed in the facility for the resident,

will be permitted to be readmitted to the facility immediately upon the first availability of a bed in a semiprivate room in the facility if, at the time of readmission, the resident requires the services provided by the facility.

(E) INFORMATION RESPECTING ADVANCE DIRECTIVES.—A nursing facility must comply with the requirement of section 1902(w) (relating to maintaining written policies and procedures respecting advance directives).

(F) CONTINUING RIGHTS IN CASE OF VOLUNTARY WITHDRAWAL FROM PARTICIPATION.—

[93] See Vol. II, P.L. 88–164; Title I.
[94] See Vol. II, P.L. 99–319.

(i) IN GENERAL,—In the case of a nursing facility that voluntarily withdraws from participation in a State plan under this title but continues to provide services of the type provided by nursing facilities—

(I) the facility's voluntary withdrawal from participation is not an acceptable basis for the transfer or discharge of residents of the facility who were residing in the facility on the day before the effective date of the withdrawal (including those residents who were not entitled to medical assistance as of such day);

(II) the provisions of this section continue to apply to such residents until the date of their discharge from the facility; and

(III) in the case of each individual who begins residence in the facility after the effective date of such withdrawal, the facility shall provide notice orally and in a prominent manner in writing on a separate page at the time the individual begins residence of the information described in clause (ii) and shall obtain from each such individual at such time an acknowledgment of receipt of such information that is in writing, signed by the individual, and separate from other documents signed by such individual.

Nothing in this subparagraph shall be construed as affecting any requirement of a participation agreement that a nursing facility provide advance notice to the State or the Secretary, or both, of its intention to terminate the agreement.

(ii) INFORMATION FOR NEW RESIDENTS.—The information described in this clause for a resident is the following:

(I) The facility is not participating in the program under this title with respect to that resident.

(II) The facility may transfer or discharge the resident from the facility at such time as the resident is unable to pay the charges of the facility, even though the resident may have become eligible for medical assistance for nursing facility services under this title.

(iii) CONTINUATION OF PAYMENTS AND OVERSIGHT AUTHORITY.—Notwithstanding any other provision of this title, with respect to the residents described in clause (i)(I), a participation agreement of a facility described in clause (i) is deemed to continue in effect under such plan after the effective date of the facility's voluntary withdrawal from participation under the State plan for purposes of—

(I) receiving payments under the State plan for nursing facility services provided to such residents;

(II) maintaining compliance with all applicable requirements of this title; and

(III) continuing to apply the survey, certification, and enforcement authority provided under subsections (g) and (h) (including involuntary termination of a participation agreement deemed continued under this clause).

(iv) NO APPLICATION TO NEW RESIDENTS.—This paragraph (other than subclause (III) of clause (i)) shall not apply to an individual who begins residence in a facility on or after the effective date of the withdrawal from participation under this subparagraph.

(3) ACCESS AND VISITATION RIGHTS.—A nursing facility must—

(A) permit immediate access to any resident by any representative of the Secretary, by any representative of the State, by an ombudsman or agency described in subclause (II), (III), or (IV) of paragraph (2)(B)(iii), or by the resident's individual physician;

(B) permit immediate access to a resident, subject to the resident's right to deny or withdraw consent at any time, by immediate family or other relatives of the resident;

(C) permit immediate access to a resident, subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, by others who are visiting with the consent of the resident;

(D) permit reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and

(E) permit representatives of the State ombudsman (described in paragraph (2)(B)(iii)(II)), with the permission of the resident (or the resident's legal representative) and consistent with State law, to examine a resident's clinical records.

(4) Equal access to quality care.—

(A) IN GENERAL.—A nursing facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services required under the State plan for all individuals regardless of source of payment.

(B) CONSTRUCTION.—

(i) NOTHING PROHIBITING ANY CHARGES FOR NON-MEDICAID PATIENTS.—Subparagraph (A) shall not be construed as prohibiting a nursing facility from charging any amount for services furnished, consistent with the notice in paragraph (1)(B) describing such charges.

(ii) NO ADDITIONAL SERVICES REQUIRED.— Subparagraph (A) shall not be construed as requiring a State to offer additional services on behalf of a resident than are otherwise provided under the State plan.

(5) ADMISSIONS POLICY.—

(A) ADMISSIONS.—With respect to admissions practices, a nursing facility must—

(i)(I) not require individuals applying to reside or residing in the facility to waive their rights to benefits under this title or title XVIII, (II) not require oral or written assurance that such individuals are not eligi-

ble for, or will not apply for, benefits under this title or title XVIII, and (III) prominently display in the facility written information, and provide to such individuals oral and written information, about how to apply for and use such benefits and how to receive refunds for previous payments covered by such benefits;

(ii) not require a third party guarantee of payment to the facility as a condition of admission (or expedited admission) to, or continued stay in, the facility; and

(iii) in the case of an individual who is entitled to medical assistance for nursing facility services, not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan under this title, any gift, money, donation, or other consideration as a precondition of admitting (or expediting the admission of) the individual to the facility or as a requirement for the individual's continued stay in the facility.

(B) Construction.—

(i) NO PREEMPTION OF STRICTER STANDARDS.—Subparagraph (A) shall not be construed as preventing States or political subdivisions therein from prohibiting, under State or local law, the discrimination against individuals who are entitled to medical assistance under the State plan with respect to admissions practices of nursing facilities.

(ii) CONTRACTS WITH LEGAL REPRESENTATIVES.—Subparagraph (A)(ii) shall not be construed as preventing a facility from requiring an individual, who has legal access to a resident's income or resources available to pay for care in the facility, to sign a contract (without incurring personal financial liability) to provide payment from the resident's income or resources for such care.

(iii) CHARGES FOR ADDITIONAL SERVICES REQUESTED.—Subparagraph (A)(iii) shall not be construed as preventing a facility from charging a resident, eligible for medical assistance under the State plan, for items or services the resident has requested and received and that are not specified in the State plan as included in the term "nursing facility services".

(iv) BONA FIDE CONTRIBUTIONS.—Subparagraph (A)(iii) shall not be construed as prohibiting a nursing facility from soliciting, accepting, or receiving a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the resident (or potential resident), but only to the extent that such contribution is not a condition of admission, expediting admission, or continued stay in the facility.

(6) PROTECTION OF RESIDENT FUNDS.—

(A) IN GENERAL.—The nursing facility—

(i) may not require residents to deposit their personal funds with the facility, and

(ii) upon the written authorization of the resident, must hold, safeguard, and account for such personal

funds under a system established and maintained by the facility in accordance with this paragraph.

(B) MANAGEMENT OF PERSONAL FUNDS.—Upon written authorization of a resident under subparagraph (A)(ii), the facility must manage and account for the personal funds of the resident deposited with the facility as follows:

(i) DEPOSIT.—The facility must deposit any amount of personal funds in excess of $50 with respect to a resident in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the facility must maintain such funds in a non-interest bearing account or petty cash fund.

(ii) ACCOUNTING AND RECORDS.—The facility must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a resident deposited with the facility, and afford the resident (or a legal representative of the resident) reasonable access to such record.

(iii) NOTICE OF CERTAIN BALANCES.—The facility must notify each resident receiving medical assistance under the State plan under title XIX when the amount in the resident's account reaches $200 less than the dollar amount determined under section 1611(a)(3)(B) and the fact that if the amount in the account (in addition to the value of the resident's other nonexempt resources) reaches the amount determined under such section the resident may lose eligibility for such medical assistance or for benefits under title XVI.

(iv) Conveyance upon death.—Upon the death of a resident with such an account, the facility must convey promptly the resident's personal funds (and a final accounting of such funds) to the individual administering the resident's estate.

(C) ASSURANCE OF FINANCIAL SECURITY.—The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.

(D) LIMITATION ON CHARGES TO PERSONAL FUNDS.—The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under this title or title XVIII.

(7) Limitation on charges in case of medicaid-eligible individuals.—

(A) In general.—A nursing facility may not impose charges, for certain medicaid-eligible individuals for nursing facility services covered by the State under its plan under this title, that exceed the payment amounts established by the State for such services under this title.

(B) Certain medicaid individuals defined.—In subparagraph (A), the term "certain medicaid-eligible individual" means an individual who is entitled to medical assistance for nursing facility services in the facility under this title but with respect to whom such benefits are not being paid

because, in determining the amount of the individual's income to be applied monthly to payment for the costs of such services, the amount of such income exceeds the payment amounts established by the State for such services under this title.

(8) POSTING OF SURVEY RESULTS.—A nursing facility must post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility conducted under subsection (g).

(d) REQUIREMENTS RELATING TO ADMINISTRATION AND OTHER MATTERS.—

(1) ADMINISTRATION.—

(A) IN GENERAL.—A nursing facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident (consistent with requirements established under subsection (f)(5)).

(B) REQUIRED NOTICES.—If a change occurs in—

(i) the persons with an ownership or control interest (as defined in section 1124(a)(3)) in the facility,

(ii) the persons who are officers, directors, agents, or managing employees (as defined in section 1126(b)) of the facility,

(iii) the corporation, association, or other company responsible for the management of the facility, or

(iv) the individual who is the administrator or director of nursing of the facility,

the nursing facility must provide notice to the State agency responsible for the licensing of the facility, at the time of the change, of the change and of the identity of each new person, company, or individual described in the respective clause.

(C) Nursing facility administrator.—The administrator of a nursing facility must meet standards established by the Secretary under subsection (f)(4).

(2) LICENSING AND LIFE SAFETY CODE.—

(A) LICENSING.—A nursing facility must be licensed under applicable State and local law.

(B) LIFE SAFETY CODE.—A nursing facility must meet such provisions of such edition (as specified by the Secretary in regulation) of the Life Safety Code of the National Fire Protection Association as are applicable to nursing homes; except that—

(i) the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a facility, but only if such waiver would not adversely affect the health and safety of residents or personnel, and

(ii) the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects residents of and personnel in nursing facilities.

(3) Sanitary and infection control and physical environment.—A nursing facility must—

(A) establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection, and

(B) be designed, constructed, equipped, and maintained in a manner to protect the health and safety of residents, personnel, and the general public.

(4) MISCELLANEOUS.—

(A) COMPLIANCE WITH FEDERAL, STATE, AND LOCAL LAWS AND PROFESSIONAL STANDARDS.—A nursing facility must operate and provide services in compliance with all applicable Federal, State, and local laws and regulations (including the requirements of section 1124) and with accepted professional standards and principles which apply to professionals providing services in such a facility.

(B) OTHER.—A nursing facility must meet such other requirements relating to the health and safety of residents or relating to the physical facilities thereof as the Secretary may find necessary.

(e) STATE REQUIREMENTS RELATING TO NURSING FACILITY REQUIREMENTS.—As a condition of approval of its plan under this title, a State must provide for the following:

(1) SPECIFICATION AND REVIEW OF NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS AND OF NURSE AIDE COMPETENCY EVALUATION PROGRAMS.—The State must—

(A) by not later than January 1, 1989, specify those training and competency evaluation programs, and those competency evaluation programs, that the State approves for purposes of subsection (b)(5) and that meet the requirements established under subsection (f)(2), and

(B) by not later than January 1, 1990, provide for the review and reapproval of such programs, at a frequency and using a methodology consistent with the requirements established under subsection (f)(2)(A)(iii).

The failure of the Secretary to establish requirements under subsection (f)(2) shall not relieve any State of its responsibility under this paragraph.

(2) Nurse aide registry.—

(A) IN GENERAL.—By not later than January 1, 1989, the State shall establish and maintain a registry of all individuals who have satisfactorily completed a nurse aide training and competency evaluation program, or a nurse aide competency evaluation program, approved under paragraph (1) in the State, or any individual described in subsection (f)(2)(B)(ii) or in subparagraph (B), (C), or (D) of section 6901(b)(4) of the Omnibus Budget Reconciliation Act of 1989.

(B) INFORMATION IN REGISTRY.—The registry under subparagraph (A) shall provide (in accordance with regulations of the Secretary) for the inclusion of specific documented findings by a State under subsection (g)(1)(C) of resident neglect or abuse or misappropriation of resident property involving an individual listed in the registry, as

well as any brief statement of the individual disputing the findings. The State shall make available to the public information in the registry. In the case of inquiries to the registry concerning an individual listed in the registry, any information disclosed concerning such a finding shall also include disclosure of any such statement in the registry relating to the finding or a clear and accurate summary of such a statement.

(C) PROHIBITION AGAINST CHARGES.—A State may not impose any charges on a nurse aide relating to the registry established and maintained under subparagraph (A).

(3) STATE APPEALS PROCESS FOR TRANSFERS AND DISCHARGES.—The State, for transfers and discharges from nursing facilities effected on or after October 1, 1989, must provide for a fair mechanism, meeting the guidelines established under subsection (f)(3), for hearing appeals on transfers and discharges of residents of such facilities; but the failure of the Secretary to establish such guidelines under such subsection shall not relieve any State of its responsibility under this paragraph.

(4) NURSING FACILITY ADMINISTRATOR STANDARDS.—By not later than July 1, 1989, the State must have implemented and enforced the nursing facility administrator standards developed under subsection (f)(4) respecting the qualification of administrators of nursing facilities.

(5) SPECIFICATION OF RESIDENT ASSESSMENT INSTRUMENT.—Effective July 1, 1990, the State shall specify the instrument to be used by nursing facilities in the State in complying with the requirement of subsection (b)(3)(A)(iii). Such instrument shall be—

(A) one of the instruments designated under subsection (f)(6)(B), or

(B) an instrument which the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by the Secretary under subsection (f)(6)(A).

(6) Notice of medicaid rights.—Each State, as a condition of approval of its plan under this title, effective April 1, 1988, must develop (and periodically update) a written notice of the rights and obligations of residents of nursing facilities (and spouses of such residents) under this title.

(7) STATE REQUIREMENTS FOR PREADMISSION SCREENING AND RESIDENT REVIEW.—

(A) PREADMISSION SCREENING.—

(i) IN GENERAL.—Effective January 1, 1989, the State must have in effect a preadmission screening program, for making determinations (using any criteria developed under subsection (f)(8)) described in subsection (b)(3)(F) for mentally ill and mentally retarded individuals (as defined in subparagraph (G)) who are admitted to nursing facilities on or after January 1, 1989. The failure of the Secretary to develop minimum criteria under subsection (f)(8) shall not relieve any State of its responsibility to have a preadmission screening program under this subpara-

graph or to perform resident reviews under subparagraph (B).

(ii) CLARIFICATION WITH RESPECT TO CERTAIN READMISSIONS.—The preadmission screening program under clause (i) need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.

(iii) EXCEPTION FOR CERTAIN HOSPITAL DISCHARGES.—The preadmission screening program under clause (i) shall not apply to the admission to a nursing facility of an individual—

(I) who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,

(II) who requires nursing facility services for the condition for which the individual received care in the hospital, and

(III) whose attending physician has certified, before admission to the facility, that the individual is likely to require less than 30 days of nursing facility services.

(B) State requirement for resident review.—

(i) FOR MENTALLY ILL RESIDENTS.—As of April 1, 1990, in the case of each resident of a nursing facility who is mentally ill, the State mental health authority must review and determine (using any criteria developed under subsection (f)(8) and based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority)—

(I) whether or not the resident, because of the resident's physical and mental condition, requires the level of services provided by a nursing facility or requires the level of services of an inpatient psychiatric hospital for individuals under age 21 (as described in section 1905(h)) or of an institution for mental diseases providing medical assistance to individuals 65 years of age or older; and

(II) whether or not the resident requires specialized services for mental illness.

(ii) FOR MENTALLY RETARDED RESIDENTS.—As of April 1, 1990, in the case of each resident of a nursing facility who is mentally retarded, the State mental retardation or developmental disability authority must review and determine (using any criteria developed under subsection (f)(8))—

(I) whether or not the resident, because of the resident's physical and mental condition, requires the level of services provided by a nursing facility or requires the level of services of an intermediate care facility described under section 1905(d); and

(II) whether or not the resident requires specialized services for mental retardation.

(iii) REVIEW REQUIRED UPON CHANGE IN RESIDENT'S CONDITION.—A review and determination under clause (i) or (ii) must be conducted promptly after a nursing facility has notified the State mental health authority or State mental retardation or developmental disability authority, as applicable, under subsection (b)(3)(E) with respect to a mentally ill or mentally retarded resident, that there has been a significant change in the resident's physical or mental condition.

(iv) Prohibition of delegation.—A State mental health authority, a State mental retardation or developmental disability authority, and a State may not delegate (by subcontract or otherwise) their responsibilities under this subparagraph to a nursing facility (or to an entity that has a direct or indirect affiliation or relationship with such a facility).

(C) RESPONSE TO PREADMISSION SCREENING AND RESIDENT REVIEW.—As of April 1, 1990, the State must meet the following requirements:

(i) LONG-TERM RESIDENTS NOT REQUIRING NURSING FACILITY SERVICES, BUT REQUIRING SPECIALIZED SERVICES.—In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility, but to require specialized services for mental illness or mental retardation, and who has continuously resided in a nursing facility for at least 30 months before the date of the determination, the State must, in consultation with the resident's family or legal representative and caregivers—

(I) inform the resident of the institutional and noninstitutional alternatives covered under the State plan for the resident,

(II) offer the resident the choice of remaining in the facility or of receiving covered services in an alternative appropriate institutional or noninstitutional setting,

(III) clarify the effect on eligibility for services under the State plan if the resident chooses to leave the facility (including its effect on readmission to the facility), and

(IV) regardless of the resident's choice, provide for (or arrange for the provision of) such specialized services for the mental illness or mental retardation.

A State shall not be denied payment under this title for nursing facility services for a resident described in this clause because the resident does not require the level of services provided by such a facility, if the resident chooses to remain in such a facility.

(ii) OTHER RESIDENTS NOT REQUIRING NURSING FACILITY SERVICES, BUT REQUIRING SPECIALIZED SERVICES.—In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility, but to require specialized services for mental illness or mental retar-

dation, and who has not continuously resided in a nursing facility for at least 30 months before the date of the determination, the State must, in consultation with the resident's family or legal representative and care-givers—

(I) arrange for the safe and orderly discharge of the resident from the facility, consistent with the requirements of subsection (c)(2),

(II) prepare and orient the resident for such discharge, and

(III) provide for (or arrange for the provision of) such specialized services for the mental illness or mental retardation.

(iii) Residents not requiring nursing facility services and not requiring specialized services.—In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility and not to require specialized services for mental illness or mental retardation, the State must—

(I) arrange for the safe and orderly discharge of the resident from the facility, consistent with the requirements of subsection (c)(2), and

(II) prepare and orient the resident for such discharge.

(iv) Annual report.—Each State shall report to the Secretary annually concerning the number and disposition of residents described in each of clauses (ii) and (iii).[95]

(D) DENIAL OF PAYMENT.—

(i) For failure to conduct preadmission screening or review.—No payment may be made under section 1903(a) with respect to nursing facility services furnished to an individual for whom a determination is required under subsection (b)(3)(F) or subparagraph (B) but for whom the determination is not made.

(ii) For certain residents not requiring nursing facility level of services.—No payment may be made under section 1903(a) with respect to nursing facility services furnished to an individual (other than an individual described in subparagraph (C)(i)) who does not require the level of services provided by a nursing facility.

(E) PERMITTING ALTERNATIVE DISPOSITION PLANS.—With respect to residents of a nursing facility who are mentally retarded or mentally ill and who are determined under subparagraph (B) not to require the level of services of such a facility, but who require specialized services for mental illness or mental retardation, a State and the nursing facility shall be considered to be in compliance with the requirements of subparagraphs (A) through (C) of this paragraph if, before April 1, 1989, the State and the Secretary have entered into an agreement relating to the disposition of such residents of the facility and the State is in compliance with such agreement. Such an agreement

[95] See Vol. II, P.L. 100-203, §4215 [as amended by P.L. 101-508, §4801(b)(5)(B)], with respect to the required annual report to Congress.

may provide for the disposition of the residents after the date specified in subparagraph (C). The State may revise such an agreement, subject to the approval of the Secretary, before October 1, 1991, but only if, under the revised agreement, all residents subject to the agreement who do not require the level of services of such a facility are discharged from the facility by not later than April 1, 1994.

(F) Appeals procedures.—Each State, as a condition of approval of its plan under this title, effective January 1, 1989, must have in effect an appeals process for individuals adversely affected by determinations under subparagraph (A) or (B).

(G) DEFINITIONS.—In this paragraph and in subsection (b)(3)(F):

(i) An individual is considered to be "mentally ill" if the individual has a serious mental illness (as defined by the Secretary in consultation with the National Institute of Mental Health) and does not have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder) or a diagnosis (other than a primary diagnosis) of dementia and a primary diagnosis that is not a serious mental illness.

(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded or a person with a related condition (as described in section 1905(d)).

(iii) The term "specialized services" has the meaning given such term by the Secretary in regulations, but does not include, in the case of a resident of a nursing facility, services within the scope of services which the facility must provide or arrange for its residents under subsection (b)(4).

(f) Responsibilities of Secretary Relating to Nursing Facility Requirements.—

(1) GENERAL RESPONSIBILITY.—It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in nursing facilities under State plans approved under this title, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.

(2) REQUIREMENTS FOR NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS AND FOR NURSE AIDE COMPETENCY EVALUATION PROGRAMS.—

(A) IN GENERAL.—For purposes of subsections (b)(5) and (e)(1)(A), the Secretary shall establish, by not later than September 1, 1988—

(i) requirements for the approval of nurse aide training and competency evaluation programs, including requirements relating to (I) the areas to be covered in such a program (including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents, basic restorative services, and residents' rights) and content of the curriculum, (II) minimum hours of

initial and ongoing training and retraining (including not less than 75 hours in the case of initial training), (III) qualifications of instructors, and (IV) procedures for determination of competency;

(ii) requirements for the approval of nurse aide competency evaluation programs, including requirement relating to the areas to be covered in such a program, including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents, basic restorative services, and residents' rights, and procedures for determination of competency;

(iii) requirements respecting the minimum frequency and methodology to be used by a State in reviewing such programs' compliance with the requirements for such programs; and

(iv) requirements, under both such programs, that—

(I) provide procedures for determining competency that permit a nurse aide, at the nurse aide's option, to establish competency through procedures or methods other than the passing of a written examination and to have the competency evaluation conducted at the nursing facility at which the aide is (or will be) employed (unless the facility is described in subparagraph (B)(iii)(I)),

(II) prohibit the imposition on a nurse aide who is employed by (or who has received an offer of employment from) a facility on the date on which the aide begins either such program of any charges (including any charges for textbooks and other required course materials and any charges for the competency evaluation) for either such program, and

(III) in the case of a nurse aide not described in subclause (II) who is employed by (or who has received an offer of employment from) a facility not later than 12 months after completing either such program, the State shall provide for the reimbursement of costs incurred in completing such program on a prorata basis during the period in which the nurse aide is so employed.

(B) APPROVAL OF CERTAIN PROGRAMS.—Such requirements—

(i) may permit approval of programs offered by or in facilities, as well as outside facilities (including employee organizations), and of programs in effect on the date of the enactment of this section[96] ;

(ii) shall permit a State to find that an individual who has completed (before July 1, 1989) a nurse aide training and competency evaluation program shall be deemed to have completed such a program approved under subsection (b)(5) if the State determines that, at the time the program was offered, the program met

[96] December 22, 1987 [P.L. 100–203; 101 Stat. 1330].

the requirements for approval under such paragraph; and

(iii) subject to subparagraphs (C) and (D)[97], shall prohibit approval of such a program—

(I) offered by or in a nursing facility which, within the previous 2 years—

(a) has operated under a waiver under subsection (b)(4)(C)(ii) that was granted on the basis of a demonstration that the facility is unable to provide the nursing care required under subsection (b)(4)(C)(i) for a period in excess of 48 hours during a week;

(b) has been subject to an extended (or partial extended) survey under section 1819(g)(2)(B)(i) or subsection (g)(2)(B)(i); or

(c) has been assessed a civil money penalty described in section 1819(h)(2)(B)(ii) or subsection (h)(2)(A)(ii) of not less than $5,000, or has been subject to a remedy described in subsection (h)(1)(B)(i), clauses (i), (iii), or (iv) of subsection (h)(2)(A), clauses (i) or (iii) of section 1819(h)(2)(B), or section 1819(h)(4), or

(II) offered by or in a nursing facility unless the State makes the determination, upon an individual's completion of the program, that the individual is competent to provide nursing and nursing-related services in nursing facilities.

A State may not delegate (through subcontract or otherwise) its responsibility under clause (iii)(II) to the nursing facility.

(C) WAIVER AUTHORIZED.—Clause (iii)(I) of subparagraph (B) shall not apply to a program offered in (but not by) a nursing facility (or skilled nursing facility for purposes of title XVIII) in a State if the State—

(i) determines that there is no other such program offered within a reasonable distance of the facility,

(ii) assures, through an oversight effort, that an adequate environment exists for operating the program in the facility, and

(iii) provides notice of such determination and assurances to the State long–term care ombudsman.

(D)[98] WAIVER OF DISAPPROVAL OF NURSE-AIDE TRAINING PROGRAMS.—Upon application of a nursing facility, the Secretary may waive the application of subparagraph (B)(iii)(I)(c) if the imposition of the civil monetary penalty was not related to the quality of care provided to residents of the facility. Nothing in this subparagraph shall be construed as eliminating any requirement upon a facility to pay a civil monetary penalty described in the preceding sentence

(3) Federal guidelines for state appeals process for transfers and discharges.—For purposes of subsections (c)(2)(B)(iii) and

[97] P.L. 108-173, §932(c)(2)(A), struck out "subparagraph (C)" and substituted "subparagraphs (C) and (D)", effective December 8, 2003, applicable to appeals filed on or after October 1, 2004.

[98] P.L. 108-173, §932(c)(2)(B), added subparagraph (D), effective December 8, 2003, applicable to appeals filed on or after October 1, 2004.

(e)(3), by not later than October 1, 1988, the Secretary shall establish guidelines for minimum standards which State appeals processes under subsection (e)(3) must meet to provide a fair mechanism for hearing appeals on transfers and discharges of residents from nursing facilities.

(4) SECRETARIAL STANDARDS QUALIFICATION OF ADMINISTRATORS.—For purposes of subsections (d)(1)(C) and (e)(4), the Secretary shall develop, by not later than March 1, 1988, standards to be applied in assuring the qualifications of administrators of nursing facilities.

(5) CRITERIA FOR ADMINISTRATION.—The Secretary shall establish criteria for assessing a nursing facility's compliance with the requirement of subsection (d)(1) with respect to—

(A) its governing body and management,

(B) agreements with hospitals regarding transfers of residents to and from the hospitals and to and from other nursing facilities,

(C) disaster preparedness,

(D) direction of medical care by a physician,

(E) laboratory and radiological services,

(F) clinical records, and

(G) resident and advocate participation.

(6) SPECIFICATION OF RESIDENT ASSESSMENT DATA SET AND INSTRUMENTS.—The Secretary shall—

(A) not later than January 1, 1989, specify a minimum data set of core elements and common definitions for use by nursing facilities in conducting the assessments required under subsection (b)(3), and establish guidelines for utilization of the data set; and

(B) by not later than April 1, 1990, designate one or more instruments which are consistent with the specification made under subparagraph (A) and which a State may specify under subsection (e)(5)(A) for use by nursing facilities in complying with the requirements of subsection (b)(3)(A)(iii).

(7) List of items and services furnished in nursing facilities not chargeable to the personal funds of a resident.—

(A) REGULATIONS REQUIRED.—Pursuant to the requirement of section 21(b) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977[99], the Secretary shall issue regulations, on or before the first day of the seventh month to begin after the date of enactment of this section[100], that define those costs which may be charged to the personal funds of residents in nursing facilities who are individuals receiving medical assistance with respect to nursing facility services under this title and those costs which are to be included in the payment amount under this title for nursing facility services.

(B) RULE IF FAILURE TO PUBLISH REGULATIONS.— If the Secretary does not issue the regulations under subparagraph (A) on or before the date required in that subparagraph, in the case of a resident of a nursing facility who is eligible to receive benefits for nursing facility services

[99] See Vol. II, P.L. 95–142.
[100] December 22, 1987.

under this title, for purposes of section 1902(a)(28)(B), the Secretary shall be deemed to have promulgated regulations under this paragraph which provide that the costs which may not be charged to the personal funds of such resident (and for which payment is considered to be made under this title) include, at a minimum, the costs for routine personal hygiene items and services furnished by the facility.

(8) Federal minimum criteria and monitoring for preadmission screening and resident review.—

(A) MINIMUM CRITERIA.—The Secretary shall develop, by not later than October 1, 1988, minimum criteria for States to use in making determinations under subsections (b)(3)(F) and (e)(7)(B) and in permitting individuals adversely affected to appeal such determinations, and shall notify the States of such criteria.

(B) MONITORING COMPLIANCE.—The Secretary shall review, in a sufficient number of cases to allow reasonable inferences, each State's compliance with the requirements of subsection (e)(7)(C)(ii) (relating to discharge and placement for active treatment of certain residents).

(9) CRITERIA FOR MONITORING STATE WAIVERS.— The Secretary shall develop, by not later than October 1, 1988, criteria and procedures for monitoring State performances in granting waivers pursuant to subsection (b)(4)(C)(ii).

(g) SURVEY AND CERTIFICATION PROCESS.—

(1) STATE AND FEDERAL RESPONSIBILITY.—

(A) IN GENERAL.—Under each State plan under this title, the State shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of nursing facilities (other than facilities of the State) with the requirements of subsections (b), (c), and (d). The Secretary shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of State nursing facilities with the requirements of such subsections.

(B) EDUCATIONAL PROGRAM.—Each State shall conduct periodic educational programs for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies under this section.

(C) INVESTIGATION OF ALLEGATIONS OF RESIDENT NEGLECT AND ABUSE AND MISAPPROPRIATION OF RESIDENT PROPERTY.—The State shall provide, through the agency responsible for surveys and certification of nursing facilities under this subsection, for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility in providing services to such a resident. The State shall, after notice to the individual involved and a reasonable opportunity for a hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations. If the State finds that a nurse aide has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the

nurse aide and the registry of such finding. If the State finds that any other individual used by the facility has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the appropriate licensure authority. A State shall not make a finding that an individual has neglected a resident if the individual demonstrates that such neglect was caused by factors beyond the control of the individual.

(D) REMOVAL OF NAME FROM NURSE AIDE REGISTRY.—

(i) IN GENERAL.—In the case of a finding of neglect under subparagraph (C), the State shall establish a procedure to permit a nurse aide to petition the State to have his or her name removed from the registry upon a determination by the State that—

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

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

(ii) TIMING OF DETERMINATION.—In no case shall a determination on a petition submitted under clause (i) be made prior to the expiration of the 1–year period beginning on the date on which the name of the petitioner was added to the registry under subparagraph (C).

(E) Construction.—The failure of the Secretary to issue regulations to carry out this subsection shall not relieve a State of its responsibility under this subsection.

(2) SURVEYS.—

(A) ANNUAL STANDARD SURVEY.—

(i) IN GENERAL.—Each nursing facility shall be subject to a standard survey, to be conducted without any prior notice to the facility. Any individual who notifies (or causes to be notified) a nursing facility of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). The Secretary shall review each State's procedures for scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

(ii) CONTENTS.—Each standard survey shall include, for a case-mix stratified sample of residents—

(I) a survey of the quality of care furnished, as measured by indicators of medical, nursing, and rehabilitative care, dietary and nutrition services, activities and social participation, and sanitation, infection control, and the physical environment,

(II) written plans of care provided under subsection (b)(2) and an audit of the residents' assessments under subsection (b)(3) to determine

the accuracy of such assessments and the adequacy of such plans of care, and

(III) a review of compliance with residents' rights under subsection (c).

(iii) Frequency.—

(I) IN GENERAL.—Each nursing facility shall be subject to a standard survey not later than 15 months after the date of the previous standard survey conducted under this subparagraph. The statewide average interval between standard surveys of a nursing facility shall not exceed 12 months.

(II) SPECIAL SURVEYS.—If not otherwise conducted under subclause (I), a standard survey (or an abbreviated standard survey) may be conducted within 2 months of any change of ownership, administration, management of a nursing facility, or director of nursing in order to determine whether the change has resulted in any decline in the quality of care furnished in the facility.

(B) EXTENDED SURVEYS.—

(i) IN GENERAL.—Each nursing facility which is found, under a standard survey, to have provided substandard quality of care shall be subject to an extended survey. Any other facility may, at the Secretary's or State's discretion, be subject to such an extended survey (or a partial extended survey).

(ii) TIMING.—The extended survey shall be conducted immediately after the standard survey (or, if not practicable, not later than 2 weeks after the date of completion of the standard survey).

(iii) CONTENTS.—In such an extended survey, the survey team shall review and identify the policies and procedures which produced such substandard quality of care and shall determine whether the facility has complied with all the requirements described in subsections (b), (c), and (d). Such review shall include an expansion of the size of the sample of residents' assessments reviewed and a review of the staffing, of in-service training, and, if appropriate, of contracts with consultants.

(iv) CONSTRUCTION.—Nothing in this paragraph shall be construed as requiring an extended or partial extended survey as a prerequisite to imposing a sanction against a facility under subsection (h) on the basis of findings in a standard survey.

(C) SURVEY PROTOCOL.—Standard and extended surveys shall be conducted—

(i) based upon a protocol which the Secretary has developed, tested, and validated by not later than January 1, 1990, and

(ii) by individuals, of a survey team, who meet such minimum qualifications as the Secretary establishes by not later than such date.

The failure of the Secretary to develop, test, or validate such protocols or to establish such minimum qualifications shall not relieve any State of its responsibility (or the Secretary of the Secretary's responsibility) to conduct surveys under this subsection.

(D) Consistency of surveys.—Each State shall implement programs to measure and reduce inconsistency in the application of survey results among surveyors.

(E) SURVEY TEAMS.—

(i) IN GENERAL.—Surveys under this subsection shall be conducted by a multidisciplinary team of professionals (including a registered professional nurse).

(ii) PROHIBITION OF CONFLICTS OF INTEREST.—A State may not use as a member of a survey team under this subsection an individual who is serving (or has served within the previous 2 years) as a member of the staff of, or as a consultant to, the facility surveyed respecting compliance with the requirements of subsections (b), (c), and (d), or who has a personal or familial financial interest in the facility being surveyed.

(iii) TRAINING.—The Secretary shall provide for the comprehensive training of State and Federal surveyors in the conduct of standard and extended surveys under this subsection, including the auditing of resident assessments and plans of care. No individual shall serve as a member of a survey team unless the individual has successfully completed a training and testing program in survey and certification techniques that has been approved by the Secretary.

(3) VALIDATION SURVEYS.—

(A) IN GENERAL.—The Secretary shall conduct onsite surveys of a representative sample of nursing facilities in each State, within 2 months of the date of surveys conducted under paragraph (2) by the State, in a sufficient number to allow inferences about the adequacies of each State's surveys conducted under paragraph (2). In conducting such surveys, the Secretary shall use the same survey protocols as the State is required to use under paragraph (2). If the State has determined that an individual nursing facility meets the requirements of subsections (b), (c), and (d), but the Secretary determines that the facility does not meet such requirements, the Secretary's determination as to the facility's noncompliance with such requirements is binding and supersedes that of the State survey.

(B) Scope.—With respect to each State, the Secretary shall conduct surveys under subparagraph (A) each year with respect to at least 5 percent of the number of nursing facilities surveyed by the State in the year, but in no case less than 5 nursing facilities in the State.

(C) REDUCTION IN ADMINISTRATIVE COSTS FOR SUBSTANDARD PERFORMANCE.—If the Secretary finds, on the basis of such surveys, that a State has failed to perform surveys as required under paragraph (2) or that a State's survey and certification performance otherwise is not adequate, the Secretary may provide for the training of survey

teams in the State and shall provide for a reduction of the payment otherwise made to the State under section 1903(a)(2)(D) with respect to a quarter equal to 33 percent multiplied by a fraction, the denominator of which is equal to the total number of residents in nursing facilities surveyed by the Secretary that quarter and the numerator of which is equal to the total number of residents in nursing facilities which were found pursuant to such surveys to be not in compliance with any of the requirements of subsections (b), (c), and (d). A State that is dissatisfied with the Secretary's findings under this subparagraph may obtain reconsideration and review of the findings under section 1116 in the same manner as a State may seek reconsideration and review under that section of the Secretary's determination under section 1116(a)(1).

(D) Special surveys of compliance.—Where the Secretary has reason to question the compliance of a nursing facility with any of the requirements of subsections (b), (c), and (d), the Secretary may conduct a survey of the facility and, on the basis of that survey, make independent and binding determinations concerning the extent to which the nursing facility meets such requirements.

(4) INVESTIGATION OF COMPLAINTS AND MONITORING NURSING FACILITY COMPLIANCE.—Each State shall maintain procedures and adequate staff to—

(A) investigate complaints of violations of requirements by nursing facilities, and

(B) monitor, on-site, on a regular, as needed basis, a nursing facility's compliance with the requirements of subsections (b), (c), and (d), if—

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements, has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

A State may maintain and utilize a specialized team (including an attorney, an auditor, and appropriate health care professionals) for the purpose of identifying, surveying, gathering and preserving evidence, and carrying out appropriate enforcement actions against substandard nursing facilities.

(5) Disclosure of results of inspections and activities.—

(A) PUBLIC INFORMATION.—Each State, and the Secretary, shall make available to the public—

(i) information respecting all surveys and certifications made respecting nursing facilities, including statements of deficiencies, within 14 calendar days after such information is made available to those facilities, and approved plans of correction,

(ii) copies of cost reports of such facilities filed under this title or under title XVIII,

(iii) copies of statements of ownership under section 1124, and

(iv) information disclosed under section 1126.

(B) NOTICE TO OMBUDSMAN.—Each State shall notify the State long-term care ombudsman (established under title III or VII of the Older Americans Act of 1965 [101] in accordance with section 712 of the Act) of the State's findings of noncompliance with any of the requirements of subsections (b), (c), and (d), or of any adverse action taken against a nursing facility under paragraphs (1), (2), or (3) of subsection (h), with respect to a nursing facility in the State.

(C) Notice to physicians and nursing facility administrator licensing board.—If a State finds that a nursing facility has provided substandard quality of care, the State shall notify—

(i) the attending physician of each resident with respect to which such finding is made, and

(ii) any State board responsible for the licensing of the nursing facility administrator of the facility.

(D) ACCESS TO FRAUD CONTROL UNITS.—Each State shall provide its State medicaid fraud and abuse control unit (established under section 1903(q)) with access to all information of the State agency responsible for surveys and certifications under this subsection.

(h) ENFORCEMENT PROCESS.—

(1) IN GENERAL.—If a State finds, on the basis of a standard, extended, or partial extended survey under subsection (g)(2) or otherwise, that a nursing facility no longer meets a requirement of subsection (b), (c), or (d), and further finds that the facility's deficiencies—

(A) immediately jeopardize the health or safety of its residents, the State shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(A)(iii), or terminate the facility's participation under the State plan and may provide, in addition, for one or more of the other remedies described in paragraph (2); or

(B) do not immediately jeopardize the health or safety of its residents, the State may—

(i) terminate the facility's participation under the State plan,

(ii) provide for one or more of the remedies described in paragraph (2), or

(iii) do both.

Nothing in this paragraph shall be construed as restricting the remedies available to a State to remedy a nursing facility's deficiencies. If a State finds that a nursing facility meets the requirements of subsections (b), (c), and (d), but, as of a previous period, did not meet such requirements, the State may provide for a civil money penalty under paragraph (2)(A)(ii) for the days in which it finds that the facility was not in compliance with such requirements.

(2) Specified remedies.—

(A) LISTING.—Except as provided in subparagraph (B)(ii), each State shall establish by law (whether statute or regulation) at least the following remedies:

[101] See Vol. II, P.L. 89–73.

(i) Denial of payment under the State plan with respect to any individual admitted to the nursing facility involved after such notice to the public and to the facility as may be provided for by the State.

(ii) A civil money penalty assessed and collected, with interest, for each day in which the facility is or was out of compliance with a requirement of subsection (b), (c), or (d). Funds collected by a State as a result of imposition of such a penalty (or as a result of the imposition by the State of a civil money penalty for activities described in subsections (b)(3)(B)(ii)(I), (b)(3)(B)(ii)(II), or (g)(2)(A)(i)) shall be applied to the protection of the health or property of residents of nursing facilities that the State or the Secretary finds deficient, including payment for the costs of relocation of residents to other facilities, maintenance of operation of a facility pending correction of deficiencies or closure, and reimbursement of residents for personal funds lost.

(iii) The appointment of temporary management to oversee the operation of the facility and to assure the health and safety of the facility's residents, where there is a need for temporary management while—

(I) there is an orderly closure of the facility, or

(II) improvements are made in order to bring the facility into compliance with all the requirements of subsections (b), (c), and (d).

The temporary management under this clause shall not be terminated under subclause (II) until the State has determined that the facility has the management capability to ensure continued compliance with all the requirements of subsections (b), (c), and (d).

(iv) The authority, in the case of an emergency, to close the facility, to transfer residents in that facility to other facilities, or both.

The State also shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies. In addition, the State may provide for other specified remedies, such as directed plans of correction.

(B) DEADLINE AND GUIDANCE.—(i) Except as provided in clause (ii), as a condition for approval of a State plan for calendar quarters beginning on or after October 1, 1989, each State shall establish the remedies described in clauses (i) through (iv) of subparagraph (A) by not later than October 1, 1989. The Secretary shall provide, through regulations by not later than October 1, 1988, guidance to States in establishing such remedies; but the failure of the Secretary to provide such guidance shall not relieve a State of the responsibility for establishing such remedies.

(ii) A State may establish alternative remedies (other than termination of participation) other than those described in clauses (i) through (iv) of subparagraph (A), if the State demonstrates to the Secretary's satisfaction that the alternative remedies are as effective in deterring noncompliance and correcting deficiencies as those described in subparagraph (A).

(C) Assuring prompt compliance.—If a nursing facility has not complied with any of the requirements of subsections (b), (c), and (d), within 3 months after the date the facility is found to be out of compliance with such requirements, the State shall impose the remedy described in subparagraph (A)(i) for all individuals who are admitted to the facility after such date.

(D) REPEATED NONCOMPLIANCE.—In the case of a nursing facility which, on 3 consecutive standard surveys conducted under subsection (g)(2), has been found to have provided substandard quality of care, the State shall (regardless of what other remedies are provided)—

(i) impose the remedy described in subparagraph (A)(i), and

(ii) monitor the facility under subsection (g)(4)(B),

until the facility has demonstrated, to the satisfaction of the State, that it is in compliance with the requirements of subsections (b), (c), and (d), and that it will remain in compliance with such requirements.

(E) Funding.—The reasonable expenditures of a State to provide for temporary management and other expenses associated with implementing the remedies described in clauses (iii) and (iv) of subparagraph (A) shall be considered, for purposes of section 1903(a)(7), to be necessary for the proper and efficient administration of the State plan.

(F) INCENTIVES FOR HIGH QUALITY CARE.—In addition to the remedies specified in this paragraph, a State may establish a program to reward, through public recognition, incentive payments, or both, nursing facilities that provide the highest quality care to residents who are entitled to medical assistance under this title. For purposes of section 1903(a)(7), proper expenses incurred by a State in carrying out such a program shall be considered to be expenses necessary for the proper and efficient administration of the State plan under this title.

(3) Secretarial authority.—

(A) FOR STATE NURSING FACILITIES.—With respect to a State nursing facility, the Secretary shall have the authority and duties of a State under this subsection, including the authority to impose remedies described in clauses (i), (ii), and (iii) of paragraph (2)(A).

(B) OTHER NURSING FACILITIES.—With respect to any other nursing facility in a State, if the Secretary finds that a nursing facility no longer meets a requirement of subsection (b), (c), (d), or (e), and further finds that the facility's deficiencies—

(i) immediately jeopardize the health or safety of its residents, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies

through the remedy specified in subparagraph (C)(iii), or terminate the facility's participation under the State plan and may provide, in addition, for one or more of the other remedies described in subparagraph (C); or

(ii) do not immediately jeopardize the health or safety of its residents, the Secretary may impose any of the remedies described in subparagraph (C).

Nothing in this subparagraph shall be construed as restricting the remedies available to the Secretary to remedy a nursing facility's deficiencies. If the Secretary finds that a nursing facility meets such requirements but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subparagraph (C)(ii) for the days on which he finds that the facility was not in compliance with such requirements.

(C) Specified remedies.—The Secretary may take the following actions with respect to a finding that a facility has not met an applicable requirement:

(i) DENIAL OF PAYMENT.—The Secretary may deny any further payments to the State for medical assistance furnished by the facility to all individuals in the facility or to individuals admitted to the facility after the effective date of the finding.

(ii) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—The Secretary may impose a civil money penalty in an amount not to exceed $10,000 for each day of noncompliance. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(iii) APPOINTMENT OF TEMPORARY MANAGEMENT.—In consultation with the State, the Secretary may appoint temporary management to oversee the operation of the facility and to assure the health and safety of the facility's residents, where there is a need for temporary management while—

(I) there is an orderly closure of the facility, or

(II) improvements are made in order to bring the facility into compliance with all the requirements of subsections (b), (c), and (d).

The temporary management under this clause shall not be terminated under subclause (II) until the Secretary has determined that the facility has the management capability to ensure continued compliance with all the requirements of subsections (b), (c), and (d).

The Secretary shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies. In ad-

dition, the Secretary may provide for other specified remedies, such as directed plans of correction.

(D) CONTINUATION OF PAYMENTS PENDING REMEDIATION.—The Secretary may continue payments, over a period of not longer than 6 months after the effective date of the findings, under this title with respect to a nursing facility not in compliance with a requirement of subsection (b), (c), or (d), if—

(i) the State survey agency finds that it is more appropriate to take alternative action to assure compliance of the facility with the requirements than to terminate the certification of the facility, and

(ii) 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.

The Secretary shall establish guidelines for approval of corrective actions requested by States under this subparagraph.

(4) Effective period of denial of payment.—A finding to deny payment under this subsection shall terminate when the State or Secretary (or both, as the case may be) finds that the facility is in substantial compliance with all the requirements of subsections (b), (c), and (d).

(5) IMMEDIATE TERMINATION OF PARTICIPATION FOR FACILITY WHERE STATE OR SECRETARY FINDS NONCOMPLIANCE AND IMMEDIATE JEOPARDY.—If either the State or the Secretary finds that a nursing facility has not met a requirement of subsection (b), (c), or (d), and finds that the failure immediately jeopardizes the health or safety of its residents, the State or the Secretary, respectively shall notify the other of such finding, and the State or the Secretary, respectively, shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(A)(iii) or (3)(C)(iii), or terminate the facility's participation under the State plan. If the facility's participation in the State plan is terminated by either the State or the Secretary, the State shall provide for the safe and orderly transfer of the residents eligible under the State plan consistent with the requirements of subsection (c)(2).

(6) Special rules where state and secretary do not agree on finding of noncompliance.—

(A) STATE FINDING OF NONCOMPLIANCE AND NO SECRETARIAL FINDING OF NONCOMPLIANCE.—If the Secretary finds that a nursing facility has met all the requirements of subsections (b), (c), and (d), but a State finds that the facility has not met such requirements and the failure does not immediately jeopardize the health or safety of its residents, the State's findings shall control and the remedies imposed by the State shall be applied.

(B) SECRETARIAL FINDING OF NONCOMPLIANCE AND NO STATE FINDING OF NONCOMPLIANCE.—If the Secretary finds that a nursing facility has not met all the requirements of subsections (b), (c), and (d), and that the failure does not immediately jeopardize the health or safety of its residents, but the State has not made such a finding, the Secretary—

(i) may impose any remedies specified in paragraph (3)(C) with respect to the facility, and

(ii) shall (pending any termination by the Secretary) permit continuation of payments in accordance with paragraph (3)(D).

(7) SPECIAL RULES FOR TIMING OF TERMINATION OF PARTICIPATION WHERE REMEDIES OVERLAP.—If both the Secretary and the State find that a nursing facility has not met all the requirements of subsections (b), (c), and (d), and neither finds that the failure immediately jeopardizes the health or safety of its residents—

(A)(i) if both find that the facility's participation under the State plan should be terminated, the State's timing of any termination shall control so long as the termination date does not occur later than 6 months after the date of the finding to terminate;

(ii) if the Secretary, but not the State, finds that the facility's participation under the State plan should be terminated, the Secretary shall (pending any termination by the Secretary) permit continuation of payments in accordance with paragraph (3)(D); or

(iii) if the State, but not the Secretary, finds that the facility's participation under the State plan should be terminated, the State's decision to terminate, and timing of such termination, shall control; and

(B)(i) if the Secretary or the State, but not both, establishes one or more remedies which are additional or alternative to the remedy of terminating the facility's participation under the State plan, such additional or alternative remedies shall also be applied, or

(ii) if both the Secretary and the State establish one or more remedies which are additional or alternative to the remedy of terminating the facility's participation under the State plan, only the additional or alternative remedies of the Secretary shall apply.

(8) CONSTRUCTION.—The remedies provided under this subsection are in addition to those otherwise available under State or Federal law and shall not be construed as limiting such other remedies, including any remedy available to an individual at common law. The remedies described in clauses (i), (iii), and (iv) of paragraph (2)(A) may be imposed during the pendency of any hearing. The provisions of this subsection shall apply to a nursing facility (or portion thereof) notwithstanding that the facility (or portion thereof) also is a skilled nursing facility for purposes of title XVIII.

(9) Sharing of information.—Notwithstanding any other provision of law, all information concerning nursing facilities required by this section to be filed with the Secretary or a State agency shall be made available by such facilities to Federal or State employees for purposes consistent with the effective administration of programs established under this title and title XVIII, including investigations by State medicaid fraud control units.

(i) CONSTRUCTION.—Where requirements or obligations under this section are identical to those provided under section 1819 of this Act, the fulfillment of those requirements or obligations under

section 1819 shall be considered to be the fulfillment of the corresponding requirements or obligations under this section.

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 [102],

(II) title V of this Act, or

(III) title V of the Indian Health Care Improvement Act [103];

(ii) participates in a program established under—

(I) section 17 of the Child Nutrition Act of 1966 [104], or

(II) section 4(a) of the Agriculture and Consumer Protection Act of 1973 [105];

(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).

[102] See Vol. II, P.L. 78–410.
[103] See Vol. II, P.L. 94–437.
[104] See Vol. II, P.L. 89–642.
[105] See Vol. II, P.L. 93–86.

(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.

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.

PRESUMPTIVE ELIGIBILITY FOR CERTAIN BREAST OR CERVICAL CANCER PATIENTS

SEC. 1920B. [42 U.S.C. 1396r–1b] (a) STATE OPTION.—A State plan approved under section 1902 may provide for making medical assistance available to an individual described in section 1902(aa) (relating to certain breast or cervical cancer patients) during a presumptive eligibility period.

(b) DEFINITIONS.—For purposes of this section:

(1) PRESUMPTIVE ELIGIBILITY PERIOD.—The term "presumptive eligibility period" means, with respect to an individual described in subsection (a), the period that—

(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1902(aa); and

(B) ends with (and includes) the earlier of—

(i) the day on which a determination is made with respect to the eligibility of such individual for services under the State plan; or

(ii) in the case of such an individual who does not file an application by the last day of the month follow-

ing the month during which the entity makes the determination referred to in subparagraph (A), such last day.

(2) QUALIFIED ENTITY.—

(A) In general.—Subject to subparagraph (B), the term "qualified entity" means any entity that—

(i) is eligible for payments under a State plan approved under this title; and

(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

(B) REGULATIONS.—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) RULE OF CONSTRUCTION.—Nothing in this paragraph 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) ADMINISTRATION.—

(1) IN GENERAL.—The State agency shall provide qualified entities with—

(A) such forms as are necessary for an application to be made by an individual described in subsection (a) for medical assistance under the State plan; and

(B) information on how to assist such individuals in completing and filing such forms.

(2) NOTIFICATION REQUIREMENTS.—A qualified entity that determines under subsection (b)(1)(A) that an individual described in subsection (a) 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 such individual 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) APPLICATION FOR MEDICAL ASSISTANCE.—In the case of an individual described in subsection (a) who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the individual shall apply 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.

(d) PAYMENT.—Notwithstanding any other provision of this title, medical assistance that—

(1) is furnished to an individual described in subsection (a)—

(A) during a presumptive eligibility period;

(B) by a entity that is eligible for payments under the State plan; and

(2) is included in the care and services covered by the State plan, shall be treated as medical assistance provided by such

plan for purposes of clause (4) of the first sentence of section 1905(b).

INFORMATION CONCERNING SANCTIONS TAKEN BY STATE LICENSING AUTHORITIES AGAINST HEALTH CARE PRACTITIONERS AND PROVIDERS

SEC. 1921. [42 U.S.C. 1396r–2] (a) INFORMATION REPORTING REQUIREMENT. The requirement referred to in section 1902(a)(49) is that the State must provide for the following:

(1) INFORMATION REPORTING SYSTEM.—The State must have in effect a system of reporting the following information with respect to formal proceedings (as defined by the Secretary in regulations) concluded against a health care practitioner or entity by any authority of the State (or of a political subdivision thereof) responsible for the licensing of health care practitioners (or any peer review organization or private accreditation entity reviewing the services provided by health care practitioners) or entities:

(A) Any adverse action taken by such licensing authority as a result of the proceeding, including any revocation or suspension of a license (and the length of any such suspension), reprimand, censure, or probation.

(B) Any dismissal or closure of the proceedings by reason of the practitioner or entity surrendering the license or leaving the State or jurisdiction.

(C) Any other loss of the license of the practitioner or entity, whether by operation of law, voluntary surrender, or otherwise.

(D) Any negative action or finding by such authority, organization, or entity regarding the practitioner or entity.

(2) ACCESS TO DOCUMENTS.—The State must provide the Secretary (or an entity designated by the Secretary) with access to such documents of the authority described in paragraph (1) as may be necessary for the Secretary to determine the facts and circumstances concerning the actions and determinations described in such paragraph for the purpose of carrying out this Act.

(b) FORM OF INFORMATION.—The information described in subsection (a)(1) shall be provided to the Secretary (or to an appropriate private or public agency, under suitable arrangements made by the Secretary with respect to receipt, storage, protection of confidentiality, and dissemination of information) in such a form and manner as the Secretary determines to be appropriate in order to provide for activities of the Secretary under this Act and in order to provide, directly or through suitable arrangements made by the Secretary, information—

(1) to agencies administering Federal health care programs, including private entities administering such programs under contract,

(2) to licensing authorities described in subsection (a)(1),

(3) to State agencies administering or supervising the administration of State health care programs (as defined in section 1128(h)),

(4) to utilization and quality control peer review organizations described in part B of title XI and to appropriate entities with contracts under section 1154(a)(4)(C) with respect to eligible organizations reviewed under the contracts,

(5) to State medicaid fraud control units (as defined in section 1903(q)),

(6) to hospitals and other health care entities (as defined in section 431 of the Health Care Quality Improvement Act of 1986[106]), with respect to physicians or other licensed health care practitioners that have entered (or may be entering) into an employment or affiliation relationship with, or have applied for clinical privileges or appointments to the medical staff of, such hospitals or other health care entities (and such information shall be deemed to be disclosed pursuant to section 427 of, and be subject to the provisions of, that Act),

(7) to the Attorney General and such other law enforcement officials as the Secretary deems appropriate, and

(8) upon request, to the Comptroller General,

in order for such authorities to determine the fitness of individuals to provide health care services, to protect the health and safety of individuals receiving health care through such programs, and to protect the fiscal integrity of such programs.

(c) CONFIDENTIALITY OF INFORMATION PROVIDED.—The Secretary shall provide for suitable safeguards for the confidentiality of the information furnished under subsection (a). Nothing in this subsection shall prevent the disclosure of such information by a party which is otherwise authorized, under applicable State law, to make such disclosure.

(d) APPROPRIATE COORDINATION.—The Secretary shall provide for the maximum appropriate coordination in the implementation of subsection (a) of this section and section 422 of the Health Care Quality Improvement Act of 1986.

CORRECTION AND REDUCTION PLANS FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

SEC. 1922. [42 U.S.C. 1396r–3] (a) If the Secretary finds that an intermediate care facility for the mentally retarded has substantial deficiencies which do not pose an immediate threat to the health and safety of residents (including failure to provide active treatment), the State may elect, subject to the limitations in this section, to—

(1) submit, within the number of days specified by the Secretary in regulations which apply to submission of compliance plans with respect to deficiencies of such type, a written plan of correction which details the extent of the facility's current compliance with the standards promulgated by the Secretary, including all deficiencies identified during a validation survey, and which provides for a timetable for completion of necessary steps to correct all staffing deficiencies within 6 months, and a timetable for rectifying all physical plant deficiencies within 6 months; or

(2) submit, within a time period consisting of the number of days specified for submissions under paragraph (1) plus 35 days, a written plan for permanently reducing the number of certified beds, within a maximum of 36 months, in order to permit any noncomplying buildings (or distinct parts thereof) to be vacated and any staffing deficiencies to be corrected (hereinafter in this section referred to as a "reduction plan").

[106] See Vol. II, P.L. 99–660, Title IV.

(b) As conditions of approval of any reduction plan submitted pursuant to subsection (a)(2), the State must—

(1) provide for a hearing to be held at the affected facility at least 35 days prior to submission of the reduction plan, with reasonable notice thereof to the staff and residents of the facility, responsible members of the residents' families, and the general public;

(2) demonstrate that the State has successfully provided home and community services similar to the services proposed to be provided under the reduction plan for similar individuals eligible for medical assistance; and

(3) provide assurances that the requirements of subsection (c) shall be met with respect to the reduction plan.

(c) The reduction plan must—

(1) identify the number and service needs of existing facility residents to be provided home or community services and the timetable for providing such services, in 6 month intervals, within the 36-month period;

(2) describe the methods to be used to select such residents for home and community services and to develop the alternative home and community services to meet their needs effectively;

(3) describe the necessary safeguards that will be applied to protect the health and welfare of the former residents of the facility who are to receive home or community services, including adequate standards for consumer and provider participation and assurances that applicable State licensure and applicable State and Federal certification requirements will be met in providing such home or community services;

(4) provide that residents of the affected facility who are eligible for medical assistance while in the facility shall, at their option, be placed in another setting (or another part of the affected facility) so as to retain their eligibility for medical assistance;

(5) specify the actions which will be taken to protect the health and safety of, and to provide active treatment for, the residents who remain in the affected facility while the reduction plan is in effect;

(6) provide that the ratio of qualified staff to residents at the affected facility (or the part thereof) which is subject to the reduction plan will be the higher of—

(A) the ratio which the Secretary determines is necessary in order to assure the health and safety of the residents of such facility (or part thereof); or

(B) the ratio which was in effect at the time that the finding of substantial deficiencies (referred to in subsection (a)) was made; and

(7) provide for the protection of the interests of employees affected by actions under the reduction plan, including—

(A) arrangements to preserve employee rights and benefits;

(B) training and retraining of such employees where necessary;

(C) redeployment of such employees to community settings under the reduction plan; and

(D) making maximum efforts to guarantee the employment of such employees (but this requirement shall not be construed to guarantee the employment of any employee).

(d)(1) The Secretary must provide for a period of not less than 30 days after the submission of a reduction plan by a State, during which comments on such reduction plan may be submitted to the Secretary, before the Secretary approves or disapproves such reduction plan.

(2) If the Secretary approves more than 15 reduction plans under this section in any fiscal year, any reduction plans approved in addition to the first 15 such plans approved, must be for a facility (or part thereof) for which the costs of correcting the substantial deficiencies (referred to in subsection (a)) are $2,000,000 or greater (as demonstrated by the State to the satisfaction of the Secretary).

(e)(1) If the Secretary, at the conclusion of the 6-month plan of correction described in subsection (a)(1), determines that the State has substantially failed to correct the deficiencies described in subsection (a), the Secretary may terminate the facility's provider agreement in accordance with the provisions of section 1910(b).

(2) In the case of a reduction plan described in subsection (a)(2), if the Secretary determines, at the conclusion of the initial 6-month period or any 6-month interval thereafter, that the State has substantially failed to meet the requirements of subsection (c), the Secretary shall—

(A) terminate the facility's provider agreement in accordance with the provisions of section 1910(b); or

(B) if the State has failed to meet such requirements despite good faith efforts, disallow, for purposes of Federal financial participation, an amount equal to 5 percent of the cost of care for all eligible individuals in the facility for each month for which the State fails to meet such requirements.

(f) The provisions of this section shall apply only to plans of correction and reduction plans approved by the Secretary by January 1, 1990.

ADJUSTMENT IN PAYMENT FOR INPATIENT HOSPITAL SERVICES FURNISHED BY DISPROPORTIONATE SHARE HOSPITALS[107]

SEC. 1923. [42 U.S.C. 1396r–4] (a) IMPLEMENTATION OF REQUIREMENT.—

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

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

[107] See Vol. II, P.L. 106–554, §1(a)(6)[701(c)], with respect to the application of the Medicaid DSH transition rule to public hospitals in all States; see §1(a)(6)[701(d)], with respect to assistance for certain public hospitals; and §1(a)(6)[701(e)], with respect to DSH payment accountability standards.

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

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

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

(C) If a State plan under this title provides for payments for inpatient hospital services on a prospective basis (whether per diem, per case, or otherwise), in order for the plan to be considered to have met such requirement of section 1902(a)(13)(A) as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, a State plan amendment that provides, in the case of hospitals defined by the State as disproportionate share hospitals under paragraph (1)(A), for an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1989, involving exceptionally high costs or exceptionally long lengths of stay for individuals under one year of age.

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

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

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

(b) HOSPITALS DEEMED DISPROPORTIONATE SHARE.—

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

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

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

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

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

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

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

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

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

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

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

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

(4) The Secretary may not restrict a State's authority to designate hospitals as disproportionate share hospitals under this section. The previous sentence shall not be construed to affect

the authority of the Secretary to reduce payments pursuant to section 1903(w)(1)(A)(iii) if the Secretary determines that, as a result of such designations, there is in effect a hold harmless provision described in section 1903(w)(4).

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

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

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

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

(A) applies equally to all hospitals of each type; and

(B) results in an adjustment for each type of hospital that is reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under a State plan approved under this title or to low-income patients,

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

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

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

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

(i) the inpatients of which are predominantly individuals under 18 years of age; or

(ii) which does not offer nonemergency obstetric services to the general population as of the date of the enactment of this Act [108].

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

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

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

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

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

[108] December 22, 1987, ("this Act" refers to P.L. 100–203).

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

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

(D) subsection (g) shall apply.

(f) LIMITATION ON FEDERAL FINANCIAL PARTICIPATION.—

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

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

State or District	DSH Allotment (in millions of dollars)				
	FY 98	FY 99	FY 00	FY 01	FY 02
Alabama	293	269	248	246	246
Alaska	10	10	10	9	9
Arizona	81	81	81	81	81
Arkansas	2	2	2	2	2
California	1,085	1,086	986	931	877
Colorado	93	85	79	74	74
Connecticut	200	194	184	160	160
Delaware	4	4	4	4	4
District of Columbia	23	23	32	32	32
Florida	207	203	197	185	160
Georgia	253	248	241	228	215
Hawaii	0	0	0	0	0
Idaho	1	1	1	1	1
Illinois	203	199	193	182	172
Indiana	2-4	197	191	181	171
Iowa	8	8	8	8	8
Kansas	51	49	42	36	33
Louisiana	880	795	713	658	631
Maine	103	99	84	84	84
Maryland	72	70	68	64	61
Massachusetts	288	282	273	259	244
Michigan	249	244	237	224	212
Minnesota	18	16	33	33	33
Mississippi	143	141	136	129	1 22
Missouri	436	423	379	379	379
Montana	0.2	0.2	0.2	0.2	0.2
Nebraska	5	5	5	5	5
Nevada	37	37	37	37	37
New Hampshire	140	136	130	130	130
New Jersey	600	582	515	515	515
New Mexico	5	5	9	9	9
New York	1,512	1,482	1,436	1,361	1,285
North Carolina	278	272	264	250	236
North Dakota	1	1	1	1	1
Ohio	382	274	363	344	325
Oklahoma	16	16	16	16	16
Oregon	20	20	20	20	20
Pennsylvania	629	518	502	476	440
Rhode Island	62	60	58	55	52
South Carolina	313	303	262	262	262
South Dakota	1	1	1	1	1
Tennessee	0	0	0	0	0
Texas	979	950	806	765	765
Utah	3	3	3	3	3
Vermont	18	18	18	18	18
Virginia	70	68	58	55	52

State or District	DSH Allotment (in millions of dollars)				
	FY 98	FY 99	FY 00	FY 01	FY 02
Washington	174	171	165	157	14 8
West Virginia	64	83	61	58	54
Wisconsin	7	7	7	7	7
Wyoming	0	0	1	1	1

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

(A) IN GENERAL.—Except as provided in paragraph (6), the DSH[109] allotment for any State for fiscal year 2003 and each succeeding fiscal year is equal to the DSH allotment for the State for the preceding fiscal year under paragraph (2) or this paragraph, increased, subject to subparagraphs (B) and (C)[110] paragraph (5), by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average), for the previous fiscal year.

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

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

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

(C)[111] SPECIAL, TEMPORARY INCREASE IN ALLOTMENTS ON A ONE-TIME, NON-CUMULATIVE BASIS.—The DSH allotment for any State (other than a State with a DSH allotment determined under paragraph (5))—

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

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

(D) FISCAL YEAR SPECIFIED.—For purposes of subparagraph (C)(ii), the fiscal year specified in this subparagraph for a State is the first fiscal year for which the Secretary estimates that the DSH allotment for that State will equal (or no longer exceed) the DSH allotment for that State under the law as in effect before the date of the enactment of this subparagraph.[112]

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

[109] P.L. 108-173, §1001(c)(1), struck out "The DSH" and substituted "Except as provided in paragraph (6), the DSH", effective December 8, 2003.

[110] P.L. 108-173, §1001(a)(1), struck out "subparagraph (B)" and substituted "subparagraphs (B) and (C)".

[111] P.L. 108-173, §1002(a)(2), added subparagraph (C), effective December 8, 2003.

[112] P.L. 108-173, §1001(a)(2), added subparagraph (D), effective December 8, 2003.

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

(i) fiscal year 2001, shall be the DSH allotment determined under paragraph (2) for fiscal year 2000 increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average) for fiscal year 2000; and

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

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

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

(5) SPECIAL RULE FOR [113]LOW DSH STATES.—

(A) FOR FISCAL YEARS 2001 THROUGH 2003 FOR EXTREMELY LOW DSH STATES.—In the case of[114] a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 1999, as reported to the Administrator of the Health Care Financing Administration as of August 31, 2000, is greater than 0 but less than 1 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for fiscal year 2001 shall be increased to 1 percent of the State's total amount of expenditures under such plan for such assistance during such fiscal year. In subsequent fiscal years before fiscal year 2004[115], such increased allotment is subject to an increase for inflation as provided in paragraph (3)(A).

(B)[116] For fiscal year 2004 and subsequent fiscal years.—In the case of a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 2000, as reported to the Administrator of the Centers for Medicare and Medicaid Services as of August 31, 2003, is greater than 0 but less than 3 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for the State with respect to—

(i) fiscal year 2004 shall be the DSH allotment for the State for fiscal year 2003 increased by 16 percent;

[113] P.L. 108-173, §1001(b)(1), struck out "EXTREMELY", effective December 8, 2003.

[114] P.L. 108-173, §1001(b)(2), struck out "In the case of" and substituted "(A) For fiscal years 2001 through 2003 for extremely low DSH states.—In the case of", effective December 8, 2003.

[115] P.L. 108-173, §1001(b)(3), inserted "before fiscal year 2004", effective December 8, 2003.

[116] P.L. 108-173, §1001(b)(4), added subparagraph (B), effective December 8, 2003.

(ii) each succeeding fiscal year before fiscal year 2009 shall be the DSH allotment for the State for the previous fiscal year increased by 16 percent; and

(iii) fiscal year 2009 and any subsequent fiscal year, shall be the DSH allotment for the State for the previous year subject to an increase for inflation as provided in paragraph (3)(A).

(6)[117] ALLOTMENT ADJUSTMENT.—Only with respect to fiscal year 2004 or 2005, if a statewide waiver under section 1115 is revoked or terminated before the end of either such fiscal year and there is no DSH allotment for the State, the Secretary shall—

(A) permit the State whose waiver was revoked or terminated to submit an amendment to its State plan that would describe the methodology to be used by the State (after the effective date of such revocation or termination) to identify and make payments to disproportionate share hospitals, including children's hospitals and institutions for mental diseases or other mental health facilities (other than State-owned institutions or facilities), on the basis of the proportion of patients served by such hospitals that are low-income patients with special needs; and

(B) provide for purposes of this subsection for computation of an appropriate DSH allotment for the State for fiscal year 2004 or 2005 (or both) that would not exceed the amount allowed under paragraph (3)(B)(ii) and that does not result in greater expenditures under this title than would have been made if such waiver had not been revoked or terminated.

In determining the amount of an appropriate DSH allotment under subparagraph (B) for a State, the Secretary shall take into account the level of DSH expenditures for the State for the fiscal year preceding the fiscal year in which the waiver commenced.

(7)[118] DEFINITION OF STATE.—In this subsection, the term State" means the 50 States and the District of Columbia.

(g) LIMIT ON AMOUNT OF PAYMENT TO HOSPITAL.—

(1) AMOUNT OF ADJUSTMENT SUBJECT TO UNCOMPENSATED COSTS.—

(A) IN GENERAL.—A payment adjustment during a fiscal year shall not be considered to be consistent with subsection (c) with respect to a hospital if the payment adjustment exceeds the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year. For purposes of the preceding sentence, payments made to a hospital for services provided to indigent patients made by a State or a unit of local government with-

[117] P.L. 108-173, §1001(c)(3), added this paragraph (6), effective December 8, 2003.
[118] P.L. 108-173, §1001(c)(2), redesignated the former paragraph (6) as paragraph (7).

in a State shall not be considered to be a source of third party payment.

(B) LIMIT TO PUBLIC HOSPITALS DURING TRANSITION PERIOD.—With respect to payment adjustments during a State fiscal year that begins before January 1, 1995, subparagraph (A) shall apply only to hospitals owned or operated by a State (or by an instrumentality or a unit of government within a State).

(C) MODIFICATIONS FOR PRIVATE HOSPITALS.—With respect to hospitals that are not owned or operated by a State (or by an instrumentality or a unit of government within a State), the Secretary may make such modifications to the manner in which the limitation on payment adjustments is applied to such hospitals as the Secretary considers appropriate.

(2) ADDITIONAL AMOUNT DURING TRANSITION PERIOD FOR CERTAIN HOSPITALS WITH HIGH DISPROPORTIONATE SHARE.—

(A) IN GENERAL.—In the case of a hospital with high disproportionate share (as defined in subparagraph (B)), a payment adjustment during a State fiscal year that begins before January 1, 1995, shall be considered consistent with subsection (c) if the payment adjustment does not exceed 200 percent of the costs of furnishing hospital services described in paragraph (1)(A) during the year, but only if the Governor of the State certifies to the satisfaction of the Secretary that the hospital's applicable minimum amount is used for health services during the year. In determining the amount that is used for such services during a year, there shall be excluded any amounts received under the Public Health Service Act[119], title V, title XVIII, or from third party payors (not including the State plan under this title) that are used for providing such services during the year.

(B) HOSPITALS WITH HIGH DISPROPORTIONATE SHARE DEFINED.—In subparagraph (A), a hospital is a "hospital with high disproportionate share" if—

(i) the hospital is owned or operated by a State (or by an instrumentality or a unit of government within a State); and

(ii) the hospital—

(I) meets the requirement described in subsection (b)(1)(A), or

(II) has the largest number of inpatient days attributable to individuals entitled to benefits under the State plan of any hospital in such State for the previous State fiscal year.

(C) APPLICABLE MINIMUM AMOUNT DEFINED.—In subparagraph (A), the "applicable minimum amount" for a hospital for a fiscal year is equal to the difference between the amount of the hospital's payment adjustment for the fiscal year and the costs to the hospital of furnishing hospital services described in paragraph (1)(A) during the fiscal year.

[119] P.L. 78–410.

(h) LIMITATION ON CERTAIN STATE DSH EXPENDITURES.—

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

(A) 1995 IMD DSH PAYMENT ADJUSTMENTS.—The total State DSH expenditures that are attributable to fiscal year 1995 for payments to institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH, and as approved by the Secretary).

(B) APPLICABLE PERCENTAGE OF 1995 TOTAL DSH PAYMENT ALLOTMENT.—The amount of such payment adjustments which are equal to the applicable percentage of the Federal share of payment adjustments made to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for the State for payments to institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH, and as approved by the Secretary).

(2) APPLICABLE PERCENTAGE.—

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

(i) each of fiscal years 1998, 1999, and 2000, is the percentage determined under subparagraph (B); or

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

(I) For fiscal year 2001, 50 percent.

(II) For fiscal year 2002, 40 percent.

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

(B) 1995 PERCENTAGE.—The percentage determined under this subparagraph is the ratio (determined as a percentage) of—

(i) the Federal share of payment adjustments made to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for the State (as reported by the State not later than January 1, 1997, on HCFA Form 64, and as approved by the Secretary) for payments to institutions for mental diseases and other mental health facilities, to

(ii) the State 1995 DSH spending amount.

(C) STATE 1995 DSH SPENDING AMOUNT.—For purposes of subparagraph (B)(ii), the "State 1995 DSH spending a mount", with respect to a State, is the Federal medical assistance percentage (for fiscal year 1995) of the payment adjustments made under subsection (c) under the State plan that are attributable to the fiscal year 1995 DSH allotment for the State (as reported by the State not later than January 1, 1997, on HCFA Form 64, and as approved by the Secretary).

(i) REQUIREMENT FOR DIRECT PAYMENT.—

(1) IN GENERAL.—No payment may be made under section 1903(a)(1) with respect to a payment adjustment made under this section, for services furnished by a hospital on or after October 1, 1997, with respect to individuals eligible for medical assistance under the State plan who are enrolled with a managed care entity (as defined in section 1932(a)(1)(B)) or under any other managed care arrangement unless a payment, equal to the amount of the payment adjustment—

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

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

(2) EXCEPTION FOR CURRENT ARRANGEMENTS.—Paragraph (1) shall not apply to a payment adjustment provided pursuant to a payment arrangement in effect on July 1, 1997.

(j)[120] ANNUAL REPORTS AND OTHER REQUIREMENTS REGARDING PAYMENT ADJUSTMENTS.—With respect to fiscal year 2004 and each fiscal year thereafter, the Secretary shall require a State, as a condition of receiving a payment under section 1903(a)(1) with respect to a payment adjustment made under this section, to do the following:

(1) REPORT.—The State shall submit an annual report that includes the following

(A) An identification of each disproportionate share hospital that received a payment adjustment under this section for the preceding fiscal year and the amount of the payment adjustment made to such hospital for the preceding fiscal year.

(B) Such other information as the Secretary determines necessary to ensure the appropriateness of the payment adjustments made under this section for the preceding fiscal year.

(2) INDEPENDENT CERTIFIED AUDIT—The State shall annually submit to the Secretary an independent certified audit that verifies each of the following:

(A) The extent to which hospitals in the State have reduced their uncompensated care costs to reflect the total amount of claimed expenditures made under this section.

(B) Payments under this section to hospitals that comply with the requirements of subsection (g).

(C) Only the uncompensated care costs of providing inpatient hospital and outpatient hospital services to individuals described in paragraph (1)(A) of such subsection are included in the calculation of the hospital-specific limits under such subsection.

(D) The State included all payments under this title, including supplemental payments, in the calculation of such hospital-specific limits.

(E) The State has separately documented and retained a record of all of its costs under this title, claimed expenditures under this title, uninsured costs in determining payment adjustments under this section, and any payments

[120] P.L. 108-173, §1001(d), added subsection (j), effective December 8, 2003.

made on behalf of the uninsured from payment adjustments under this section.

TREATMENT OF INCOME AND RESOURCES FOR CERTAIN INSTITUTIONALIZED SPOUSES

SEC. 1924. [42 U.S.C. 1396r–5] (a) Special Treatment for Institutionalized Spouses.—

(1) SUPERSEDES OTHER PROVISIONS.—In determining the eligibility for medical assistance of an institutionalized spouse (as defined in subsection (h)(1)), the provisions of this section supersede any other provision of this title (including sections 1902(a)(17) and 1902(f)) which is inconsistent with them.

(2) NO COMPARABLE TREATMENT REQUIRED.—Any different treatment provided under this section for institutionalized spouses shall not, by reason of paragraph (10) or (17) of section 1902(a), require such treatment for other individuals.

(3) DOES NOT AFFECT CERTAIN DETERMINATIONS.—Except as this section specifically provides, this section does not apply to—

(A) the determination of what constitutes income or resources, or

(B) the methodology and standards for determining and evaluating income and resources.

(4) APPLICATION IN CERTAIN STATES AND TERRITORIES.—

(A) APPLICATION IN STATES OPERATING UNDER DEMONSTRATION PROJECTS.—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 meet the requirements of this section in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title.

(B) NO APPLICATION IN COMMONWEALTHS AND TERRITORIES.—This section shall only apply to a State that is one of the 50 States or the District of Columbia.

(5) APPLICATION TO INDIVIDUALS RECEIVING SERVICES UNDER PACE PROGRAMS.—This section applies to individuals receiving institutional or noninstitutional services under a PACE demonstration waiver program (as defined in section 1934(a)(7)) or under a PACE program under section 1934 or 1894.

(b) RULES FOR TREATMENT OF INCOME.—

(1) SEPARATE TREATMENT OF INCOME.—During any month in which an institutionalized spouse is in the institution, except as provided in paragraph (2), no income of the community spouse shall be deemed available to the institutionalized spouse.

(2) ATTRIBUTION OF INCOME.—In determining the income of an institutionalized spouse or community spouse for purposes of the post-eligibility income determination described in subsection (d), except as otherwise provided in this section and regardless of any State laws relating to community property or the division of marital property, the following rules apply:

(A) NON-TRUST PROPERTY.—Subject to subparagraphs (C) and (D), in the case of income not from a trust, unless the instrument providing the income otherwise specifically provides—

(i) if payment of income is made solely in the name of the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

(ii) if payment of income is made in the names of the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

(iii) if payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

(B) TRUST PROPERTY.—In the case of a trust—

(i) except as provided in clause (ii), income shall be attributed in accordance with the provisions of this title (including sections 1902(a)(17) and 1917(d)), and

(ii) income shall be considered available to each spouse as provided in the trust, or, in the absence of a specific provision in the trust—

(I) if payment of income is made solely to the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

(II) if payment of income is made to both the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

(III) if payment of income is made to the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

(C) Property with no instrument.—In the case of income not from a trust in which there is no instrument establishing ownership, subject to subparagraph (D), one-half of the income shall be considered to be available to the institutionalized spouse and one-half to the community spouse.

(D) REBUTTING OWNERSHIP.—The rules of subparagraphs (A) and (C) are superseded to the extent that an institutionalized spouse can establish, by a preponderance of the evidence, that the ownership interests in income are other than as provided under such subparagraphs.

(c) RULES FOR TREATMENT OF RESOURCES.—

(1) COMPUTATION OF SPOUSAL SHARE AT TIME OF INSTITUTIONALIZATION.—

(A) TOTAL JOINT RESOURCES.—There shall be computed (as of the beginning of the first continuous period of insti-

tutionalization (beginning on or after September 30, 1989) of the institutionalized spouse)—

(i) the total value of the resources to the extent either the institutionalized spouse or the community spouse has an ownership interest, and

(ii) a spousal share which is equal to ½ of such total value.

(B) ASSESSMENT.—At the request of an institutionalized spouse or community spouse, at the beginning of the first continuous period of institutionalization (beginning on or after September 30, 1989) of the institutionalized spouse and upon the receipt of relevant documentation of resources, the State shall promptly assess and document the total value described in subparagraph (A)(i) and shall provide a copy of such assessment and documentation to each spouse and shall retain a copy of the assessment for use under this section. If the request is not part of an application for medical assistance under this title, the State may, at its option as a condition of providing the assessment, require payment of a fee not exceeding the reasonable expenses of providing and documenting the assessment. At the time of providing the copy of the assessment, the State shall include a notice indicating that the spouse will have a right to a fair hearing under subsection (e)(2).

(2) ATTRIBUTION OF RESOURCES AT TIME OF INITIAL ELIGIBILITY DETERMINATION.—In determining the resources of an institutionalized spouse at the time of application for benefits under this title, regardless of any State laws relating to community property or the division of marital property—

(A) except as provided in subparagraph (B), all the resources held by either the institutionalized spouse, community spouse, or both, shall be considered to be available to the institutionalized spouse, and

(B) resources shall be considered to be available to an institutionalized spouse, but only to the extent that the amount of such resources exceeds the amount computed under subsection (f)(2)(A) (as of the time of application for benefits).

(3) ASSIGNMENT OF SUPPORT RIGHTS.—The institutionalized spouse shall not be ineligible by reason of resources determined under paragraph (2) to be available for the cost of care where—

(A) the institutionalized spouse has assigned to the State any rights to support from the community spouse;

(B) the institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment but the State has the right to bring a support proceeding against a community spouse without such assignment; or

(C) the State determines that denial of eligibility would work an undue hardship.

(4) Separate treatment of resources after eligibility for benefits established.—During the continuous period in which an institutionalized spouse is in an institution and after the month in which an institutionalized spouse is determined to be eligible for benefits under this title, no resources of the community

spouse shall be deemed available to the institutionalized spouse.

(5) RESOURCES DEFINED.—In this section, the term "resources" does not include—

(A) resources excluded under subsection (a) or (d) of section 1613, and

(B) resources that would be excluded under section 1613(a)(2)(A) but for the limitation on total value described in such section.

(d) PROTECTING INCOME FOR COMMUNITY SPOUSE.—

(1) ALLOWANCES TO BE OFFSET FROM INCOME OF INSTITUTIONALIZED SPOUSE.—After an institutionalized spouse is determined or redetermined to be eligible for medical assistance, in determining the amount of the spouse's income that is to be applied monthly to payment for the costs of care in the institution, there shall be deducted from the spouse's monthly income the following amounts in the following order:

(A) A personal needs allowance (described in section 1902(q)(1)), in an amount not less than the amount specified in section 1902(q)(2).

(B) A community spouse monthly income allowance (as defined in paragraph (2)), but only to the extent income of the institutionalized spouse is made available to (or for the benefit of) the community spouse.

(C) A family allowance, for each family member, equal to at least ⅓ of the amount by which the amount described in paragraph (3)(A)(i) exceeds the amount of the monthly income of that family member.

(D) Amounts for incurred expenses for medical or remedial care for the institutionalized spouse (as provided under section 1902(r)).

In subparagraph (C), the term "family member" only includes minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse.

(2) Community spouse monthly income allowance defined.—In this section (except as provided in paragraph (5)), the "community spouse monthly income allowance" for a community spouse is an amount by which—

(A) except as provided in subsection (e), the minimum monthly maintenance needs allowance (established under and in accordance with paragraph (3)) for the spouse, exceeds

(B) the amount of monthly income otherwise available to the community spouse (determined without regard to such an allowance).

(3) ESTABLISHMENT OF MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—

(A) IN GENERAL.—Each State shall establish a minimum monthly maintenance needs allowance for each community spouse which, subject to subparagraph (C), is equal to or exceeds—

(i) the applicable percent (described in subparagraph (B)) of 1/12 of the income official poverty line (defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Om-

nibus Budget Reconciliation Act of 1981[121]) for a family unit of 2 members; plus

(ii) an excess shelter allowance (as defined in paragraph (4)).

A revision of the official poverty line referred to in clause (i) shall apply to medical assistance furnished during and after the second calendar quarter that begins after the date of publication of the revision.

(B) Applicable percent.—For purposes of subparagraph (A)(i), the "applicable percent" described in this paragraph, effective as of—

(i) September 30, 1989, is 122 percent,

(ii) July 1, 1991, is 133 percent, and

(iii) July 1, 1992, is 150 percent.

(C) CAP ON MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—The minimum monthly maintenance needs allowance established under subparagraph (A) may not exceed $1,500 (subject to adjustment under subsections (e) and (g)).

(4) EXCESS SHELTER ALLOWANCE DEFINED.—In paragraph (3)(A)(ii), the term "excess shelter allowance" means, for a community spouse, the amount by which the sum of—

(A) the spouse's expenses for rent or mortgage payment (including principal and interest), taxes and insurance and, in the case of a condominium or cooperative, required maintenance charge, for the community spouse's principal residence, and

(B) the standard utility allowance (used by the State under section 5(e) of the Food Stamp Act of 1977[122]) or, if the State does not use such an allowance, the spouse's actual utility expenses,

exceeds 30 percent of the amount described in paragraph (3)(A)(i), except that, in the case of a condominium or cooperative, for which a maintenance charge is included under subparagraph (A), any allowance under subparagraph (B) shall be reduced to the extent the maintenance charge includes utility expenses.

(5) Court ordered support.—If a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance for the spouse shall be not less than the amount of the monthly income so ordered.

(e) NOTICE AND FAIR HEARING.—

(1) NOTICE.—Upon—

(A) a determination of eligibility for medical assistance of an institutionalized spouse, or

(B) a request by either the institutionalized spouse, or the community spouse, or a representative acting on behalf of either spouse,

each State shall notify both spouses (in the case described in subparagraph (A)) or the spouse making the request (in the case described in subparagraph (B)) of the amount of the community spouse monthly income allowance (described in sub-

[121] See Vol. II, P.L. 97–35, §673(2).
[122] See Vol. II, P.L. 88–525.

section (d)(1)(B)), of the amount of any family allowances (described in subsection (d)(1)(C)), of the method for computing the amount of the community spouse resources allowance permitted under subsection (f), and of the spouse's right to a fair hearing under this subsection respecting ownership or availability of income or resources, and the determination of the community spouse monthly income or resource allowance.

(2) Fair hearing.—

(A) IN GENERAL.—If either the institutionalized spouse or the community spouse is dissatisfied with a determination of—

(i) the community spouse monthly income allowance;

(ii) the amount of monthly income otherwise available to the community spouse (as applied under subsection (d)(2)(B));

(iii) the computation of the spousal share of resources under subsection (c)(1);

(iv) the attribution of resources under subsection (c)(2); or

(v) the determination of the community spouse resource allowance (as defined in subsection (f)(2));

such spouse is entitled to a fair hearing described in section 1902(a)(3) with respect to such determination if an application for benefits under this title has been made on behalf of the institutionalized spouse. Any such hearing respecting the determination of the community spouse resource allowance shall be held within 30 days of the date of the request for the hearing.

(B) Revision of minimum monthly maintenance needs allowance.—If either such spouse establishes that the community spouse needs income, above the level otherwise provided by the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, there shall be substituted, for the minimum monthly maintenance needs allowance in subsection (d)(2)(A), an amount adequate to provide such additional income as is necessary.

(C) REVISION OF COMMUNITY SPOUSE RESOURCE ALLOWANCE.—If either such spouse establishes that the community spouse resource allowance (in relation to the amount of income generated by such an allowance) is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, there shall be substituted, for the community spouse resource allowance under subsection (f)(2), an amount adequate to provide such a minimum monthly maintenance needs allowance.

(f) PERMITTING TRANSFER OF RESOURCES TO COMMUNITY SPOUSE.—

(1) IN GENERAL.—An institutionalized spouse may, without regard to section 1917(c)(1), transfer an amount equal to the community spouse resource allowance (as defined in paragraph (2)), but only to the extent the resources of the institutionalized spouse are transferred to (or for the sole benefit of) the community spouse. The transfer under the preceding sentence shall be made as soon as practicable after the date of the initial determination of eligibility, taking into account such time

as may be necessary to obtain a court order under paragraph (3).

(2) COMMUNITY SPOUSE RESOURCE ALLOWANCE DEFINED.—In paragraph (1), the "community spouse resource allowance" for a community spouse is an amount (if any) by which—

(A) the greatest of—

(i) $12,000 (subject to adjustment under subsection (g)), or, if greater (but not to exceed the amount specified in clause (ii)(II)) an amount specified under the State plan,

(ii) the lesser of (I) the spousal share computed under subsection (c)(1), or (II) $60,000 (subject to adjustment under subsection (g)),

(iii) the amount established under subsection (e)(2); or

(iv) the amount transferred under a court order under paragraph (3);

exceeds

(B) the amount of the resources otherwise available to the community spouse (determined without regard to such an allowance).

(3) Transfers under court orders.—If a court has entered an order against an institutionalized spouse for the support of the community spouse, section 1917 shall not apply to amounts of resources transferred pursuant to such order for the support of the spouse or a family member (as defined in subsection (d)(1)).

(g) INDEXING DOLLAR AMOUNTS.—For services furnished during a calendar year after 1989, the dollar amounts specified in subsections (d)(3)(C), (f)(2)(A)(i), and (f)(2)(A)(ii)(II) shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) between September 1988 and the September before the calendar year involved.

(h) DEFINITIONS.—In this section:

(1) The term "institutionalized spouse" means an individual who—

(A) is in a medical institution or nursing facility or who (at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI), and

(B) is married to a spouse who is not in a medical institution or nursing facility;

but does not include any such individual who is not likely to meet the requirements of subparagraph (A) for at least 30 consecutive days.

(2) The term "community spouse" means the spouse of an institutionalized spouse.

EXTENSION OF ELIGIBILITY FOR MEDICAL ASSISTANCE [123]

SEC. 1925. [42 U.S.C. 1396r–6] (a) INITIAL 6-MONTH EXTENSION.—

(1) REQUIREMENT.—Notwithstanding any other provision of this title, each State plan approved under this title must provide that each family which was receiving aid pursuant to a

[123] See Vol. II, P.L. 108–89, §101(a), P.L. 108-262, §2, P.L. 108-308, §2, with respect to an extension of the temporary assistance for needy families block grant program.

plan of the State approved under part A of title IV in at least 3 of the 6 months immediately preceding the month in which such family becomes ineligible for such aid, because of hours of, or income from, employment of the caretaker relative (as defined in subsection (e)) or because of section 402(a)(8)(B)(ii)(II) (providing for a time-limited earned income disregard), shall, subject to paragraph (3) and without any reapplication for benefits under the plan, remain eligible for assistance under the plan approved under this title during the immediately succeeding 6-month period in accordance with this subsection.

(2) NOTICE OF BENEFITS.—Each State, in the notice of termination of aid under part A of title IV sent to a family meeting the requirements of paragraph (1)—

(A) shall notify the family of its right to extended medical assistance under this subsection and include in the notice a description of the reporting requirement of subsection (b)(2)(B)(i) and of the circumstances (described in paragraph (3)) under which such extension may be terminated; and

(B) shall include a card or other evidence of the family's entitlement to assistance under this title for the period provided in this subsection.

(3) TERMINATION OF EXTENSION.—

(A) NO DEPENDENT CHILD.—Subject to subparagraphs (B) and (C), extension of assistance during the 6-month period described in paragraph (1) to a family shall terminate (during such period) at the close of the first month in which the family ceases to include a child, whether or not the child is (or would if needy be) a dependent child under part A of title IV.

(B) Notice before termination.—No termination of assistance shall become effective under subparagraph (A) until the State has provided the family with notice of the grounds for the termination.

(C) CONTINUATION IN CERTAIN CASES UNTIL REDETERMINATION.—With respect to a child who would cease to receive medical assistance because of subparagraph (A) but who may be eligible for assistance under the State plan because the child is described in clause (i) of section 1905(a) or clause (i)(IV), (i)(VI), (i)(VII), or (ii)(IX) of section 1902(a)(10)(A), the State may not discontinue such assistance under such subparagraph until the State has determined that the child is not eligible for assistance under the plan.

(4) SCOPE OF COVERAGE.—

(A) In general.—Subject to subparagraph (B), during the 6-month extension period under this subsection, the amount, duration, and scope of medical assistance made available with respect to a family shall be the same as if the family were still receiving aid under the plan approved under part A of title IV.

(B) STATE MEDICAID "WRAP-AROUND" OPTION.—A State, at its option, may pay a family's expenses for premiums, deductibles, coinsurance, and similar costs for health insurance or other health coverage offered by an employer of

the caretaker relative or by an employer of the absent parent of a dependent child. In the case of such coverage offered by an employer of the caretaker relative—

(i) the State may require the caretaker relative, as a condition of extension of coverage under this subsection for the caretaker and the caretaker's family, to make application for such employer coverage, but only if—

(I) the caretaker relative is not required to make financial contributions for such coverage (whether through payroll deduction, payment of deductibles, coinsurance, or similar costs, or otherwise), and

(II) the State provides, directly or otherwise, for payment of any of the premium amount, deductible, coinsurance, or similar expense that the employee is otherwise required to pay; and

(ii) the State shall treat the coverage under such an employer plan as a third party liability (under section 1902(a)(25)).

Payments for premiums, deductibles, coinsurance, and similar expenses under this subparagraph shall be considered, for purposes of section 1903(a), to be payments for medical assistance.

(b) ADDITIONAL 6-MONTH EXTENSION.—

(1) REQUIREMENT.—Notwithstanding any other provision of this title, each State plan approved under this title shall provide that the State shall offer to each family, which has received assistance during the entire 6-month period under subsection (a) and which meets the requirement of paragraph (2)(B)(i), in the last month of the period the option of extending coverage under this subsection for the succeeding 6-month period, subject to paragraph (3).

(2) Notice and reporting requirements.—

(A) Notices.—

(i) NOTICE DURING INITIAL EXTENSION PERIOD OF OPTION AND REQUIREMENTS.—Each State, during the 3rd and 6th month of any extended assistance furnished to a family under subsection (a), shall notify the family of the family's option for additional extended assistance under this subsection. Each such notice shall include (I) in the 3rd month notice, a statement of the reporting requirement under subparagraph (B)(i), and, in the 6th month notice, a statement of the reporting requirement under subparagraph (B)(ii), (II) a statement as to whether any premiums are required for such additional extended assistance, and (III) a description of other out-of-pocket expenses, benefits, reporting and payment procedures, and any pre-existing condition limitations, waiting periods, or other coverage limitations imposed under any alternative coverage options offered under paragraph (4)(D). The 6th month notice under this subparagraph shall describe the amount of any premium required of a particular family for each of the first 3 months of additional extended assistance under this subsection.

(ii) NOTICE DURING ADDITIONAL EXTENSION PERIOD OF REPORTING REQUIREMENTS AND PREMIUMS.—Each State, during the 3rd month of any additional extended assistance furnished to a family under this subsection, shall notify the family of the reporting requirement under subparagraph (B)(ii) and a statement of the amount of any premium required for such extended assistance for the succeeding 3 months.

(B) Reporting requirements.—

(i) DURING INITIAL EXTENSION PERIOD.—Each State shall require (as a condition for additional extended assistance under this subsection) that a family receiving extended assistance under subsection (a) report to the State, not later than the 21st day of the 4th month in the period of extended assistance under subsection (a), on the family's gross monthly earnings and on the family's costs for such child care as is necessary for the employment of the caretaker relative in each of the first 3 months of that period. A State may permit such additional extended assistance under this subsection notwithstanding a failure to report under this clause if the family has established, to the satisfaction of the State, good cause for the failure to report on a timely basis.

(ii) DURING ADDITIONAL EXTENSION PERIOD.—Each State shall require that a family receiving extended assistance under this subsection report to the State, not later than the 21st day of the 1st month and of the 4th month in the period of additional extended assistance under this subsection, on the family's gross monthly earnings and on the family's costs for such child care as is necessary for the employment of the caretaker relative in each of the 3 preceding months.

(iii) CLARIFICATION ON FREQUENCY OF REPORTING.—A State may not require that a family receiving extended assistance under this subsection or subsection (a) report more frequently than as required under clause (i) or (ii).

(3) TERMINATION OF EXTENSION.—

(A) In general.—Subject to subparagraphs (B) and (C), extension of assistance during the 6-month period described in paragraph (1) to a family shall terminate (during the period) as follows:

(i) NO DEPENDENT CHILD.—The extension shall terminate at the close of the first month in which the family ceases to include a child, whether or not the child is (or would if needy be) a dependent child under part A of title IV.

(ii) FAILURE TO PAY ANY PREMIUM.—If the family fails to pay any premium for a month under paragraph (5) by the 21st day of the following month, the extension shall terminate at the close of that following month, unless the family has established, to the satisfaction of the State, good cause for the failure to pay such premium on a timely basis.

(iii) QUARTERLY INCOME REPORTING AND TEST.—The extension under this subsection shall terminate at the close of the 1st or 4th month of the 6-month period if—

(I) the family fails to report to the State, by the 21st day of such month, the information required under paragraph (2)(B)(ii), unless the family has established, to the satisfaction of the State, good cause for the failure to report on a timely basis;

(II) the caretaker relative had no earnings in one or more of the previous 3 months, unless such lack of any earnings was due to an involuntary loss of employment, illness, or other good cause, established to the satisfaction of the State; or

(III) the State determines that the family's average gross monthly earnings (less such costs for such child care as is necessary for the employment of the caretaker relative) during the immediately preceding 3-month period exceed 185 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 [124]) applicable to a family of the size involved.

Information described in clause (iii)(I) shall be subject to the restrictions on use and disclosure of information provided under section 402(a)(9). Instead of terminating a family's extension under clause (iii)(I), a State, at its option, may provide for suspension of the extension until the month after the month in which the family reports information required under paragraph (2)(B)(ii), but only if the family's extension has not otherwise been terminated under subclause (II) or (III) of clause (iii). The State shall make determinations under clause (iii)(III) for a family each time a report under paragraph (2)(B)(ii) for the family is received.

(B) NOTICE BEFORE TERMINATION.—No termination of assistance shall become effective under subparagraph (A) until the State has provided the family with notice of the grounds for the termination, which notice shall include (in the case of termination under subparagraph (A)(iii)(II), relating to no continued earnings) a description of how the family may reestablish eligibility for medical assistance under the State plan. No such termination shall be effective earlier than 10 days after the date of mailing of such notice.

(C) CONTINUATION IN CERTAIN CASES UNTIL REDETERMINATION.—

(i) DEPENDENT CHILDREN.—With respect to a child who would cease to receive medical assistance because of subparagraph (A)(i) but who may be eligible for assistance under the State plan because the child is described in clause (i) of section 1905(a) or clause (i)(IV),

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

(i)(VI), (i)(VII), or (ii)(IX) of section 1902(a)(10)(A), the State may not discontinue such assistance under such subparagraph until the State has determined that the child is not eligible for assistance under the plan.

(ii) MEDICALLY NEEDY.—With respect to an individual who would cease to receive medical assistance because of clause (ii) or (iii) of subparagraph (A) but who may be eligible for assistance under the State plan because the individual is within a category of person for which medical assistance under the State plan is available under section 1902(a)(10)(C) (relating to medically needy individuals), the State may not discontinue such assistance under such subparagraph until the State has determined that the individual is not eligible for assistance under the plan.

(4) COVERAGE.—

(A) IN GENERAL.—During the extension period under this subsection—

(i) the State plan shall offer to each family medical assistance which (subject to subparagraphs (B) and (C)) is the same amount, duration, and scope as would be made available to the family if it were still receiving aid under the plan approved under part A of title IV; and

(ii) the State plan may offer alternative coverage described in subparagraph (D).

(B) Elimination of most non-acute care benefits.—At a State's option and notwithstanding any other provision of this title, a State may choose not to provide medical assistance under this subsection with respect to any (or all) of the items and services described in paragraphs (4)(A), (6), (7), (8), (11), (13), (14), (15), (16), (18), (20), and (21) of section 1905(a).

(C) State medicaid "wrap-around" option.—At a State's option, the State may elect to apply the option described in subsection (a)(4)(B) (relating to "wrap-around" coverage) for families electing medical assistance under this subsection in the same manner as such option applies to families provided extended eligibility for medical assistance under subsection (a).

(D) Alternative assistance.—At a State's option, the State may offer families a choice of health care coverage under one or more of the following, instead of the medical assistance otherwise made available under this subsection:

(i) Enrollment in family option of employer plan.—Enrollment of the caretaker relative and dependent children in a family option of the group health plan offered to the caretaker relative.

(ii) Enrollment in family option of State employee plan.—Enrollment of the caretaker relative and dependent children in a family option within the options of the group health plan or plans offered by the State to State employees.

(iii) Enrollment in state uninsured plan.—Enrollment of the caretaker relative and dependent children in a basic State health plan offered by the State to in-

dividuals in the State (or areas of the State) otherwise unable to obtain health insurance coverage.

(iv) ENROLLMENT IN MEDICAID MANAGED CARE ORGANIZATION.—Enrollment of the caretaker relative and dependent children in a medicaid managed care organization (as defined in section 1903(m)(1)(A)) and the applicable requirements of section 1932.

If a State elects to offer an option to enroll a family under this subparagraph, the State shall pay any premiums and other costs for such enrollment imposed on the family and may pay deductibles and coinsurance imposed on the family. A State's payment of premiums for the enrollment of families under this subparagraph (not including any premiums otherwise payable by an employer and less the amount of premiums collected from such families under paragraph (5)) and payment of any deductibles and coinsurance shall be considered, for purposes of section 1903(a)(1), to be payments for medical assistance.

(E) PROHIBITION ON COST-SHARING FOR MATERNITY AND PREVENTIVE PEDIATRIC CARE.—

(i) IN GENERAL.—If a State offers any alternative option under subparagraph (D) for families, under each such option the State must assure that care described in clause (ii) is available without charge to the families through—

(I) payment of any deductibles, coinsurance, and other cost-sharing respecting such care, or

(II) providing coverage under the State plan for such care without any cost-sharing,

or any combination of such mechanisms.

(ii) Care described.—The care described in this clause consists of—

(I) services related to pregnancy (including prenatal, delivery, and post partum services), and

(II) ambulatory preventive pediatric care (including ambulatory early and periodic screening, diagnosis, and treatment services under section 1905(a)(4)(B)) for each child who meets the age and date of birth requirements to be a qualified child under section 1905(n)(2).

(5) Premium.—

(A) PERMITTED.—Notwithstanding any other provision of this title (including section 1916), a State may impose a premium for a family for additional extended coverage under this subsection for a premium payment period (as defined in subparagraph (D)(i)), but only if the family's average gross monthly earnings (less the average monthly costs for such child care as is necessary for the employment of the caretaker relative) for the premium base period 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 [125]) applicable to a family of the size involved.

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

(B) LEVEL MAY VARY BY OPTION OFFERED.—The level of such premium may vary, for the same family, for each option offered by a State under paragraph (4)(D).

(C) Limit on premium.—In no case may the amount of any premium under this paragraph for a family for a month in either of the premium payment periods described in subparagraph (D)(i) exceed 3 percent of the family's average gross monthly earnings (less the average monthly costs for such child care as is necessary for the employment of the caretaker relative) during the premium base period (as defined in subparagraph (D)(ii)).

(D) Definitions.—In this paragraph:

(i) A "premium payment period" described in this clause is a 3-month period beginning with the 1st or 4th month of the 6-month additional extension period provided under this subsection.

(ii) The term "premium base period" means, with respect to a particular premium payment period, the period of 3 consecutive months the last of which is 4 months before the beginning of that premium payment period.

(c) Applicability in States and Territories.—

(1) States operating under demonstration projects.—In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115(a), the Secretary shall require the State to meet the requirements of this section in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title.

(2) Inapplicability in commonwealths and territories.—The provisions of this section shall only apply to the 50 States and the District of Columbia.

(d) General Disqualification for Fraud.—

(1) Ineligibility for aid.—This section shall not apply to an individual who is a member of a family which has received aid under part A of title IV if the State makes a finding that, at any time during the last 6 months in which the family was receiving such aid before otherwise being provided extended eligibility under this section, the individual was ineligible for such aid because of fraud.

(2) General disqualifications.—For additional provisions relating to fraud and program abuse, see sections 1128, 1128A, and 1128B.

(e) Caretaker Relative Defined.—In this section, the term "caretaker relative" has the meaning of such term as used in part A of title IV.

(f) SUNSET.—This section shall not apply with respect to families that cease to be eligible for aid under part A of title IV after September 30, 2003 [126].

[126] P.L. 108-40, §7(a), struck out "2002" and substituted "2003", effective July 1, 2003.

SEC. 1926. [Repealed.[127]]

PAYMENT FOR COVERED OUTPATIENT DRUGS

SEC. 1927. [42 U.S.C. 1396r–8] (a) Requirement for Rebate Agreement.—

(1) IN GENERAL.—In order for payment to be available under section 1903(a) or under part B of title XVIII[128] for covered outpatient drugs of a manufacturer, the manufacturer must have entered into and have in effect a rebate agreement described in subsection (b) with the Secretary, on behalf of States (except that, the Secretary may authorize a State to enter directly into agreements with a manufacturer), and must meet the requirements of paragraph (5) (with respect to drugs purchased by a covered entity on or after the first day of the first month that begins after the date of the enactment of title VI of the Veterans Health Care Act of 1992[129]) and paragraph (6). Any agreement between a State and a manufacturer prior to April 1, 1991, shall be deemed to have been entered into on January 1, 1991, and payment to such manufacturer shall be retroactively calculated as if the agreement between the manufacturer and the State had been entered into on January 1, 1991. If a manufacturer has not entered into such an agreement before March 1, 1991, such an agreement, subsequently entered into, shall become effective as of the date on which the agreement is entered into or, at State option, on any date thereafter on or before the first day of the calendar quarter that begins more than 60 days after the date the agreement is entered into.

(2) EFFECTIVE DATE.—Paragraph (1) shall first apply to drugs dispensed under this title on or after January 1, 1991.

(3) AUTHORIZING PAYMENT FOR DRUGS NOT COVERED UNDER REBATE AGREEMENTS.—Paragraph (1), and section 1903(i)(10)(A), shall not apply to the dispensing of a single source drug or innovator multiple source drug if (A)(i) the State has made a determination that the availability of the drug is essential to the health of beneficiaries under the State plan for medical assistance; (ii) such drug has been given a rating of 1-A by the Food and Drug Administration; and (iii)(I) the physician has obtained approval for use of the drug in advance of its dispensing in accordance with a prior authorization program described in subsection (d), or (II) the Secretary has reviewed and approved the State's determination under subparagraph (A); or (B) the Secretary determines that in the first calendar quarter of 1991, there were extenuating circumstances.

(4) EFFECT ON EXISTING AGREEMENTS.—In the case of a rebate agreement in effect between a State and a manufacturer on the date of the enactment of this section, such agreement, for the initial agreement period specified therein, shall be considered to be a rebate agreement in compliance with this section with respect to that State, if the State agrees to report to the Secretary any rebates paid pursuant to the agreement and

[127] P.L. 105–33, §4713(a); 111 Stat. 509.

[128] P.L. 108–173, §303(i)(4)(A), inserted "or under part B of title XVIII", effective December 8, 2003.

[129] November 4, 1992.

such agreement provides for a minimum aggregate rebate of 10 percent of the State's total expenditures under the State plan for coverage of the manufacturer's drugs under this title. If, after the initial agreement period, the State establishes to the satisfaction of the Secretary that an agreement in effect on the date of the enactment of this section provides for rebates that are at least as large as the rebates otherwise required under this section, and the State agrees to report any rebates under the agreement to the Secretary, the agreement shall be considered to be a rebate agreement in compliance with the section for the renewal periods of such agreement.

(5) LIMITATION ON PRICES OF DRUGS PURCHASED BY COVERED ENTITIES.—

(A) AGREEMENT WITH SECRETARY.—A manufacturer meets the requirements of this paragraph if the manufacturer has entered into an agreement with the Secretary that meets the requirements of section 340B of the Public Health Service Act [130] with respect to covered outpatient drugs purchased by a covered entity on or after the first day of the first month that begins after the date of the enactment of this paragraph [131].

(B) COVERED ENTITY DEFINED.—In this subsection, the term "covered entity" means an entity described in section 340B(a)(4) of the Public Health Service Act.

(C) Establishment of alternative mechanism to ensure against duplicate discounts or rebates.—If the Secretary does not establish a mechanism under section 340B(a)(5)(A) of the Public Health Service Act within 12 months of the date of the enactment of such section [132], the following requirements shall apply:

(i) Entities.—Each covered entity shall inform the single State agency under section 1902(a)(5) when it is seeking reimbursement from the State plan for medical assistance described in section 1905(a)(12) with respect to a unit of any covered outpatient drug which is subject to an agreement under section 340B(a) of such Act.

(ii) State agency.—Each such single State agency shall provide a means by which a covered entity shall indicate on any drug reimbursement claims form (or format, where electronic claims management is used) that a unit of the drug that is the subject of the form is subject to an agreement under section 340B of such Act, and not submit to any manufacturer a claim for a rebate payment under subsection (b) with respect to such a drug.

(D) Effect of subsequent amendments.—In determining whether an agreement under subparagraph (A) meets the requirements of section 340B of the Public Health Service Act, the Secretary shall not take into account any amendments to such section that are enacted after the enactment of title VI of the Veterans Health Care Act of 1992 [133].

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[130] See Vol. II, P.L. 78–410.
[131] November 4, 1992 (P.L. 102–585; 106 Stat. 6943).
[132] November 4, 1992.
[133] November 4, 1992.

(E) DETERMINATION OF COMPLIANCE.—A manufacturer is deemed to meet the requirements of this paragraph if the manufacturer establishes to the satisfaction of the Secretary that the manufacturer would comply (and has offered to comply) with the provisions of section 340B of the Public Health Service Act (as in effect immediately after the enactment of this paragraph, and would have entered into an agreement under such section (as such section was in effect at such time), but for a legislative change in such section after the date of the enactment of this paragraph.

(6) REQUIREMENTS RELATING TO MASTER AGREEMENTS FOR DRUGS PROCURED BY DEPARTMENT OF VETERANS AFFAIRS AND CERTAIN OTHER FEDERAL AGENCIES.—

(A) IN GENERAL.—A manufacturer meets the requirements of this paragraph if the manufacturer complies with the provisions of section 8126 of title 38, United States Code[134] , including the requirement of entering into a master agreement with the Secretary of Veterans Affairs under such section.

(B) Effect of subsequent amendments.—In determining whether a master agreement described in subparagraph (A) meets the requirements of section 8126 of title 38, United States Code, the Secretary shall not take into account any amendments to such section that are enacted after the enactment of title VI of the Veterans Health Care Act of 1992.

(C) DETERMINATION OF COMPLIANCE.—A manufacturer is deemed to meet the requirements of this paragraph if the manufacturer establishes to the satisfaction of the Secretary that the manufacturer would comply (and has offered to comply) with the provisions of section 8126 of title 38, United States Code (as in effect immediately after the enactment of this paragraph) and would have entered into an agreement under such section (as such section was in effect at such time), but for a legislative change in such section after the date of the enactment of this paragraph.

(b) TERMS OF REBATE AGREEMENT.—

(1) PERIODIC REBATES.—

(A) IN GENERAL.—A rebate agreement under this subsection shall require the manufacturer to provide, to each State plan approved under this title, a rebate for a rebate period in an amount specified in subsection (c) for covered outpatient drugs of the manufacturer dispensed after December 31, 1990, for which payment was made under the State plan for such period. Such rebate shall be paid by the manufacturer not later than 30 days after the date of receipt of the information described in paragraph (2) for the period involved.

(B) OFFSET AGAINST MEDICAL ASSISTANCE.—Amounts received by a State under this section (or under an agreement authorized by the Secretary under subsection (a)(1) or an agreement described in subsection (a)(4)) in any quarter shall be considered to be a reduction in the

[134] See Vol. II, Title 38.

amount expended under the State plan in the quarter for medical assistance for purposes of section 1903(a)(1).

(2) State provision of information.—

(A) STATE RESPONSIBILITY.—Each State agency under this title shall report to each manufacturer not later than 60 days after the end of each rebate period and in a form consistent with a standard reporting format established by the Secretary, information on the total number of units of each dosage form and strength and package size of each covered outpatient drug dispensed after December 31, 1990, for which payment was made under the plan during the period, and shall promptly transmit a copy of such report to the Secretary.

(B) AUDITS.—A manufacturer may audit the information provided (or required to be provided) under subparagraph (A). Adjustments to rebates shall be made to the extent that information indicates that utilization was greater or less than the amount previously specified.

(3) Manufacturer provision of price information.—

(A) IN GENERAL.—Each manufacturer with an agreement in effect under this section shall report to the Secretary—

(i) not later than 30 days after the last day of each rebate period under the agreement (beginning on or after January 1, 1991), on the average manufacturer price (as defined in subsection (k)(1)) and, (for single source drugs and innovator multiple source drugs), the manufacturer's best price (as defined in subsection (c)(2)(B)) for covered outpatient drugs for the rebate period under the agreement, [135] ; [136]

(ii) not later than 30 days after the date of entering into an agreement under this section on the average manufacturer price (as defined in subsection (k)(1)) as of October 1, 1990 for each of the manufacturer's covered outpatient drugs; and [137]

(iii) [138] for calendar quarters beginning on or after January 1, 2004, in conjunction with reporting required under clause (i) and by National Drug Code (including package size)—

(I) the manufacturer's average sales price (as defined in section 1847A(c)) and the total number of units specified under section 1847A(b)(2)(A);

(II) if required to make payment under section 1847A, the manufacturer's wholesale acquisition cost, as defined in subsection (c)(6) of such section; and

(III) information on those sales that were made at a nominal price or otherwise described in section 1847A(c)(2)(B);

for a drug or biological described in subparagraph (C), (D), (E), or (G) of section 1842(o)(1) or section 1881(b)(13)(A)(ii).

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[135] As an original; comma should probably be deleted.

[136] P.L. 108–173, §303(i)(4)(B)(i), struck out "and" and substituted a semicolon, effective December 8, 2003.

[137] P.L. 108–173, §303(i)(4)(B)(ii), struck out the period and substituted "; and", effective December 8, 2003.

[138] P.L. 108–173, §303(i)(4)(B)(iii), added clause (iii), effective December 8, 2003.

Information reported under this subparagraph is subject to audit by the Inspector General of the Department of Health and Human Services.

(B) VERIFICATION SURVEYS OF AVERAGE MANUFACTURER PRICE.—The Secretary may survey wholesalers and manufacturers that directly distribute their covered outpatient drugs, when necessary, to verify manufacturer prices reported under subparagraph (A). The Secretary may impose a civil monetary penalty in an amount not to exceed $100,000 on a wholesaler, manufacturer, or direct seller, if the wholesaler, manufacturer, or direct seller of a covered outpatient drug refuses a request for information about charges or prices by the Secretary in connection with a survey under this subparagraph or knowingly provides false information. The provisions of section 1128A (other than subsections (a) (with respect to amounts of penalties or additional assessments) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(C) PENALTIES.—

(i) FAILURE TO PROVIDE TIMELY INFORMATION.—In the case of a manufacturer with an agreement under this section that fails to provide information required under subparagraph (A) on a timely basis, the amount of the penalty shall be increased by $10,000 for each day in which such information has not been provided and such amount shall be paid to the Treasury, and, if such information is not reported within 90 days of the deadline imposed, the agreement shall be suspended for services furnished after the end of such 90-day period and until the date such information is reported (but in no case shall such suspension be for a period of less than 30 days).

(ii) FALSE INFORMATION.—Any manufacturer with an agreement under this section that knowingly provides false information is subject to a civil money penalty in an amount not to exceed $100,000 for each item of false information. Such civil money penalties are in addition to other penalties as may be prescribed by law. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(D) CONFIDENTIALITY OF INFORMATION.—Notwithstanding any other provision of law, information disclosed by manufacturers or wholesalers under this paragraph or under an agreement with the Secretary of Veterans Affairs described in subsection (a)(6)(A)(ii) is confidential and shall not be disclosed by the Secretary or the Secretary of Veterans Affairs or a State agency (or contractor therewith) in a form which discloses the identity of a specific manufacturer or wholesaler, prices charged for drugs by such manufacturer or wholesaler, except—

(i) as the Secretary determines to be necessary to carry out this section,

(ii) to permit the Comptroller General to review the information provided, and

(iii) to permit the Director of the Congressional Budget Office to review the information provided.

The previous sentence shall also apply to information disclosed under section 1860D-2(d)(2) or 1860D-4(c)(2)(E)[139] and drug pricing data reported under the first sentence of section 1860D-31(i)(1)[140].

(4) LENGTH OF AGREEMENT.—

(A) In general.—A rebate agreement shall be effective for an initial period of not less than 1 year and shall be automatically renewed for a period of not less than one year unless terminated under subparagraph (B).

(B) Termination.—

(i) By the secretary.—The Secretary may provide for termination of a rebate agreement for violation of the requirements of the agreement or other good cause shown. Such termination shall not be effective earlier than 60 days after the date of notice of such termination. The Secretary shall provide, upon request, a manufacturer with a hearing concerning such a termination, but such hearing shall not delay the effective date of the termination.

(ii) BY A MANUFACTURER.—A manufacturer may terminate a rebate agreement under this section for any reason. Any such termination shall not be effective until the calendar quarter beginning at least 60 days after the date the manufacturer provides notice to the Secretary.

(iii) EFFECTIVENESS OF TERMINATION.—Any termination under this subparagraph shall not affect rebates due under the agreement before the effective date of its termination.

(iv) NOTICE TO STATES.—In the case of a termination under this subparagraph, the Secretary shall provide notice of such termination to the States within not less than 30 days before the effective date of such termination.

(v) APPLICATION TO TERMINATIONS OF OTHER AGREEMENTS.—The provisions of this subparagraph shall apply to the terminations of agreements described in section 340B(a)(1) of the Public Health Service Act and master agreements described in section 8126(a) of title 38, United States Code.[141]

(C) DELAY BEFORE REENTRY.—In the case of any rebate agreement with a manufacturer under this section which is terminated, another such agreement with the manufacturer (or a successor manufacturer) may not be entered into until a period of 1 calendar quarter has elapsed since

[139] P.L. 108–173, §101(e)(4), added "The previous sentence shall also apply to information disclosed under section 1860D-2(d)(2) or 1860D-4(c)(2)(E)", effective December 8, 2003.

[140] P.L. 108–173, §105(b), added "and drug pricing data reported under the first sentence of section 1860D-31(i)(1)", effective December 8, 2003.

[141] See Vol. II, P.L. 78–410, §340B and Title 38, §8126.

the date of the termination, unless the Secretary finds good cause for an earlier reinstatement of such an agreement.

(c) Determination of Amount of Rebate.—

(1) BASIC REBATE FOR SINGLE SOURCE DRUGS AND INNOVATOR MULTIPLE SOURCE DRUGS.—

(A) IN GENERAL.—Except as provided in paragraph (2), the amount of the rebate specified in this subsection for a rebate period (as defined in subsection (k)(8)) with respect to each dosage form and strength of a single source drug or an innovator multiple source drug shall be equal to the product of—

(i) the total number of units of each dosage form and strength paid for under the State plan in the rebate period (as reported by the State); and

(ii) subject to subparagraph (B)(ii), the greater of—

(I) the difference between the average manufacturer price and the best price (as defined in subparagraph (C)) for the dosage form and strength of the drug, or

(II) the minimum rebate percentage (specified in subparagraph (B)(i)) of such average manufacturer price,

for the rebate period.

(B) RANGE OF REBATES REQUIRED.—

(i) Minimum rebate percentage.—For purposes of subparagraph (A)(ii)(II), the "minimum rebate percentage" for rebate periods beginning—

(I) after December 31, 1990, and before October 1, 1992, is 12.5 percent;

(II) after September 30, 1992, and before January 1, 1994, is 15.7 percent;

(III) after December 31, 1993, and before January 1, 1995, is 15.4 percent;

(IV) after December 31, 1994, and before January 1, 1996, is 15.2 percent; and

(V) after December 31, 1995, is 15.1 percent.

(ii) Temporary limitation on maximum rebate amount.—In no case shall the amount applied under subparagraph (A)(ii) for a rebate period beginning—

(I) before January 1, 1992, exceed 25 percent of the average manufacturer price; or

(II) after December 31, 1991, and before January 1, 1993, exceed 50 percent of the average manufacturer price.

(C) Best price defined.—For purposes of this section—

(i) IN GENERAL.—The term "best price" means, with respect to a single source drug or innovator multiple source drug of a manufacturer, the lowest price available from the manufacturer during the rebate period to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity within the United States, excluding—

(I) any prices charged on or after October 1, 1992, to the Indian Health Service, the Department of Veterans Affairs, a State home

receiving funds under section 1741 of title 38, United States Code[142] , the Department of Defense, the Public Health Service, or a covered entity described in subsection (a)(5)(B) (including inpatient prices charged to hospitals described in section 340B(a)(4)(L) of the Public Health Service Act)[143];

(II) any prices charged under the Federal Supply Schedule of the General Services Administration;

(III) any prices used under a State pharmaceutical assistance program;[144]

(IV) any depot prices and single award contract prices, as defined by the Secretary, of any agency of the Federal Government;[145]

(V)[146] the prices negotiated from drug manufacturers for covered discount card drugs under an endorsed discount card program under section 1860D-31; and

(VI)[147] any prices charged which are negotiated by a prescription drug plan under part D of title XVIII, by an MA-PD plan under part C of such title with respect to covered part D drugs or by a qualified retiree prescription drug plan (as defined in section 1860D-22(a)(2)) with respect to such drugs on behalf of individuals entitled to benefits under part A or enrolled under part B of such title.

(ii) SPECIAL RULES.—The term "best price"—

(I) shall be inclusive of cash discounts, free goods that are contingent on any purchase requirement, volume discounts, and rebates (other than rebates under this section);

(II) shall be determined without regard to special packaging, labeling, or identifiers on the dosage form or product or package; and

(III) shall not take into account prices that are merely nominal in amount.

(iii)[148] APPLICATION OF AUDITING AND RECORDKEEPING REQUIREMENTS.—With respect to a covered entity described in section 340B(a)(4)(L) of the Public Health Service Act, any drug purchased for inpatient use shall be subject to the auditing and recordkeeping requirements described in section 340B(a)(5)(C) of the Public Health Service Act.

(2) Additional rebate for single source and innovator multiple source drugs.—

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[142] See Vol. II, Title 38.

[143] P.L. 108–173, §1002(a)(1), inserted "(including inpatient prices charged to hospitals described in section 340B(a)(4)(L) of the Public Health Service Act)", effective December 8, 2003.

[144] P.L. 108–173, §103(e)(1)(A), struck out "and", effective December 8, 2003.

[145] P.L. 108–173, §103(e)(1)(B), struck out the period and substituted a semicolon, effective December 8, 2003.

[146] P.L. 108–173, §103(e)(1)(C), added subclause (V), effective December 8, 2003.

[147] P.L. 108–173, §103(e)(1)(C), adds this subclause (VI), to be applicable to prices charged for drugs dispensed on or after January 1, 2006.

[148] P.L. 108–173, §1002(a)(2), added clause (iii), effective December 8, 2003.

(A) IN GENERAL.—The amount of the rebate specified in this subsection for a rebate period, with respect to each dosage form and strength of a single source drug or an innovator multiple source drug, shall be increased by an amount equal to the product of—

(i) the total number of units of such dosage form and strength dispensed after December 31, 1900, for which payment was made under the State plan for the rebate period; and

(ii) the amount (if any) by which—

(I) the average manufacturer price for the dosage form and strength of the drug for the period, exceeds

(II) the average manufacturer price for such dosage form and strength for the calendar quarter beginning July 1, 1990 (without regard to whether or not the drug has been sold or transferred to an entity, including a division or subsidiary of the manufacturer, after the first day of such quarter), increased by the percentage by which the consumer price index for all urban consumers (United States city average) for the month before the month in which the rebate period begins exceeds such index for September 1990.

(B) TREATMENT OF SUBSEQUENTLY APPROVED DRUGS.—In the case of a covered outpatient drug approved by the Food and Drug Administration after October 1, 1990, clause (ii)(II) of subparagraph (A) shall be applied by substituting "the first full calendar quarter after the day on which the drug was first marketed" for "the calendar quarter beginning July 1, 1990" and "the month prior to the first month of the first full calendar quarter after the day on which the drug was first marketed" for "September 1990".

(3) Rebate for other drugs.—

(A) IN GENERAL.—The amount of the rebate paid to a State for a rebate period with respect to each dosage form and strength of covered outpatient drugs (other than single source drugs and innovator multiple source drugs) shall be equal to the product of—

(i) the applicable percentage (as described in subparagraph (B)) of the average manufacturer price for the dosage form and strength for the rebate period, and

(ii) the total number of units of such dosage form and strength dispensed after December 31, 1990, for which payment was made under the State plan for the rebate period.

(B) APPLICABLE PERCENTAGE DEFINED.—For purposes of subparagraph (A)(i), the "applicable percentage" for rebate periods beginning—

(i) before January 1, 1994, is 10 percent, and

(ii) after December 31, 1993, is 11 percent.

(d) LIMITATIONS ON COVERAGE OF DRUGS.—

(1) PERMISSIBLE RESTRICTIONS.—(A) A State may subject to prior authorization any covered outpatient drug. Any such

prior authorization program shall comply with the requirements of paragraph (5).

(B) A State may exclude or otherwise restrict coverage of a covered outpatient drug if—

(i) the prescribed use is not for a medically accepted indication (as defined in subsection (k)(6));

(ii) the drug is contained in the list referred to in paragraph (2);

(iii) the drug is subject to such restrictions pursuant to an agreement between a manufacturer and a State authorized by the Secretary under subsection (a)(1) or in effect pursuant to subsection (a)(4); or

(iv) the State has excluded coverage of the drug from its formulary established in accordance with paragraph (4).

(2) LIST OF DRUGS SUBJECT TO RESTRICTION.—The following drugs or classes of drugs, or their medical uses, may be excluded from coverage or otherwise restricted:

(A) Agents when used for anorexia, weight loss, or weight gain.

(B) Agents when used to promote fertility.

(C) Agents when used for cosmetic purposes or hair growth.

(D) Agents when used for the symptomatic relief of cough and colds.

(E) Agents when used to promote smoking cessation.

(F) Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.

(G) Nonprescription drugs.

(H) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

(I) Barbiturates.

(J) Benzodiazepines.

(3) UPDATE OF DRUG LISTINGS.—The Secretary shall, by regulation, periodically update the list of drugs or classes of drugs described in paragraph (2) or their medical uses, which the Secretary has determined, based on data collected by surveillance and utilization review programs of State medical assistance programs, to be subject to clinical abuse or inappropriate use.

(4) REQUIREMENTS FOR FORMULARIES.—A State may establish a formulary if the formulary meets the following requirements:

(A) The formulary is developed by a committee consisting of physicians, pharmacists, and other appropriate individuals appointed by the Governor of the State (or, at the option of the State, the State's drug use review board established under subsection (g)(3)).

(B) Except as provided in subparagraph (C), the formulary includes the covered outpatient drugs of any manufacturer which has entered into and complies with an agreement under subsection (a) (other than any drug excluded from coverage or otherwise restricted under paragraph (2)).

(C) A covered outpatient drug may be excluded with respect to the treatment of a specific disease or condition for an identified population (if any) only if, based on the drug's labeling (or, in the case of a drug the prescribed use of which is not approved under the Federal Food, Drug, and Cosmetic Act[149] but is a medically accepted indication, based on information from the appropriate compendia described in subsection (k)(6)), the excluded drug does not have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness, or clinical outcome of such treatment for such population over other drugs included in the formulary and there is a written explanation (available to the public) of the basis for the exclusion.

(D) The State plan permits coverage of a drug excluded from the formulary (other than any drug excluded from coverage or otherwise restricted under paragraph (2)) pursuant to a prior authorization program that is consistent with paragraph (5).

(E) The formulary meets such other requirements as the Secretary may impose in order to achieve program savings consistent with protecting the health of program beneficiaries.

A prior authorization program established by a State under paragraph (5) is not a formulary subject to the requirements of this paragraph.

(5) REQUIREMENTS OF PRIOR AUTHORIZATION PROGRAMS.—A State plan under this title may require, as a condition of coverage or payment for a covered outpatient drug for which Federal financial participation is available in accordance with this section, with respect to drugs dispensed on or after July 1, 1991, the approval of the drug before its dispensing for any medically accepted indication (as defined in subsection (k)(6)) only if the system providing for such approval—

(A) provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization; and

(B) except with respect to the drugs on the list referred to in paragraph (2), provides for the dispensing of at least 72-hour supply of a covered outpatient prescription drug in an emergency situation (as defined by the Secretary).

(6) OTHER PERMISSIBLE RESTRICTIONS.—A State may impose limitations, with respect to all such drugs in a therapeutic class, on the minimum or maximum quantities per prescription or on the number of refills, if such limitations are necessary to discourage waste, and may address instances of fraud or abuse by individuals in any manner authorized under this Act.

(e) TREATMENT OF PHARMACY REIMBURSEMENT LIMITS.—

(1) IN GENERAL.—During the period beginning on January 1, 1991, and ending on December 31, 1994—

(A) a State may not reduce the payment limits established by regulation under this title or any limitation described in paragraph (3) with respect to the ingredient cost

[149] P.L. 75–717.

of a covered outpatient drug or the dispensing fee for such a drug below the limits in effect as of January 1, 1991, and

(B) except as provided in paragraph (2), the Secretary may not modify by regulation the formula established under sections 447.331 through 447.334 of title 42, Code of Federal Regulations [150], in effect on November 5, 1990, to reduce the limits described in subparagraph (A).

(2) SPECIAL RULE.—If a State is not in compliance with the regulations described in paragraph (1)(B), paragraph (1)(A) shall not apply to such State until such State is in compliance with such regulations.

(3) EFFECT ON STATE MAXIMUM ALLOWABLE COST LIMITATIONS.—This section shall not supersede or affect provisions in effect prior to January 1, 1991, or after December 31, 1994, relating to any maximum allowable cost limitation established by a State for payment by the State for covered outpatient drugs, and rebates shall be made under this section without regard to whether or not payment by the State for such drugs is subject to such a limitation or the amount of such a limitation.

(4) ESTABLISHMENT OF UPPER PAYMENT LIMITS.—The Secretary [151] shall establish a Federal upper reimbursement limit for each multiple source drug for which the FDA has rated three or more products therapeutically and pharmaceutically equivalent, regardless of whether all such additional formulations are rated as such and shall use only such formulations when determining any such upper limit.

(f) [(f)(1)Stricken. and (f)(2) Redesignated.)] [152]

(g) DRUG USE REVIEW.—

(1) IN GENERAL.—

(A) In order to meet the requirement of section 1903(i)(10)(B), a State shall provide, by not later than January 1, 1993, for a drug use review program described in paragraph (2) for covered outpatient drugs in order to assure that prescriptions (i) are appropriate, (ii) are medically necessary, and (iii) are not likely to result in adverse medical results. The program shall be designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, among physicians, pharmacists, and patients, or associated with specific drugs or groups of drugs, as well as potential and actual severe adverse reactions to drugs including education on therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse/misuse.

(B) The program shall assess data on drug use against predetermined standards, consistent with the following:

(i) compendia which shall consist of the following:

[150] See Vol. II, Title 42, CFR.

[151] P.L. 108–173, §900(e)(1)(K), struck out "HCFA" and substituted "The Secretary", effective December 8, 2003.

[152] P.L. 103-66, §13602(a)(1); 107 Stat.613.

(I) American Hospital Formulary Service Drug Information;

(II) United States Pharmacopeia-Drug Information; and [153]

(III) the DRUGDEX Information System; and

(IV) [Stricken. [154]]

(ii) the peer-reviewed medical literature.

(C) The Secretary, under the procedures established in section 1903, shall pay to each State an amount equal to 75 per centum of so much of the sums expended by the State plan during calendar years 1991 through 1993 as the Secretary determines is attributable to the statewide adoption of a drug use review program which conforms to the requirements of this subsection.

(D) States shall not be required to perform additional drug use reviews with respect to drugs dispensed to residents of nursing facilities which are in compliance with the drug regimen review procedures prescribed by the Secretary for such facilities in regulations implementing section 1919, currently at section 483.60 of title 42, Code of Federal Regulations [155].

(2) DESCRIPTION OF PROGRAM.—Each drug use review program shall meet the following requirements for covered outpatient drugs:

(A) PROSPECTIVE DRUG REVIEW.—(i) The State plan shall provide for a review of drug therapy before each prescription is filled or delivered to an individual receiving benefits under this title, typically at the point-of-sale or point of distribution. The review shall include screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions (including serious interactions with nonprescription or over-the-counter drugs), incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse/misuse. Each State shall use the compendia and literature referred to in paragraph (1)(B) as its source of standards for such review.

(ii) As part of the State's prospective drug use review program under this subparagraph applicable State law shall establish standards for counseling of individuals receiving benefits under this title by pharmacists which includes at least the following:

(I) The pharmacist must offer to discuss with each individual receiving benefits under this title or caregiver of such individual (in person, whenever practicable, or through access to a telephone service which is toll-free for long-distance calls) who presents a prescription, matters which in the exercise of the pharmacist's professional judgment (consistent with State law respecting the provision of such information), the pharmacist deems significant including the following:

(aa) The name and description of the medication.

[153] P.L. 108–173, §101(e)(9)(A), added "and", effective December 8, 2003.
[154] P.L. 108–173, §101(e)(9)(B), struck out subclause (IV), effective December 8, 2003.
[155] See Vol. II, Title 42, CFR.

(bb) The route, dosage form, dosage, route of administration, and duration of drug therapy.

(cc) Special directions and precautions for preparation, administration and use by the patient.

(dd) Common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur.

(ee) Techniques for self-monitoring drug therapy.

(ff) Proper storage.

(gg) Prescription refill information.

(hh) Action to be taken in the event of a missed dose.

(II) A reasonable effort must be made by the pharmacist to obtain, record, and maintain at least the following information regarding individuals receiving benefits under this title:

(aa) Name, address, telephone number, date of birth (or age) and gender.

(bb) Individual history where significant, including disease state or states, known allergies and drug reactions, and a comprehensive list of medications and relevant devices.

(cc) Pharmacist comments relevant to the individual's drug therapy.

Nothing in this clause shall be construed as requiring a pharmacist to provide consultation when an individual receiving benefits under this title or caregiver of such individual refuses such consultation.

(B) RETROSPECTIVE DRUG USE REVIEW.—The program shall provide, through its mechanized drug claims processing and information retrieval systems (approved by the Secretary under section 1903(r)) or otherwise, for the ongoing periodic examination of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, among physicians, pharmacists and individuals receiving benefits under this title, or associated with specific drugs or groups of drugs.

(C) APPLICATION OF STANDARDS.—The program shall, on an ongoing basis, assess data on drug use against explicit predetermined standards (using the compendia and literature referred to in subsection (1)(B) as the source of standards for such assessment) including but not limited to monitoring for therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, and clinical abuse/misuse and, as necessary, introduce remedial strategies, in order to improve the quality of care and to conserve program funds or personal expenditures.

(D) EDUCATIONAL PROGRAM.—The program shall, through its State drug use review board established under

paragraph (3), either directly or through contracts with accredited health care educational institutions, State medical societies or State pharmacists associations/societies or other organizations as specified by the State, and using data provided by the State drug use review board on common drug therapy problems, provide for active and ongoing educational outreach programs (including the activities described in paragraph (3)(C)(iii) of this subsection) to educate practitioners on common drug therapy problems with the aim of improving prescribing or dispensing practices.

(3) STATE DRUG USE REVIEW BOARD.—

(A) ESTABLISHMENT.—Each State shall provide for the establishment of a drug use review board (hereinafter referred to as the "DUR Board") either directly or through a contract with a private organization.

(B) MEMBERSHIP.—The membership of the DUR Board shall include health care professionals who have recognized knowledge and expertise in one or more of the following:

(i) The clinically appropriate prescribing of covered outpatient drugs.

(ii) The clinically appropriate dispensing and monitoring of covered outpatient drugs.

(iii) Drug use review, evaluation, and intervention.

(iv) Medical quality assurance.

The membership of the DUR Board shall be made up at least ⅓ but no more than 51 percent licensed and actively practicing physicians and at least ⅓ *** [156] licensed and actively practicing pharmacists.

(C) ACTIVITIES.—The activities of the DUR Board shall include but not be limited to the following:

(i) Retrospective DUR as defined in [157] (2)(B).

(ii) Application of standards as defined in section (2)(C).

(iii) Ongoing interventions for physicians and pharmacists, targeted toward therapy problems or individuals identified in the course of retrospective drug use reviews performed under this subsection. Intervention programs shall include, in appropriate instances, at least:

(I) information dissemination sufficient to ensure the ready availability to physicians and pharmacists in the State of information concerning its duties, powers, and basis for its standards;

(II) written, oral, or electronic reminders containing patient-specific or drug-specific (or both) information and suggested changes in prescribing or dispensing practices, communicated in a manner designed to ensure the privacy of patient-related information;

(III) use of face-to-face discussions between health care professionals who are experts in

[156] As in original.
[157] As in original. Probably should be "paragraph".

rational drug therapy and selected prescribers and pharmacists who have been targeted for educational intervention, including discussion of optimal prescribing, dispensing, or pharmacy care practices, and follow-up face-to-face discussions; and

(IV) intensified review or monitoring of selected prescribers or dispensers.

The Board shall re-evaluate interventions after an appropriate period of time to determine if the intervention improved the quality of drug therapy, to evaluate the success of the interventions and make modifications as necessary.

(D) ANNUAL REPORT.—Each State shall require the DUR Board to prepare a report on an annual basis. The State shall submit a report on an annual basis to the Secretary which shall include a description of the activities of the Board, including the nature and scope of the prospective and retrospective drug use review programs, a summary of the interventions used, an assessment of the impact of these educational interventions on quality of care, and an estimate of the cost savings generated as a result of such program. The Secretary shall utilize such report in evaluating the effectiveness of each State's drug use review program.

(h) ELECTRONIC CLAIMS MANAGEMENT.—

(1) IN GENERAL.—In accordance with chapter 35 of title 44, United States Code (relating to coordination of Federal information policy), the Secretary shall encourage each State agency to establish, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management system, for the purpose of performing on-line, real time eligibility verifications, claims data capture, adjudication of claims, and assisting pharmacists (and other authorized persons) in applying for and receiving payment.

(2) ENCOURAGEMENT.—In order to carry out paragraph (1)—

(A) for calendar quarters during fiscal years 1991 and 1992, expenditures under the State plan attributable to development of a system described in paragraph (1) shall receive Federal financial participation under section 1903(a)(3)(A)(i) (at a matching rate of 90 percent) if the State acquires, through applicable competitive procurement process in the State, the most cost-effective telecommunications network and automatic data processing services and equipment; and

(B) the Secretary may permit, in the procurement described in subparagraph (A) in the application of part 433 of title 42, Code of Federal Regulations, and parts 95, 205, and 307 of title 45, Code of Federal Regulations, the substitution of the State's request for proposal in competitive procurement for advance planning and implementation documents otherwise required.

(i) ANNUAL REPORT.—

(1) IN GENERAL.—Not later than May 1 of each year the Secretary shall transmit to the Committee on Finance of the Senate, the Committee on Energy and Commerce of the House of

Representatives, and the Committees on Aging of the Senate and the House of Representatives a report on the operation of this section in the preceding fiscal year.

(2) DETAILS.—Each report shall include information on—

(A) ingredient costs paid under this title for single source drugs, multiple source drugs, and nonprescription covered outpatient drugs;

(B) the total value of rebates received and number of manufacturers providing such rebates;

(C) how the size of such rebates compare with the size or[158] rebates offered to other purchasers of covered outpatient drugs;

(D) the effect of inflation on the value of rebates required under this section;

(E) trends in prices paid under this title for covered outpatient drugs; and

(F) Federal and State administrative costs associated with compliance with the provisions of this title.

(j) EXEMPTION OF ORGANIZED HEALTH CARE SETTINGS.—(1) Covered outpatient drugs dispensed by health maintenance organizations, including medicaid managed care organizations that contract under section 1903(m), are not subject to the requirements of this section.

(2) The State plan shall provide that a hospital (providing medical assistance under such plan) that dispenses covered outpatient drugs using drug formulary systems, and bills the plan no more than the hospital's purchasing costs for covered outpatient drugs (as determined under the State plan) shall not be subject to the requirements of this section.

(3) Nothing in this subsection shall be construed as providing that amounts for covered outpatient drugs paid by the institutions described in this subsection should not be taken into account for purposes of determining the best price as described in subsection (c).

(k) DEFINITIONS.—In the section—

(1) AVERAGE MANUFACTURER PRICE.—The term "average manufacturer price" means, with respect to a covered outpatient drug of a manufacturer for a rebate period, the average price paid to the manufacturer for the drug in the United States by wholesalers for drugs distributed to the retail pharmacy class of trade, after deducting customary prompt pay discounts.

(2) COVERED OUTPATIENT DRUG.—Subject to the exceptions in paragraph (3), the term "covered outpatient drug" means—

(A) of those drugs which are treated as prescribed drugs for purposes of section 1905(a)(12), a drug which may be dispensed only upon prescription (except as provided in paragraph (5)), and—

(i) which is approved for safety and effectiveness as a prescription drug under section 505 or 507 of the Federal Food, Drug, and Cosmetic Act[159] or which is approved under section 505(j) of such Act;

[158] As in original. Probably should be "of".
[159] See Vol. II, P.L. 75–717.

(ii)(I) which was commercially used or sold in the United States before the date of the enactment of the Drug Amendments of 1962 or which is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations [160]) to such a drug, and (II) which has not been the subject of a final determination by the Secretary that it is a "new drug" (within the meaning of section 201(p) of the Federal Food, Drug, and Cosmetic Act [161]) or an action brought by the Secretary under section 301, 302(a), or 304(a) of such Act to enforce section 502(f) or 505(a) of such Act; or

(iii)(I) which is described in section 107(c)(3) of the Drug Amendments of 1962 and for which the Secretary has determined there is a compelling justification for its medical need, or is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) for which the Secretary has not issued a notice of an opportunity for a hearing under section 505(e) of the Federal Food, Drug, and Cosmetic Act on a proposed order of the Secretary to withdraw approval of an application for such drug under such section because the Secretary has determined that the drug is less than effective for some or all conditions of use prescribed, recommended, or suggested in its labeling; and

(B) a biological product, other than a vaccine which—

(i) may only be dispensed upon prescription,

(ii) is licensed under section 351 of the Public Health Service Act, and

(iii) is produced at an establishment licensed under such section to produce such product; and

(C) insulin certified under section 506 of the Federal Food, Drug, and Cosmetic Act.

(3) LIMITING DEFINITION.—The term "covered outpatient drug" does not include any drug, biological product, or insulin provided as part of, or as incident to and in the same setting as, any of the following (and for which payment may be made under this title as part of payment for the following and not as direct reimbursement for the drug):

(A) Inpatient hospital services.

(B) Hospice services.

(C) Dental services, except that drugs for which the State plan authorizes direct reimbursement to the dispensing dentist are covered outpatient drugs.

(D) Physicians' services.

(E) Outpatient hospital services.

(F) Nursing facility services and services provided by an intermediate care facility for the mentally retarded.

(G) Other laboratory and x-ray services.

(H) Renal dialysis.

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[160] See Vol. II, Title 21, CFR.

[161] See Vol. II, P.L. 75–717.

Such term also does not include any such drug or product for which a National Drug Code number is not required by the Food and Drug Administration or a drug or biological used for a medical indication which is not a medically accepted indication. Any drug, biological product, or insulin excluded from the definition of such term as a result of this paragraph shall be treated as a covered outpatient drug for purposes of determining the best price (as defined in subsection (c)(1)(C)) for such drug, biological product, or insulin.

(4) NONPRESCRIPTION DRUGS.—If a State plan for medical assistance under this title includes coverage of prescribed drugs as described in section 1905(a)(12) and permits coverage of drugs which may be sold without a prescription (commonly referred to as "over-the-counter" drugs), if they are prescribed by a physician (or other person authorized to prescribe under State law), such a drug shall be regarded as a covered outpatient drug.

(5) MANUFACTURER.—The term "manufacturer" means any entity which is engaged in—

(A) the production, preparation, propagation, compounding, conversion, or processing of prescription drug products, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, or

(B) in the packaging, repackaging, labeling, relabeling, or distribution of prescription drug products.

Such term does not include a wholesale distributor of drugs or a retail pharmacy licensed under State law.

(6) MEDICALLY ACCEPTED INDICATION.—The term "medically accepted indication" means any use for a covered outpatient drug which is approved under the Federal Food, Drug, and Cosmetic Act[162], or the use of which is supported by one or more citations included or approved for inclusion in any of the compendia described in subsection (g)(1)(B)(i).

(7) MULTIPLE SOURCE DRUG; INNOVATOR MULTIPLE SOURCE DRUG; NONINNOVATOR MULTIPLE SOURCE DRUG; SINGLE SOURCE DRUG.—

(A) Defined.—

(i) MULTIPLE SOURCE DRUG.—The term "multiple source drug" means, with respect to a rebate period, a covered outpatient drug (not including any drug described in paragraph (5)) for which there are 2 or more drug products which—

(I) are rated as therapeutically equivalent (under the Food and Drug Administration's most recent publication of "Approved Drug Products with Therapeutic Equivalence Evaluations"),

(II) except as provided in subparagraph (B), are pharmaceutically equivalent and bioequivalent, as defined in subparagraph (C) and as determined by the Food and Drug Administration, and

(III) are sold or marketed in the State during the period.

[162] P.L. 75–717.

(ii) INNOVATOR MULTIPLE SOURCE DRUG.—The term "innovator multiple source drug" means a multiple source drug that was originally marketed under an original new drug application approved by the Food and Drug Administration.

(iii) Noninnovator multiple source drug.—The term "noninnovator multiple source drug" means a multiple source drug that is not an innovator multiple source drug.

(iv) Single source drug.—The term "single source drug" means a covered outpatient drug which is produced or distributed under an original new drug application approved by the Food and Drug Administration, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application.

(B) Exception.—Subparagraph (A)(i)(II) shall not apply if the Food and Drug Administration changes by regulation the requirement that, for purposes of the publication described in subparagraph (A)(i)(I), in order for drug products to be rated as therapeutically equivalent, they must be pharmaceutically equivalent and bioequivalent, as defined in subparagraph (C).

(C) DEFINITIONS.—For purposes of this paragraph—

(i) drug products are pharmaceutically equivalent if the products contain identical amounts of the same active drug ingredient in the same dosage form and meet compendial or other applicable standards of strength, quality, purity, and identity;

(ii) drugs are bioequivalent if they do not present a known or potential bioequivalence problem, or, if they do present such a problem, they are shown to meet an appropriate standard of bioequivalence; and

(iii) a drug product is considered to be sold or marketed in a State if it appears in a published national listing of average wholesale prices selected by the Secretary, provided that the listed product is generally available to the public through retail pharmacies in that State.

(8) REBATE PERIOD.—The term "rebate period" means, with respect to an agreement under subsection (a), a calendar quarter or other period specified by the Secretary with respect to the payment of rebates under such agreement.

(9) STATE AGENCY.—The term "State agency" means the agency designated under section 1902(a)(5) to administer or supervise the administration of the State plan for medical assistance.

PROGRAM FOR DISTRIBUTION OF PEDIATRIC VACCINES

SEC. 1928. [42 U.S.C. 1396s] (a) Establishment of Program.—

(1) IN GENERAL.—In order to meet the requirement of section 1902(a)(62), each State shall establish a pediatric vaccine distribution program (which may be administered by the State department of health), consistent with the requirements of this section, under which—

(A) each vaccine-eligible child (as defined in subsection (b)), in receiving an immunization with a qualified pediatric vaccine (as defined in subsection (h)(8)) from a program-registered provider (as defined in subsection (c)) on or after October 1, 1994, is entitled to receive the immunization without charge for the cost of such vaccine; and

(B)(i) each program-registered provider who administers such a pediatric vaccine to a vaccine-eligible child on or after such date is entitled to receive such vaccine under the program without charge either for the vaccine or its delivery to the provider, and (ii) no vaccine is distributed under the program to a provider unless the provider is a program-registered provider.

(2) DELIVERY OF SUFFICIENT QUANTITIES OF PEDIATRIC VACCINES TO IMMUNIZE FEDERALLY VACCINE-ELIGIBLE CHILDREN.—

(A) IN GENERAL.—The Secretary shall provide under subsection (d) for the purchase and delivery on behalf of each State meeting the requirement of section 1902(a)(62) (or, with respect to vaccines administered by an Indian tribe or tribal organization to Indian children, directly to the tribe or organization), without charge to the State, of such quantities of qualified pediatric vaccines as may be necessary for the administration of such vaccines to all federally vaccine-eligible children in the State on or after October 1, 1994. This paragraph constitutes budget authority in advance of appropriations Acts, and represents the obligation of the Federal Government to provide for the purchase and delivery to States of the vaccines (or payment under subparagraph (C)) in accordance with this paragraph.

(B) SPECIAL RULES WHERE VACCINE IS UNAVAILABLE.—To the extent that a sufficient quantity of a vaccine is not available for purchase or delivery under subsection (d), the Secretary shall provide for the purchase and delivery of the available vaccine in accordance with priorities established by the Secretary, with priority given to federally vaccine-eligible children unless the Secretary finds there are other public health considerations.

(C) SPECIAL RULES WHERE STATE IS A MANUFACTURER.—

(i) PAYMENTS IN LIEU OF VACCINES.—In the case of a State that manufactures a pediatric vaccine the Secretary, instead of providing the vaccine on behalf of a State under subparagraph (A), shall provide to the State an amount equal to the value of the quantity of such vaccine that otherwise would have been delivered on behalf of the State under such subparagraph but only if the State agrees that such payments will only be used for purposes relating to pediatric immunizations.

(ii) DETERMINATION OF VALUE.—In determining the amount to pay a State under clause (i) with respect to a pediatric vaccine, the value of the quantity of vaccine shall be determined on the basis of the price in effect for the qualified pediatric vaccine under contracts under subsection (d). If more than 1 such contract is in effect, the Secretary shall determine such value on the basis of the average of the prices under

the contracts, after weighting each such price in relation to the quantity of vaccine under the contract involved.

(b) VACCINE-ELIGIBLE CHILDREN.—For purposes of this section:

(1) IN GENERAL.—The term "vaccine-eligible child" means a child who is a federally vaccine-eligible child (as defined in paragraph (2)) or a State vaccine-eligible child (as defined in paragraph (3)).

(2) Federally vaccine-eligible child.—

(A) In general.—The term "federally vaccine-eligible child" means any of the following children:

(i) A medicaid-eligible child.

(ii) A child who is not insured.

(iii) A child who (I) is administered a qualified pediatric vaccine by a federally-qualified health center (as defined in section 1905(l)(2)(B)) or a rural health clinic (as defined in section 1905(l)(1)), and (II) is not insured with respect to the vaccine.

(iv) A child who is an Indian (as defined in subsection (h)(3)).

(B) DEFINITIONS.—In subparagraph (A):

(i) The term "medicaid-eligible" means, with respect to a child, a child who is entitled to medical assistance under a state plan approved under this title.

(ii) The term "insured" means, with respect to a child—

(I) for purposes of subparagraph (A)(ii), that the child is enrolled under, and entitled to benefits under, a health insurance policy or plan, including a group health plan, a prepaid health plan, or an employee welfare benefit plan under the Employee Retirement Income Security Act of 1974 [163]; and

(II) for purposes of subparagraph (A)(iii)(II) with respect to a pediatric vaccine, that the child is entitled to benefits under such a health insurance policy or plan, but such benefits are not available with respect to the cost of the pediatric vaccine.

(3) STATE VACCINE-ELIGIBLE CHILD.—The term "State vaccine-eligible child" means, with respect to a State and a qualified pediatric vaccine, a child who is within a class of children for which the State is purchasing the vaccine pursuant to subsection (d)(4)(B).

(c) PROGRAM-REGISTERED PROVIDERS.—

(1) DEFINED.—In this section, except as otherwise provided, the term "program-registered provider" means, with respect to a State, any health care provider that—

(A) is licensed or otherwise authorized for administration of pediatric vaccines under the law of the State in which the administration occurs (subject to section 333(e) of the Public Health Service Act), without regard to whether or not the provider participates in the plan under this title;

(B) submits to the State an executed provider agreement described in paragraph (2); and

[163] P.L. 93–406.

(C) has not been found, by the Secretary or the State, to have violated such agreement or other applicable requirements established by the Secretary or the State consistent with this section.

(2) PROVIDER AGREEMENT.—A provider agreement for a provider under this paragraph is an agreement (in such form and manner as the Secretary may require) that the provider agrees as follows:

(A)(i) Before administering a qualified pediatric vaccine to a child, the provider will ask a parent of the child such questions as are necessary to determine whether the child is a vaccine-eligible child, but the provider need not independently verify the answers to such questions.

(ii) The provider will, for a period of time specified by the Secretary, maintain records of responses made to the questions.

(iii) The provider will, upon request, make such records available to the State and to the Secretary, subject to section 1902(a)(7).

(B)(i) Subject to clause (ii), the provider will comply with the schedule, regarding the appropriate periodicity, dosage, and contraindications applicable to pediatric vaccines, that is established and periodically reviewed and, as appropriate, revised by the advisory committee referred to in subsection (e), except in such cases as, in the provider's medical judgment subject to accepted medical practice, such compliance is medically inappropriate.

(ii) The provider will provide pediatric vaccines in compliance with applicable State law, including any such law relating to any religious or other exemption.

(C)(i) In administering a qualified pediatric vaccine to a vaccine-eligible child, the provider will not impose a charge for the cost of the vaccine. A program-registered provider is not required under this section to administer such a vaccine to each child for whom an immunization with the vaccine is sought from the provider.

(ii) The provider may impose a fee for the administration of a qualified pediatric vaccine so long as the fee in the case of a federally vaccine-eligible child does not exceed the costs of such administration (as determined by the Secretary based on actual regional costs for such administration).

(iii) The provider will not deny administration of a qualified pediatric vaccine to a vaccine-eligible child due to the inability of the child's parent to pay an administration fee.

(3) ENCOURAGING INVOLVEMENT OF PROVIDERS.—Each program under this section shall provide, in accordance with criteria established by the Secretary—

(A) for encouraging the following to become program-registered providers: private health care providers, the Indian Health Service, health care providers that receive funds under title V of the Indian Health Care Improvement

Act[164], and health programs or facilities operated by Indian tribes or tribal organizations; and

(B) for identifying, with respect to any population of vaccine-eligible children a substantial portion of whose parents have a limited ability to speak the English language, those program-registered providers who are able to communicate with the population involved in the language and cultural context that is most appropriate.

(4) STATE REQUIREMENTS.—Except as the Secretary may permit in order to prevent fraud and abuse and for related purposes, a State may not impose additional qualifications or conditions, in addition to the requirements of paragraph (1), in order that a provider qualify as a program-registered provider under this section. This subsection does not limit the exercise of State authority under section 1915(b).

(d) NEGOTIATION OF CONTRACTS WITH MANUFACTURERS.—

(1) IN GENERAL.—For the purpose of meeting obligations under this section, the Secretary shall negotiate and enter into contracts with manufacturers of pediatric vaccines consistent with the requirements of this subsection and, to the maximum extent practicable, consolidate such contracting with any other contracting activities conducted by the Secretary to purchase vaccines. The Secretary may enter into such contracts under which the Federal Government is obligated to make outlays, the budget authority for which is not provided for in advance in appropriations Acts, for the purchase and delivery of pediatric vaccines under subsection (a)(2)(A).

(2) AUTHORITY TO DECLINE CONTRACTS.—The Secretary may decline to enter into such contracts and may modify or extend such contracts.

(3) CONTRACT PRICE.—

(A) IN GENERAL.—The Secretary, in negotiating the prices at which pediatric vaccines will be purchased and delivered from a manufacturer under this subsection, shall take into account quantities of vaccines to be purchased by States under the option under paragraph (4)(B).

(B) NEGOTIATION OF DISCOUNTED PRICE FOR CURRENT VACCINES.—With respect to contracts entered into under this subsection for a pediatric vaccine for which the Centers for Disease Control and Prevention has a contract in effect under section 317(j)(1) of the Public Health Service Act[165] as of May 1, 1993, no price for the purchase of such vaccine for vaccine-eligible children shall be agreed to by the Secretary under this subsection if the price per dose of such vaccine (including delivery costs and any applicable excise tax established under section 4131 of the Internal Revenue Code of 1986[166]) exceeds the price per dose for the vaccine in effect under such a contract as of such date increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) from May 1993 to the month before the month in which such contract is entered into.

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[164] See Vol. II, P.L. 94–437.
[165] See Vol. II, P.L. 78–410.
[166] See Vol. II, P.L. 83–591.

(C) NEGOTIATION OF DISCOUNTED PRICE FOR NEW VACCINES.—With respect to contracts entered into for a pediatric vaccine not described in subparagraph (B), the price for the purchase of such vaccine shall be a discounted price negotiated by the Secretary that may be established without regard to such subparagraph.

(4) QUANTITIES AND TERMS OF DELIVERY.—Under such contracts—

(A) the Secretary shall provide, consistent with paragraph (6), for the purchase and delivery on behalf of States (and tribes and tribal organizations) of quantities of pediatric vaccines for federally vaccine-eligible children; and

(B) each State, at the option of the State, shall be permitted to obtain additional quantities of pediatric vaccines (subject to amounts specified to the Secretary by the State in advance of negotiations) through purchasing the vaccines from the manufacturers at the applicable price negotiated by the Secretary consistent with paragraph (3), if (i) the State agrees that the vaccines will be used to provide immunizations only for children who are not federally vaccine-eligible children and (ii) the State provides to the Secretary such information (at a time and manner specified by the Secretary, including in advance of negotiations under paragraph (1)) as the Secretary determines to be necessary, to provide for quantities of pediatric vaccines for the State to purchase pursuant to this subsection and to determine annually the percentage of the vaccine market that is purchased pursuant to this section and this subparagraph.

The Secretary shall enter into the initial negotiations under the preceding sentence not later than 180 days after the date of the enactment of the Omnibus Budget Reconciliation Act of 1993 [167].

(5) CHARGES FOR SHIPPING AND HANDLING.—The Secretary may enter into a contract referred to in paragraph (1) only if the manufacturer involved agrees to submit to the Secretary such reports as the Secretary determines to be appropriate to assure compliance with the contract and if, with respect to a State program under this section that does not provide for the direct delivery of qualified pediatric vaccines, the manufacturer involved agrees that the manufacturer will provide for the delivery of the vaccines on behalf of the State in accordance with such program and will not impose any charges for the costs of such delivery (except to the extent such costs are provided for in the price established under paragraph (3)).

(6) ASSURING ADEQUATE SUPPLY OF VACCINES.—The Secretary, in negotiations under paragraph (1), shall negotiate for quantities of pediatric vaccines such that an adequate supply of such vaccines will be maintained to meet unanticipated needs for the vaccines. For purposes of the preceding sentence, the Secretary shall negotiate for a 6-month supply of vaccines in addition to the quantity that the Secretary otherwise would provide for in such negotiations. In carrying out this paragraph, the Secretary shall consider the potential for outbreaks

[167] August 10, 1993 [P.L. 103–66; 107 Stat. 312].

of the diseases with respect to which the vaccines have been developed.

(7) MULTIPLE SUPPLIERS.—In the case of the pediatric vaccine involved, the Secretary shall, as appropriate, enter into a contract referred to in paragraph (1) with each manufacturer of the vaccine that meets the terms and conditions of the Secretary for an award of such a contract (including terms and conditions regarding safety and quality). With respect to multiple contracts entered into pursuant to this paragraph, the Secretary may have in effect different prices under each of such contracts and, with respect to a purchase by States pursuant to paragraph (4)(B), the Secretary shall determine which of such contracts will be applicable to the purchase.

(e) USE OF PEDIATRIC VACCINES LIST.—The Secretary shall use, for the purpose of the purchase, delivery, and administration of pediatric vaccines under this section, the list established (and periodically reviewed and as appropriate revised) by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention).

(f) Requirement of State Maintenance of Immunization Laws.—In the case of a State that had in effect as of May 1, 1993, a law that requires some or all health insurance policies or plans to provide some coverage with respect to a pediatric vaccine, a State program under this section does not comply with the requirements of this section unless the State certifies to the Secretary that the State has not modified or repealed such law in a manner that reduces the amount of coverage so required.

(g) TERMINATION.—This section, and the requirement of section 1902(a)(62), shall cease to be in effect beginning on such date as may be prescribed in Federal law providing for immunization services for all children as part of a broad-based reform of the national health care system.

(h) DEFINITIONS.—For purposes of this section:

(1) The term "child" means an individual 18 years of age or younger.

(2) The term "immunization" means an immunization against a vaccine-preventable disease.

(3) The terms "Indian", "Indian tribe" and "tribal organization" have the meanings given such terms in section 4 of the Indian Health Care Improvement Act [168].

(4) The term "manufacturer" means any corporation, organization, or institution, whether public or private (including Federal, State, and local departments, agencies, and instrumentalities), which manufactures, imports, processes, or distributes under its label any pediatric vaccine. The term "manufacture" means to manufacture, import, process, or distribute a vaccine.

(5) The term "parent" includes, with respect to a child, an individual who qualifies as a legal guardian under State law.

(6) The term "pediatric vaccine" means a vaccine included on the list under subsection (e). [169]

(7) The term "program-registered provider" has the meaning given such term in subsection (c).

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[168] See Vol. II, P.L. 94–437.

[169] See Vol. II, P.L. 103–66, §13631(d), with respect to continued coverage of costs of a pediatric vaccine under certain group health plans.

(8) The term "qualified pediatric vaccine" means a pediatric vaccine with respect to which a contract is in effect under subsection (d).

(9) The terms "vaccine-eligible child", "federally vaccine-eligible child", and "State vaccine-eligible child" have the meaning given such terms in subsection (b).

HOME AND COMMUNITY CARE FOR FUNCTIONALLY DISABLED ELDERLY INDIVIDUALS

SEC. 1929. [42 U.S.C. 1396t] (a) HOME AND COMMUNITY CARE DEFINED.—In this title, the term "home and community care" means one or more of the following services furnished to an individual who has been determined, after an assessment under subsection (c), to be a functionally disabled elderly individual, furnished in accordance with an individual community care plan (established and periodically reviewed and revised by a qualified community care case manager under subsection (d)):

(1) Homemaker/home health aide services.

(2) Chore services.

(3) Personal care services.

(4) Nursing care services provided by, or under the supervision of, a registered nurse.

(5) Respite care.

(6) Training for family members in managing the individual.

(7) Adult day care.

(8) In the case of an individual with chronic mental illness, day treatment or other partial hospitalization, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility).

(9) Such other home and community-based services (other than room and board) as the Secretary may approve.

(b) FUNCTIONALLY DISABLED ELDERLY INDIVIDUAL DEFINED.—

(1) In general.—In this title, the term "functionally disabled elderly individual" means an individual who—

(A) is 65 years of age or older,

(B) is determined to be a functionally disabled individual under subsection (c), and

(C) subject to section 1902(f) (as applied consistent with section 1902(r)(2)), is receiving supplemental security income benefits under title XVI (or under a State plan approved under title XVI) or, at the option of the State, is described in section 1902(a)(10)(C).

(2) TREATMENT OF CERTAIN INDIVIDUALS PREVIOUSLY COVERED UNDER A WAIVER.—(A) In the case of a State which—

(i) at the time of its election to provide coverage for home and community care under this section has a waiver approved under section 1915(c) or 1915(d) with respect to individuals 65 years of age or older, and

(ii) subsequently discontinues such waiver, individuals who were eligible for benefits under the waiver as of the date of its discontinuance and who would, but for income or resources, be eligible for medical assistance for home and community care under the plan shall, notwithstanding any other provision of this title, be deemed a functionally disabled elderly individual

for so long as the individual would have remained eligible for medical assistance under such waiver.

(B) In the case of a State which used a health insuring organization before January 1, 1986, and which, as of December 31, 1990, had in effect a waiver under section 1115 that provides under the State plan under this title for personal care services for functionally disabled individuals, the term "functionally disabled elderly individual" may include, at the option of the State, an individual who—

(i) is 65 years of age or older or is disabled (as determined under the supplemental security income program under title XVI);

(ii) is determined to meet the test of functional disability applied under the waiver as of such date; and

(iii) meets the resource requirement and income standard that apply in the State to individuals described in section 1902(a)(10)(A)(ii)(V).

(3) USE OF PROJECTED INCOME.—In applying section 1903(f)(1) in determining the eligibility of an individual (described in section 1902(a)(10)(C)) for medical assistance for home and community care, a State may, at its option, provide for the determination of the individual's anticipated medical expenses (to be deducted from income) over a period of up to 6 months.

(c) DETERMINATIONS OF FUNCTIONAL DISABILITY.—

(1) IN GENERAL.—In this section, an individual is "functionally disabled" if the individual—

(A) is unable to perform without substantial assistance from another individual at least 2 of the following 3 activities of daily living: toileting, transferring, and eating; or

(B) has a primary or secondary diagnosis of Alzheimer's disease and is (i) unable to perform without substantial human assistance (including verbal reminding or physical cueing) or supervision at least 2 of the following 5 activities of daily living: bathing, dressing, toileting, transferring, and eating; or (ii) cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors that pose serious health or safety hazards to himself or herself or others.

(2) ASSESSMENTS OF FUNCTIONAL DISABILITY.—

(A) REQUESTS FOR ASSESSMENTS.—If a State has elected to provide home and community care under this section, upon the request of an individual who is 65 years of age or older and who meets the requirements of subsection (b)(1)(C) (or another person on such individual's behalf), the State shall provide for a comprehensive functional assessment under this subparagraph which—

(i) is used to determine whether or not the individual is functionally disabled,

(ii) is based on a uniform minimum data set specified by the Secretary under subparagraph (C)(i), and

(iii) uses an instrument which has been specified by the State under subparagraph (B).

No fee may be charged for such an assessment.

(B) SPECIFICATION OF ASSESSMENT INSTRUMENT.—The State shall specify the instrument to be used in the State in complying with the requirement of subparagraph (A)(iii) which instrument shall be—

(i) one of the instruments designated under subparagraph (C)(ii); or

(ii) an instrument which the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by the Secretary in subparagraph (C)(i).

(C) SPECIFICATION OF ASSESSMENT DATA SET AND INSTRUMENTS.—The Secretary shall—

(i) not later than July 1, 1991—

(I) specify a minimum data set of core elements and common definitions for use in conducting the assessments required under subparagraph (A); and

(II) establish guidelines for use of the data set; and

(ii) by not later than July 1, 1991, designate one or more instruments which are consistent with the specification made under subparagraph (A) and which a State may specify under subparagraph (B) for use in complying with the requirements of subparagraph (A).

(D) PERIODIC REVIEW.—Each individual who qualifies as a functionally disabled elderly individual shall have the individual's assessment periodically reviewed and revised not less often than once every 12 months.

(E) CONDUCT OF ASSESSMENT BY INTERDISCIPLINARY TEAMS.—An assessment under subparagraph (A) and a review under subparagraph (D) must be conducted by an interdisciplinary team designated by the State. The Secretary shall permit a State to provide for assessments and reviews through teams under contracts—

(i) with public organizations; or

(ii) with nonpublic organizations which do not provide home and community care or nursing facility services and do not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides, community care or nursing facility services.

(F) CONTENTS OF ASSESSMENT.—The interdisciplinary team must—

(i) identify in each such assessment or review each individual's functional disabilities and need for home and community care, including information about the individual's health status, home and community environment, and informal support system; and

(ii) based on such assessment or review, determine whether the individual is (or continues to be) functionally disabled.

The results of such an assessment or review shall be used in establishing, reviewing, and revising the individual's ICCP under subsection (d)(1).

(G) APPEAL PROCEDURES.—Each State which elects to provide home and community care under this section must have in effect an appeals process for individuals adversely affected by determinations under subparagraph (F).

(d) INDIVIDUAL COMMUNITY CARE PLAN (ICCP).—

(1) INDIVIDUAL COMMUNITY CARE PLAN DEFINED.—In this section, the terms "individual community care plan" and "ICCP" mean, with respect to a functionally disabled elderly individual, a written plan which—

(A) is established, and is periodically reviewed and revised, by a qualified case manager after a face-to-face interview with the individual or primary caregiver and based upon the most recent comprehensive functional assessment of such individual conducted under subsection (c)(2);

(B) specifies, within any amount, duration, and scope limitations imposed on home and community care provided under the State plan, the home and community care to be provided to such individual under the plan, and indicates the individual's preferences for the types and providers of services; and

(C) may specify other services required by such individual.

An ICCP may also designate the specific providers (qualified to provide home and community care under the State plan) which will provide the home and community care described in subparagraph (B). Nothing in this section shall be construed as authorizing an ICCP or the State to restrict the specific persons or individuals (who are competent to provide home and community care under the State plan) who will provide the home and community care described in subparagraph (B).

(2) QUALIFIED COMMUNITY CARE CASE MANAGER DEFINED.—In this section, the term "qualified community care case manager" means a nonprofit or public agency or organization which—

(A) has experience or has been trained in establishing, and in periodically reviewing and revising, individual community care plans and in the provision of case management services to the elderly;

(B) is responsible for (i) assuring that home and community care covered under the State plan and specified in the ICCP is being provided, (ii) visiting each individual's home or community setting where care is being provided not less often than once every 90 days, and (iii) informing the elderly individual or primary caregiver on how to contact the case manager if service providers fail to properly provide services or other similar problems occur;

(C) in the case of a nonpublic agency, does not provide home and community care or nursing facility services and does not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides, home and community care or nursing facility services;

(D) has procedures for assuring the quality of case management services that includes a peer review process;

(E) completes the ICCP in a timely manner and reviews and discusses new and revised ICCPs with elderly individuals or primary caregivers; and

(F) meets such other standards, established by the Secretary, as to assure that—

(i) such a manager is competent to perform case management functions;

(ii) individuals whose home and community care they manage are not at risk of financial exploitation due to such a manager; and

(iii) meets such other standards as the State may establish.

The Secretary may waive the requirement of subparagraph (C) in the case of a nonprofit agency located in a rural area.

(3) APPEALS PROCESS.—Each State which elects to provide home and community care under this section must have in effect an appeals process for individuals who disagree with the ICCP established.

(e) CEILING ON PAYMENT AMOUNTS AND MAINTENANCE OF EFFORT.—

(1) CEILING ON PAYMENT AMOUNTS.—Payments may not be made under section 1903(a) to a State for home and community care provided under this section in a quarter to the extent that the medical assistance for such care in the quarter exceeds 50 percent of the product of—

(A) the average number of individuals in the quarter receiving such care under this section;

(B) the average per diem rate of payment which the Secretary has determined (before the beginning of the quarter) will be payable under title XVIII (without regard to coinsurance) for extended care services to be provided in the State during such quarter; and

(C) the number of days in such quarter.

(2) MAINTENANCE OF EFFORT.—

(A) ANNUAL REPORTS.—As a condition for the receipt of payment under section 1903(a) with respect to medical assistance provided by a State for home and community care (other than a waiver under section 1915(c) and other than home health care services described in section 1905(a)(7) and personal care services specified under regulations under section 1905(a)(23)), the State shall report to the Secretary, with respect to each Federal fiscal year (beginning with fiscal year 1990) and in a format developed or approved by the Secretary, the amount of funds obligated by the State with respect to the provision of home and community care to the functionally disabled elderly in that fiscal year.

(B) REDUCTION IN PAYMENT IF FAILURE TO MAINTAIN EFFORT.—If the amount reported under subparagraph (A) by a State with respect to a fiscal year is less than the amount reported under subparagraph (A) with respect to fiscal year 1989, the Secretary shall provide for a reduction in payments to the State under section 1903(a) in an amount equal to the difference between the amounts so reported.

(f) MINIMUM REQUIREMENTS FOR HOME AND COMMUNITY CARE.—

(1) REQUIREMENTS.—Home and Community care provided under this section must meet such requirements for individuals' rights and quality as are published or developed by the Secretary under subsection (k). Such requirements shall include—

(A) the requirement that individuals providing care are competent to provide such care; and

(B) the rights specified in paragraph (2).

(2) SPECIFIED RIGHTS.—The rights specified in this paragraph are as follows:

(A) The right to be fully informed in advance, orally and in writing, of the care to be provided, to be fully informed in advance of any changes in care to be provided, and (except with respect to an individual determined incompetent) to participate in planning care or changes in care.

(B) The right to voice grievances with respect to services that are (or fail to be) furnished without discrimination or reprisal for voicing grievances, and to be told how to complain to State and local authorities.

(C) The right to confidentiality of personal and clinical records.

(D) The right to privacy and to have one's property treated with respect.

(E) The right to refuse all or part of any care and to be informed of the likely consequences of such refusal.

(F) The right to education or training for oneself and for members of one's family or household on the management of care.

(G) The right to be free from physical or mental abuse, corporal punishment, and any physical or chemical restraints imposed for purposes of discipline or convenience and not included in an individual's ICCP.

(H) The right to be fully informed orally and in writing of the individual's rights.

(I) Guidelines for such minimum compensation for individuals providing such care as will assure the availability and continuity of competent individuals to provide such care for functionally disabled individuals who have functional disabilities of varying levels of severity.

(J) Any other rights established by the Secretary.

(g) MINIMUM REQUIREMENTS FOR SMALL COMMUNITY CARE SETTINGS.—

(1) SMALL COMMUNITY CARE SETTINGS DEFINED.—In this section, the term "small community care setting" means—

(A) a nonresidential setting that serves more than 2 and less than 8 individuals; or

(B) a residential setting in which more than 2 and less than 8 unrelated adults reside and in which personal services (other than merely board) are provided in conjunction with residing in the setting.

(2) MINIMUM REQUIREMENTS.—A small community care setting in which community care is provided under this section must—

(A) meet such requirements as are published or developed by the Secretary under subsection (k);

(B) meet the requirements of paragraphs (1)(A), (1)(C), (1)(D), (3), and (6) of section 1919(c), to the extent applicable to such a setting;

(C) inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting;

(D) meet any applicable State or local requirements regarding certification or licensure;

(E) meet any applicable State and local zoning, building, and housing codes, and State and local fire and safety regulations; and

(F) be designed, constructed, equipped, and maintained in a manner to protect the health and safety of residents.

(h) MINIMUM REQUIREMENTS FOR LARGE COMMUNITY CARE SETTINGS.—

(1) Large community care setting defined.—In this section, the term "large community care setting" means—

(A) a nonresidential setting in which more than 8 individuals are served; or

(B) a residential setting in which more than 8 unrelated adults reside and in which personal services are provided in conjunction with residing in the setting in which home and community care under this section is provided.

(2) MINIMUM REQUIREMENTS.—A large community care setting in which community care is provided under this section must—

(A) meet such requirements as are published or developed by the Secretary under subsection (k);

(B) meet the requirements of paragraphs (1)(A), (1)(C), (1)(D), (3), and (6) of section 1919(c), to the extent applicable to such a setting;

(C) inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives home and community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting; and

(D) meet the requirements of paragraphs (2) and (3) of section 1919(d) (relating to administration and other matters) in the same manner as such requirements apply to nursing facilities under such section; except that, in applying the requirement of section 1919(d)(2) (relating to life safety code), the Secretary shall provide for the application of such life safety requirements (if any) that are appropriate to the setting.

(3) DISCLOSURE OF OWNERSHIP AND CONTROL INTERESTS AND EXCLUSION OF REPEATED VIOLATORS.—A community care setting—

(A) must disclose persons with an ownership or control interest (including such persons as defined in section 1124(a)(3)) in the setting; and

(B) may not have, as a person with an ownership or control interest in the setting, any individual or person who has been excluded from participation in the program under

this title or who has had such an ownership or control interest in one or more community care settings which have been found repeatedly to be substandard or to have failed to meet the requirements of paragraph (2).

(i) SURVEY AND CERTIFICATION PROCESS.—

(1) CERTIFICATIONS.—

(A) RESPONSIBILITIES OF THE STATE.—Under each State plan under this title, the State shall be responsible for certifying the compliance of providers of home and community care and community care settings with the applicable requirements of subsections (f), (g) and (h). The failure of the Secretary to issue regulations to carry out this subsection shall not relieve a State of its responsibility under this subsection.

(B) RESPONSIBILITIES OF THE SECRETARY.—The Secretary shall be responsible for certifying the compliance of State providers of home and community care, and of State community care settings in which such care is provided, with the requirements of subsections (f), (g) and (h).

(C) FREQUENCY OF CERTIFICATIONS.—Certification of providers and settings under this subsection shall occur no less frequently than once every 12 months.

(2) REVIEWS OF PROVIDERS.—

(A) IN GENERAL.—The certification under this subsection with respect to a provider of home or community care must be based on a periodic review of the provider's performance in providing the care required under ICCP's in accordance with the requirements of subsection (f).

(B) Special reviews of compliance.—Where the Secretary has reason to question the compliance of a provider of home or community care with any of the requirements of subsection (f), the Secretary may conduct a review of the provider and, on the basis of that review, make independent and binding determinations concerning the extent to which the provider meets such requirements.

(3) SURVEYS OF COMMUNITY CARE SETTINGS.—

(A) IN GENERAL.—The certification under this subsection with respect to community care settings must be based on a survey. Such survey for such a setting must be conducted without prior notice to the setting. Any individual who notifies (or causes to be notified) a community care setting of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). The Secretary shall review each State's procedures for scheduling and conducting such surveys to assure that the State has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

(B) SURVEY PROTOCOL.—Surveys under this paragraph shall be conducted based upon a protocol which the Secretary has provider for under subsection (k).

(C) PROHIBITION OF CONFLICT OF INTEREST IN SURVEY TEAM MEMBERSHIP.—A State and the Secretary may not use as a member of a survey team under this paragraph an individual who is serving (or has served within the previous 2 years) as a member of the staff of, or as a consultant to, the community care setting being surveyed (or the person responsible for such setting) respecting compliance with the requirements of subsection (g) or (h) or who has a personal or familial financial interest in the setting being surveyed.

(D) VALIDATION SURVEYS OF COMMUNITY CARE SETTINGS.—The Secretary shall conduct onsite surveys of a representative sample of community care settings in each State, within 2 months of the date of surveys conducted under subparagraph (A) by the State, in a sufficient number to allow inferences about the adequacies of each State's surveys conducted under subparagraph (A). In conducting such surveys, the Secretary shall use the same survey protocols as the State is required to use under subparagraph (B). If the State has determined that an individual setting meets the requirements of subsection (g), but the Secretary determines that the setting does not meet such requirements, the Secretary's determination as to the setting's noncompliance with such requirements is binding and supersedes that of the State survey.

(E) SPECIAL SURVEYS OF COMPLIANCE.—Where the Secretary has reason to question the compliance of a community care setting with any of the requirements of subsection (g) or (h), the Secretary may conduct a survey of the setting and, on the basis of that survey, make independent and binding determinations concerning the extent to which the setting meets such requirements.

(4) INVESTIGATION OF COMPLAINTS AND MONITORING OF PROVIDERS AND SETTINGS.—Each State and the Secretary shall maintain procedures and adequate staff to investigate complaints of violations of applicable requirements imposed on providers of community care or on community care settings under subsections (f), (g) and (h).

(5) INVESTIGATION OF ALLEGATIONS OF INDIVIDUAL NEGLECT AND ABUSE AND MISAPPROPRIATION OF INDIVIDUAL PROPERTY.—The State shall provide, through the agency responsible for surveys and certification of providers of home or community care and community care settings under this subsection, for a process for the receipt, review, and investigation of allegations of individual neglect and abuse (including injuries of unknown source) by individuals providing such care or in such setting and of misappropriation of individual property by such individuals. The State shall, after notice to the individual involved and a reasonable opportunity for hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations. If the State finds that an individual has neglected or abused an individual receiving community care or misappropriated such individual's property, the State shall notify the individual against whom the finding is made. A State shall not make a finding that a person has neglected an individual receiving community care if the person demonstrates that such

neglect was caused by factors beyond the control of the person. The State shall provide for public disclosure of findings under this paragraph upon request and for inclusion, in any such disclosure of such findings, of any brief statement (or of a clear and accurate summary thereof) of the individual disputing such findings.

(6) DISCLOSURE OF RESULTS OF INSPECTIONS AND ACTIVITIES.—

(A) PUBLIC INFORMATION.—Each State, and the Secretary, shall make available to the public—

(i) information respecting all surveys, reviews, and certifications made under this subsection respecting providers of home or community care and community care settings, including statements of deficiencies,

(ii) copies of cost reports (if any) of such providers and settings filed under this title,

(iii) copies of statements of ownership under section 1124, and

(iv) information disclosed under section 1126.

(B) NOTICES OF SUBSTANDARD CARE.—If a State finds that—

(i) a provider of home or community care has provided care of substandard quality with respect to an individual, the State shall make a reasonable effort to notify promptly (I) an immediate family member of each such individual and (II) individuals receiving home or community care from that provider under this title, or

(ii) a community care setting is substandard, the State shall make a reasonable effort to notify promptly (I) individuals receiving community care in that setting, and (II) immediate family members of such individuals.

(C) ACCESS TO FRAUD CONTROL UNITS.—Each State shall provide its State medicaid fraud and abuse control unit (established under section 1903(q)) with access to all information of the State agency responsible for surveys, reviews, and certifications under this subsection.

(j) ENFORCEMENT PROCESS FOR PROVIDERS OF COMMUNITY CARE.—

(1) STATE AUTHORITY.—

(A) IN GENERAL.—If a State finds, on the basis of a review under subsection (i)(2) or otherwise, that a provider of home or community care no longer meets the requirements of this section, the State may terminate the provider's participation under the State plan and may provide in addition for a civil money penalty. Nothing in this subparagraph shall be construed as restricting the remedies available to a State to remedy a provider's deficiencies. If the State finds that a provider meets such requirements but, as of a previous period, did not meet such requirements, the State may provide for a civil money penalty under paragraph (2)(A) for the period during which it finds that the provider was not in compliance with such requirements.

(B) CIVIL MONEY PENALTY.—

(i) IN GENERAL.—Each State shall establish by law (whether statute or regulation) at least the following remedy: A civil money penalty assessed and collected, with interest, for each day in which the provider is or was out of compliance with a requirement of this section. Funds collected by a State as a result of imposition of such a penalty (or as a result of the imposition by the State of a civil money penalty under subsection (i)(3)(A)) may be applied to reimbursement of individuals for personal funds lost due to a failure of home or community care providers to meet the requirements of this section. The State also shall specify criteria, as to when and how this remedy is to be applied and the amounts of any penalties. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the penalties and shall provide for the imposition of incrementally more severe penalties for repeated or uncorrected deficiencies.

(ii) DEADLINE AND GUIDANCE.—Each State which elects to provide home and community care under this section must establish the civil money penalty remedy described in clause (i) applicable to all providers of community care covered under this section. The Secretary shall provide, through regulations or otherwise by not later than July 1, 1990, guidance to States in establishing such remedy; but the failure of the Secretary to provide such guidance shall not relieve a State of the responsibility for establishing such remedy.

(2) SECRETARIAL AUTHORITY.—

(A) FOR STATE PROVIDERS.—With respect to a State provider of home or community care, the Secretary shall have the authority and duties of a State under this subsection, except that the civil money penalty remedy described in subparagraph (C) shall be substituted for the civil money remedy described in paragraph (1)(B)(i).

(B) OTHER PROVIDERS.—With respect to any other provider of home or community care in a State, if the Secretary finds that a provider no longer meets a requirement of this section, the Secretary may terminate the provider's participation under the State plan and may provide, in addition, for a civil money penalty under subparagraph (C). If the Secretary finds that a provider meets such requirements but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subparagraph (C) for the period during which the Secretary finds that the provider was not in compliance with such requirements.

(C) CIVIL MONEY PENALTY.—If the Secretary finds on the basis of a review under subsection (i)(2) or otherwise that a home or community care provider no longer meets the requirements of this section, the Secretary shall impose a civil money penalty in an amount not to exceed $10,000 for each day of noncompliance. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to

a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). The Secretary shall specify criteria, as to when and how this remedy is to be applied and the amounts of any penalties. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the penalties and shall provide for the imposition of incrementally more severe penalties for repeated or uncorrected deficiencies.

(k) SECRETARIAL RESPONSIBILITIES.—

(1) PUBLICATION OF INTERIM REQUIREMENTS.—

(A) IN GENERAL.—The Secretary shall publish, by December 1, 1991, a proposed regulation that sets forth interim requirements, consistent with subparagraph (B), for the provision of home and community care and for community care settings, including—

(i) the requirements of subsection (c)(2) (relating to comprehensive functional assessments, including the use of assessment instruments), of subsection (d)(2)(E) (relating to qualifications for qualified case managers), of subsection (f) (relating to minimum requirements for home and community care), of subsection (g) (relating to minimum requirements for small community care settings), and of subsection (h) (relating to minimum requirements for large community care settings), and

(ii) survey protocols (for use under subsection (i)(3)(A)) which relate to such requirements.

(B) MINIMUM PROTECTIONS.—Interim requirements under subparagraph (A) and final requirements under paragraph (2) shall assure, through methods other than reliance on State licensure processes, that individuals receiving home and community care are protected from neglect, physical and sexual abuse, financial exploitation, inappropriate involuntary restraint, and the provision of health care services by unqualified personnel in community care settings.

(2) DEVELOPMENT OF FINAL REQUIREMENTS.—The Secretary shall develop, by not later than October 1, 1992—

(A) final requirements, consistent with paragraph (1)(B), respecting the provision of appropriate, quality home and community care and respecting community care settings under this section, and including at least the requirements referred to in paragraph (1)(A)(i), and

(B) survey protocols and methods for evaluating and assuring the quality of community care settings.

The Secretary may, from time to time, revise such requirements, protocols, and methods.

(3) NO DELEGATION TO STATES.—The Secretary's authority under this subsection shall not be delegated to States.

(4) No prevention of more stringent requirements by states.—Nothing in this section shall be construed as preventing States from imposing requirements that are more stringent than the requirements published or developed by the Secretary under this subsection.

(l) Waiver of Statewideness.—States may waive the requirement of section 1902(a)(1) (related to Statewideness) for a program of home and community care under this section.

(m) Limitation on Amount of Expenditures as Medical Assistance.—

(1) LIMITATION ON AMOUNT.—The amount of funds that may be expended as medical assistance to carry out the purposes of this section shall be for fiscal year 1991, $40,000,000, for fiscal year 1992, $70,000,000, for fiscal year 1993, $130,000,000, for fiscal year 1994, $160,000,000, and for fiscal year 1995, $180,000,000.

(2) ASSURANCE OF ENTITLEMENT TO SERVICE.—A State which receives Federal medical assistance for expenditures for home and community care under this section must provide home and community care specified under the Individual Community Care Plan under subsection (d) to individuals described in subsection (b) for the duration of the election period, without regard to the amount of funds available to the State under paragraph (1). For purposes of this paragraph, an election period is the period of 4 or more calendar quarters elected by the State, and approved by the Secretary, for the provision of home and community care under this section.

(3) LIMITATION ON ELIGIBILITY.—The State may limit eligibility for home and community care under this section during an election period under paragraph (2) to reasonable classifications (based on age, degree of functional disability, and need for services).

(4) ALLOCATION OF MEDICAL ASSISTANCE.—The Secretary shall establish a limitation on the amount of Federal medical assistance available to any State during the State's election period under paragraph (2). The limitation under this paragraph shall take into account the limitation under paragraph (1) and the number of elderly individuals age 65 or over residing in such State in relation to the number of such elderly individuals in the United States during 1990. For purposes of the previous sentence, elderly individuals shall, to the maximum extent practicable, be low-income elderly individuals.

COMMUNITY SUPPORTED LIVING ARRANGEMENTS SERVICES

SEC. 1930. [42 U.S.C. 1396u] (a) COMMUNITY SUPPORTED LIVING ARRANGEMENTS SERVICES.—In this title, the term "community supported living arrangements services" means one or more of the following services meeting the requirements of subsection (h) provided in a State eligible to provide services under this section (as defined in subsection (d)) to assist a developmentally disabled individual (as defined in subsection (b)) in activities of daily living necessary to permit such individual to live in the individual's own home, apartment, family home, or rental unit furnished in a community supported living arrangement setting:

(1) Personal assistance.

(2) Training and habilitation services (necessary to assist the individual in achieving increased integration, independence and productivity).

(3) 24-hour emergency assistance (as defined by the Secretary).

(4) Assistive technology.

(5) Adaptive equipment.

(6) Other services (as approved by the Secretary, except those services described in subsection (g)).

(7) Support services necessary to aid an individual to participate in community activities.

(b) DEVELOPMENTALLY DISABLED INDIVIDUAL DEFINED.—In this title the term, "developmentally disabled individual" means an individual who as defined by the Secretary is described within the term "mental retardation and related conditions" as defined in regulations as in effect on July 1, 1990, and who is residing with the individual's family or legal guardian in such individual's own home in which no more than 3 other recipients of services under this section are residing and without regard to whether or not such individual is at risk of institutionalization (as defined by the Secretary).

(c) CRITERIA FOR SELECTION OF PARTICIPATING STATES.—The Secretary shall develop criteria to review the applications of States submitted under this section to provide community supported living arrangement services. The Secretary shall provide in such criteria that during the first 5 years of the provision of services under this section that no less than 2 and no more than 8 States shall be allowed to receive Federal financial participation for providing the services described in this section.

(d) QUALITY ASSURANCE.—A State selected by the Secretary to provide services under this section shall in order to continue to receive Federal financial participation for providing services under this section be required to establish and maintain a quality assurance program, that provides that—

(1) the State will certify and survey providers of services under this section (such surveys to be unannounced and average at least 1 a year);

(2) the State will adopt standards for survey and certification that include—

(A) minimum qualifications and training requirements for provider staff;

(B) financial operating standards; and

(C) a consumer grievance process;

(3) the State will provide a system that allows for monitoring boards consisting of providers, family members, consumers, and neighbors;

(4) the State will establish reporting procedures to make available information to the public;

(5) the State will provide ongoing monitoring of the health and well-being of each recipient;

(6) the State will provide the services defined in subsection (a) in accordance with an individual support plan (as defined by the Secretary in regulations); and

(7) the State plan amendment under this section shall be reviewed by the State Council on Developmental Disabilities established under section 125 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 and the protection and advocacy system established under subtitle C of that Act.

The Secretary shall not approve a quality assurance plan under this subsection and allow a State to continue to receive Federal financial participation under this section unless the State provides

for public hearings on the plan prior to adoption and implementation of its plan under this subsection.

(e) MAINTENANCE OF EFFORT.—States selected by the Secretary to receive Federal financial participation to provide services under this section shall maintain current levels of spending for such services in order to be eligible to continue to receive Federal financial participation for the provision of such services under this section.

(f) Excluded Services.—No Federal financial participation shall be allowed for the provision of the following services under this section:

(1) Room and board.

(2) Cost of prevocational, vocational and supported employment.

(g) WAIVER OF REQUIREMENTS.—The Secretary may waive such provisions of this title as necessary to carry out the provisions of this section including the following requirements of this title—

(1) comparability of amount, duration, and scope of services; and

(2) statewideness.

(h) MINIMUM PROTECTIONS.—

(1) PUBLICATION OF INTERIM AND FINAL REQUIREMENTS.—

(A) IN GENERAL.—The Secretary shall publish, by July 1, 1991, a regulation (that shall be effective on an interim basis pending the promulgation of final regulations), and by October 1, 1992, a final regulation, that sets forth interim and final requirements, respectively, consistent with subparagraph (B), to protect the health, safety, and welfare of individuals receiving community supported living arrangements services.

(B) MINIMUM PROTECTIONS.—Interim and final requirements under subparagraph (A) shall assure, through methods other than reliance on State licensure processes or the State quality assurance programs under subsection (d), that—

(i) individuals receiving community supported living arrangements services are protected from neglect, physical and sexual abuse, and financial exploitation;

(ii) a provider of community supported living arrangements services may not use individuals who have been convicted of child or client abuse, neglect, or mistreatment or of a felony involving physical harm to an individual and shall take all reasonable steps to determine whether applicants for employment by the provider have histories indicating involvement in child or client abuse, neglect, or mistreatment or a criminal record involving physical harm to an individual;

(iii) individuals or entities delivering such services are not unjustly enriched as a result of abusive financial arrangements (such as owner lease-backs); and

(iv) individuals or entities delivering such services to clients, or relatives of such individuals, are prohibited from being named beneficiaries of life insurance policies purchased by (or on behalf of) such clients.

(2) SPECIFIED REMEDIES.—If the Secretary finds that a provider has not met an applicable requirement under subsection (h), the Secretary shall impose a civil money penalty in an

amount not to exceed $10,000 for each day of noncompliance. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(i) TREATMENT OF FUNDS.—Any funds expended under this section for medical assistance shall be in addition to funds expended for any existing services covered under the State plan, including any waiver services for which an individual receiving services under this program is already eligible.

(j) LIMITATION ON AMOUNTS OF EXPENDITURES AS MEDICAL ASSISTANCE.—The amount of funds that may be expended as medical assistance to carry out the purposes of this section shall be for fiscal year 1991, $5,000,000, for fiscal year 1992, $10,000,000, for fiscal year 1993, $20,000,000 for fiscal year 1994, $30,000,000, for fiscal year 1995, $35,000,000, and for fiscal years thereafter such sums as provided by Congress.

ASSURING COVERAGE FOR CERTAIN LOW–INCOME FAMILIES

SEC. 1931. [42 U.S.C. 1396u–1] (a) REFERENCES TO TITLE IV–A ARE REFERENCES TO PRE–WELFARE–REFORM PROVISIONS.—Subject to the succeeding provisions of this section, with respect to a State any reference in this title (or any other provision of law in relation to the operation of this title) to a provision of part A of title IV, or a State plan under such part (or a provision of such a plan), including income and resource standards and income and resource methodologies under such part or plan, shall be considered a reference to such a provision or plan as in effect as of July 16, 1996, with respect to the State.

(b) APPLICATION OF PRE–WELFARE–REFORM ELIGIBILITY CRITERIA.—

(1) IN GENERAL.—For purposes of this title, subject to paragraphs (2) and (3), in determining eligibility for medical assistance—

(A) an individual shall be treated as receiving aid or assistance under a State plan approved under part A of title IV only if the individual meets—

(i) the income and resource standards for determining eligibility under such plan, and

(ii) the eligibility requirements of such plan under subsections (a) through (c) of section 406 and section 407(a),

as in effect as of July 16, 1996; and

(B) the income and resource methodologies under such plan as of such date shall be used in the determination of whether any individual meets income and resource standards under such plan.

(2) STATE OPTION.—For purposes of applying this section, a State—

(A) may lower its income standards applicable with respect to part A of title IV, but not below the income standards applicable under its State plan under such part on May 1, 1988;

(B) may increase income or resource standards under the State plan referred to in paragraph (1) over a period

(beginning after July 16, 1996) by a percentage that does not exceed the percentage increase in the Consumer Price Index for all urban consumers (all items; United States city average) over such period; and

(C) may use income and resource methodologies that are less restrictive than the methodologies used under the State plan under such part as of July 16, 1996.

(3) OPTION TO TERMINATE MEDICAL ASSISTANCE FOR FAILURE TO MEET WORK REQUIREMENT.—

(A) INDIVIDUALS RECEIVING CASH ASSISTANCE UNDER TANF.—In the case of an individual who—

(i) is receiving cash assistance under a State program funded under part A of title IV,

(ii) is eligible for medical assistance under this title on a basis not related to section 1902(l), and

(iii) has the case assistance under such program terminated pursuant to section 407(e)(1)(B) (as in effect on or after the welfare reform effective date) because of refusing to work,

the State may terminate such individual's eligibility for medical assistance under this title until such time as there no longer is a basis for the termination of such cash assistance because of such refusal.

(B) EXCEPTION FOR CHILDREN.—Subparagraph (A) shall not be construed as permitting a State to terminate medical assistance for a minor child who is not the head of a household receiving assistance under a State program funded under part A of title IV.

(c) TREATMENT FOR PURPOSES OF TRANSITIONAL COVERAGE PROVISIONS.—

(1) TRANSITION IN THE CASE OF CHILD SUPPORT COLLECTIONS.—The provisions of section 406(h) (as in effect on July 16, 1996) shall apply, in relation to this title, with respect to individuals (and families composed of individuals) who are described in subsection (b)(1)(A), in the same manner as they applied before such date with respect to individuals who became ineligible for aid to families with dependent children as a result (wholly or partly) of the collection of child or spousal support under part D of title IV.

(2) TRANSITION IN THE CASE OF EARNINGS FROM EMPLOYMENT.—For continued medical assistance in the case of individuals (and families composed of individuals) described in subsection (b)(1)(A) who would otherwise become ineligible because of hours or income from employment, see sections 1925 and 1902(e)(1).

(d) WAIVERS.—In the case of a waiver of a provision of part A of title IV in effect with respect to a State as of July 16, 1996, or which is submitted to the Secretary before the date of the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and approved by the Secretary on or before July 1, 1997, if the waiver affects eligibility of individuals for medical assistance under this title, such waiver may (but need not) continue to be applied, at the option of the State, in relation to this title after the date the waiver would otherwise expire.

(e) STATE OPTION TO USE 1 APPLICATION FORM.—Nothing in this section, or part A of title IV, shall be construed as preventing a

State from providing for the same application form for assistance under a State program funded under part A of title IV (on or after the welfare reform effective date) and for medical assistance under this title.

(f) ADDITIONAL RULES OF CONSTRUCTION.—

(1) With respect to the reference in section 1902(a)(5) to a State plan approved under part A of title IV, a State may treat such reference as a reference either to a State program funded under such part (as in effect on and after the welfare reform effective date) or to the State plan under this title.

(2) Any reference in section 1902(a)(55) to a State plan approved under part A of title IV shall be deemed a reference to a State program funded under such part.

(3) In applying section 1903(f), the applicable income limitation otherwise determined shall be subject to increase in the same manner as income or resource standards of a State may be increased under subsection (b)(2)(B).

(g) RELATION TO OTHER PROVISIONS.—The provisions of this section shall apply notwithstanding any other provision of this Act.

(h) TRANSITIONAL INCREASED FEDERAL MATCHING RATE FOR INCREASED ADMINISTRATIVE COSTS.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall provide that with respect to administrative expenditures described in paragraph (2) the per centum specified in section 1903(a)(7) shall be increased to such percentage as the Secretary specifies.

(2) ADMINISTRATIVE EXPENDITURES DESCRIBED.—The administrative expenditures described in this paragraph are expenditures described in section 1903(a)(7) that a State demonstrates to the satisfaction of the Secretary are attributable to administrative costs of eligibility determinations that (but for the enactment of this section) would not be incurred.

(3) LIMITATION.—The total amount of additional Federal funds that are expended as a result of the application of this subsection for the period beginning with fiscal year 1997 shall not exceed $500,000,000. In applying this paragraph, the Secretary shall ensure the equitable distribution of additional funds among the States.

(i) WELFARE REFORM EFFECTIVE DATE.—In this section, the term "welfare reform date" means the effective date, with respect to a State, of title I of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (as specified in section 116 of such Act) [170].

PROVISIONS RELATING TO MANAGED CARE

SEC. 1932. [42 U.S.C. 1396u–2] (a) STATE OPTION TO USE MANAGED CARE.—

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

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

[170] See Vol. II, P.L. 104–193, §116.

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

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

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

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

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

(i) a medicaid managed care organization, as defined in section 1903(m)(1)(A), that provides or arranges for services for enrollees under a contract pursuant to section 1903(m); and

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

(2) SPECIAL RULES.—

(A) EXEMPTION OF CERTAIN CHILDREN WITH SPECIAL NEEDS.—A State may not require under paragraph (1) the enrollment in a managed care entity of an individual under 19 years of age who—

(i) is eligible for supplemental security income under title XVI;

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

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

(iv) is receiving foster care or adoption assistance under part E of title IV; or

(v) is in foster care or otherwise in an out–of–home placement.

(B) EXEMPTION OF MEDICARE BENEFICIARIES.—A State may not require under paragraph (1) the enrollment in a managed care entity of an individual who is a qualified medicare beneficiary (as defined in section 1905(p)(1)) or an individual otherwise eligible for benefits under title XVIII.

(C) INDIAN ENROLLMENT.—A State may not require under paragraph (1) the enrollment in a managed care entity of an individual who is an Indian (as defined in section 4(c) of the Indian Health Care Improvement Act of 1976 (25 U.S.C. 1603(c)) unless the entity is one of the following (and only if such entity is participating under the plan):

(i) The Indian Health Service.

(ii) An Indian health program operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self–Determination Act (25 U.S.C. 450 et seq.).

(iii) An urban Indian health program operated by an urban Indian organization pursuant to a grant or contract with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

(3) CHOICE OF COVERAGE.—

(A) IN GENERAL.—A State must permit an individual to choose a managed care entity from not less than two such entities that meet the applicable requirements of this section, and of section 1903(m) or section 1905(t).

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

(i) permits the individual to receive such assistance through not less than two physicians or case managers (to the extent that at least two physicians or case managers are available to provide such assistance in the area), and

(ii) permits the individual to obtain such assistance from any other provider in appropriate circumstances (as established by the State under regulations of the Secretary).

(C) TREATMENT OF CERTAIN COUNTY–OPERATED HEALTH INSURING ORGANIZATIONS.—A State shall be considered to meet the requirement of subparagraph (A) if—

(i) the managed care entity in which the individual is enrolled is a health–insuring organization which—

(I) first became operational prior to January 1, 1986, or

(II) is described in section 9517(c)(3) of the Omnibus Budget Reconciliation Act of 1985 (as added by section 4734(2) of the Omnibus Budget Reconciliation Act of 1990), and

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

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

(A) IN GENERAL.—The State, enrollment broker (if any), and managed care entity shall permit an individual eligible for medical assistance under the State plan under this title who is enrolled with the entity under this title to terminate (or change) such enrollment—

(i) for cause at any time (consistent with section 1903(m)(2)(A)(vi)), and

(ii) without cause—

(I) during the 90–day period beginning on the date the individual receives notice of such enrollment, and

(II) at least every 12 months thereafter.

(B) NOTICE OF TERMINATION RIGHTS.—The State shall provide for notice to each such individual of the opportunity to terminate (or change) enrollment under such conditions. Such notice shall be provided at least 60 days be-

fore each annual enrollment opportunity described in subparagraph (A)(ii)(II).

(C) ENROLLMENT PRIORITIES.—In carrying out paragraph (1)(A), the State shall establish a method for establishing enrollment priorities in the case of a managed care entity that does not have sufficient capacity to enroll all such individuals seeking enrollment under which individuals already enrolled with the entity are given priority in continuing enrollment with the entity.

(D) DEFAULT ENROLLMENT PROCESS.—In carrying out paragraph (1)(A), the State shall establish a default enrollment process—

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

(ii) that takes into consideration—

(I) maintaining existing provider–individual relationships or relationships with providers that have traditionally served beneficiaries under this title; and

(II) if maintaining such provider relationships is not possible, the equitable distribution of such individuals among qualified managed care entities available to enroll such individuals, consistent with the enrollment capacities of the entities.

(5) PROVISION OF INFORMATION.—

(A) INFORMATION IN EASILY UNDERSTOOD FORM.—Each State, enrollment broker, or managed care entity shall provide all enrollment notices and informational and instructional materials relating to such an entity under this title in a manner and form which may be easily understood by enrollees and potential enrollees of the entity who are eligible for medical assistance under the State plan under this title.

(B) INFORMATION TO ENROLLEES AND POTENTIAL ENROLLEES.—Each managed care entity that is a medicaid managed care organization shall, upon request, make available to enrollees and potential enrollees in the organization's service area information concerning the following:

(i) PROVIDERS.—The identity, locations, qualifications, and availability of health care providers that participate with the organization.

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

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

(iv) INFORMATION ON COVERED ITEMS AND SERVICES.—All items and services that are available to enrollees under the contract between the State and the organization that are covered either directly or

through a method of referral and prior authorization. Each managed care entity that is a primary care case manager shall, upon request, make available to enrollees and potential enrollees in the organization's service area the information described in clause (iii).

(C) COMPARATIVE INFORMATION.—A State that requires individuals to enroll with managed care entities under paragraph (1)(A) shall annually (and upon request) provide, directly or through the managed care entity, to such individuals a list identifying the managed care entities that are (or will be) available and information (presented in a comparative, chart–like form) relating to the following for each such entity offered:

(i) BENEFITS AND COST–SHARING.—The benefits covered and cost–sharing imposed by the entity.

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

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

(D) INFORMATION ON BENEFITS NOT COVERED UNDER MANAGED CARE ARRANGEMENT.—A State, directly or through managed care entities, shall, on or before an individual enrolls with such an entity under this title, inform the enrollee in a written and prominent manner of any benefits to which the enrollee may be entitled to under this title but which are not made available to the enrollee through the entity. Such information shall include information on where and how such enrollees may access benefits not made available to the enrollee through the entity.

(b) BENEFICIARY PROTECTIONS.—

(1) SPECIFICATION OF BENEFITS.—Each contract with a managed care entity under section 1903(m) or under section 1905(t)(3) shall specify the benefits the provision (or arrangement) for which the entity is responsible.

(2) ASSURING COVERAGE TO EMERGENCY SERVICES.—

(A) IN GENERAL.—Each contract with a medicaid managed care organization under section 1903(m) and each contract with a primary care case manager under section 1905(t)(3) shall require the organization or manager—

(i) to provide coverage for emergency services (as defined in subparagraph (B)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization or manager, and

(ii) to comply with guidelines established under section 1852(d)(2) (respecting coordination of post–stabilization care) in the same manner as such guidelines apply to Medicare+Choice plans offered under part C of title XVIII. The requirement under clause (ii) shall first apply 30 days after the date of promulgation of the guidelines referred to in such clause.

(B) EMERGENCY SERVICES DEFINED.—In subparagraph (A)(i), the term "emergency services" means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

(i) are furnished by a provider that is qualified to furnish such services under this title, and

(ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (C)).

(C) EMERGENCY MEDICAL CONDITION DEFINED.—In subparagraph (B)(ii), the term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

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

(3) PROTECTION OF ENROLLEE–PROVIDER COMMUNICATIONS.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), under a contract under section 1903(m) a medicaid managed care organization (in relation to an individual enrolled under the contract) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the contract, if the professional is acting within the lawful scope of practice.

(B) CONSTRUCTION.—Subparagraph (A) shall not be construed as requiring a medicaid managed care organization to provide, reimburse for, or provide coverage of, a counseling or referral service if the organization—

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

(ii) in the manner and through the written instrumentalities such organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the organization adopts a change in policy regarding such a counseling or referral service.

Nothing in this subparagraph shall be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974 [171].

(C) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this paragraph, the term "health care professional" means a physician (as defined in section 1861(r)) or other health care professional if coverage for the professional's services is provided under the contract referred to in subparagraph (A) for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech–language

[171] P.L. 93-406.

pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse–midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

(4) GRIEVANCE PROCEDURES.—Each medicaid managed care organization shall establish an internal grievance procedure under which an enrollee who is eligible for medical assistance under the State plan under this title, or a provider on behalf of such an enrollee, may challenge the denial of coverage of or payment for such assistance.

(5) DEMONSTRATION OF ADEQUATE CAPACITY AND SERVICES.—Each medicaid managed care organization shall provide the State and the Secretary with adequate assurances (in a time and manner determined by the Secretary) that the organization, with respect to a service area, has the capacity to serve the expected enrollment in such service area, including assurances that the organization—

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

(B) maintains a sufficient number, mix, and geographic distribution of providers of services.

(6) PROTECTING ENROLLEES AGAINST LIABILITY FOR PAYMENT.—Each medicaid managed care organization shall provide that an individual eligible for medical assistance under the State plan under this title who is enrolled with the organization may not be held liable—

(A) for the debts of the organization, in the event of the organization's insolvency,

(B) for services provided to the individual—

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

(ii) in the event of a health care provider with a contractual, referral, or other arrangement with the organization failing to receive payment from the State or the organization for such services, or

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

(7) ANTIDISCRIMINATION.—A medicaid managed care organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit an organization from including providers only to the extent necessary to meet the needs of the organization's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization.

(8) COMPLIANCE WITH CERTAIN MATERNITY AND MENTAL HEALTH REQUIREMENTS.—Each medicaid managed care organi-

zation shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act insofar as such requirements apply and are effective with respect to a health insurance issuer that offers group health insurance coverage.

(c) QUALITY ASSURANCE STANDARDS.—

(1) QUALITY ASSESSMENT AND IMPROVEMENT STRATEGY.—

(A) IN GENERAL.—If a State provides for contracts with medicaid managed care organizations under section 1903(m), the State shall develop and implement a quality assessment and improvement strategy consistent with this paragraph. Such strategy shall include the following:

(i) ACCESS STANDARDS.—Standards for access to care so that covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and specialized services capacity.

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

(iii) MONITORING PROCEDURES.—Procedures for monitoring and evaluating the quality and appropriateness of care and services to enrollees that reflect the full spectrum of populations enrolled under the contract and that includes requirements for provision of quality assurance data to the State using the data and information set that the Secretary has specified for use under part C of title XVIII or such alternative data as the Secretary approves, in consultation with the State.

(iv) PERIODIC REVIEW.—Regular, periodic examinations of the scope and content of the strategy.

(B) STANDARDS.—The strategy developed under subparagraph (A) shall be consistent with standards that the Secretary first establishes within 1 year after the date of the enactment of this section. Such standards shall not preempt any State standards that are more stringent than such standards. Guidelines relating to quality assurance that are applied under section 1915(b)(1) shall apply under this subsection until the effective date of standards for quality assurance established under this subparagraph.

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

(D) CONSULTATION.—The Secretary shall conduct activities under subparagraphs (B) and (C) in consultation with the States.

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

(A) REVIEW OF CONTRACTS.—

(i) IN GENERAL.—Each contract under section 1903(m) with a medicaid managed care organization shall provide for an annual (as appropriate) external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of, and access to, the items and services for which the or-

ganization is responsible under the contract. The requirement for such a review shall not apply until after the date that the Secretary establishes the identification method described in clause (ii).

(ii) QUALIFICATIONS OF REVIEWER.—The Secretary, in consultation with the States, shall establish a method for the identification of entities that are qualified to conduct reviews under clause (i).

(iii) USE OF PROTOCOLS.—The Secretary, in coordination with the National Governors' Association, shall contract with an independent quality review organization (such as the National Committee for Quality Assurance) to develop the protocols to be used in external independent reviews conducted under this paragraph on and after January 1, 1999.

(iv) AVAILABILITY OF RESULTS.—The results of each external independent review conducted under this subparagraph shall be available to participating health care providers, enrollees, and potential enrollees of the organization, except that the results may not be made available in a manner that discloses the identity of any individual patient.

(B) NONDUPLICATION OF ACCREDITATION.—A State may provide that, in the case of a medicaid managed care organization that is accredited by a private independent entity (such as those described in section 1852(e)(4)) or that has an external review conducted under section 1852(e)(3), the external review activities conducted under subparagraph (A) with respect to the organization shall not be duplicative of review activities conducted as part of the accreditation process or the external review conducted under such section.

(C) DEEMED COMPLIANCE FOR MEDICARE MANAGED CARE ORGANIZATIONS.—At the option of a State, the requirements of subparagraph (A) shall not apply with respect to a medicaid managed care organization if the organization is an eligible organization with a contract in effect under section 1876 or a Medicare+Choice organization with a contract in effect under part C of title XVIII and the organization has had a contract in effect under section 1903(m) at least during the previous 2–year period.

(d) PROTECTIONS AGAINST FRAUD AND ABUSE.—

(1) PROHIBITING AFFILIATIONS WITH INDIVIDUALS DEBARRED BY FEDERAL AGENCIES.—

(A) IN GENERAL.—A managed care entity may not knowingly—

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

(ii) have an employment, consulting, or other agreement with a person described in such subparagraph for the provision of items and services that are significant and material to the entity's obligations under its contract with the State.

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

(i) shall notify the Secretary of such noncompliance;

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

(iii) may not renew or otherwise extend the duration of an existing agreement with the entity unless the Secretary (in consultation with the Inspector General of the Department of Health and Human Services) provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

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

(i) is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order; or

(ii) is an affiliate (as defined in such Regulation) of a person described in clause (i).

(2) RESTRICTIONS ON MARKETING.—

(A) DISTRIBUTION OF MATERIALS.—

(i) IN GENERAL.—A managed care entity, with respect to activities under this title, may not distribute directly or through any agent or independent contractor marketing materials within any State—

(I) without the prior approval of the State, and

(II) that contain false or materially misleading information.

The requirement of subclause (I) shall not apply with respect to a State until such date as the Secretary specifies in consultation with such State.

(ii) CONSULTATION IN REVIEW OF MARKET MATERIALS.—In the process of reviewing and approving such materials, the State shall provide for consultation with a medical care advisory committee.

(B) SERVICE MARKET.—A managed care entity shall distribute marketing materials to the entire service area of such entity covered under the contract under section 1903(m) or section 1905(t)(3).

(C) PROHIBITION OF TIE–INS.—A managed care entity, or any agency of such entity, may not seek to influence an individual's enrollment with the entity in conjunction with the sale of any other insurance.

(D) PROHIBITING MARKETING FRAUD.—Each managed care entity shall comply with such procedures and conditions as the Secretary prescribes in order to ensure that, before an individual is enrolled with the entity, the individual is provided accurate oral and written information sufficient to make an informed decision whether or not to enroll.

(E) PROHIBITION OF "COLD–CALL" MARKETING.—Each managed care entity shall not, directly or indirectly, conduct door–to–door, telephonic, or other "cold–call" marketing of enrollment under this title.

(3) STATE CONFLICT–OF–INTEREST SAFEGUARDS IN MEDICAID RISK CONTRACTING.—A medicaid managed care organization may not enter into a contract with any State under section 1903(m) unless the State has in effect conflict–of–interest safeguards with respect to officers and employees of the State with responsibilities relating to contracts with such organizations or to the default enrollment process described in subsection (a)(4)(C)(ii) that are at least as effective as the Federal safeguards provided under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423), against conflicts of interest that apply with respect to Federal procurement officials with comparable responsibilities with respect to such contracts.

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

(e) SANCTIONS FOR NONCOMPLIANCE.—

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

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

(i) fails substantially to provide medically necessary items and services that are required (under law or under such organization's contract with the State) to be provided to an enrollee covered under the contract;

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

(iii) acts to discriminate among enrollees on the basis of their health status or requirements for health care services, including expulsion or refusal to reenroll an individual, except as permitted by this title, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the organization by eligible individuals whose medical condition or history indicates a need for substantial future medical services;

(iv) misrepresents or falsifies information that is furnished—

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

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

(v) fails to comply with the applicable requirements of section 1903(m)(2)(A)(x).

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

(B) RULE OF CONSTRUCTION.—Clause (i) of subparagraph (A) shall not apply to the provision of abortion services, except that a State may impose a sanction on any medicaid managed care organization that has a contract to provide abortion services if the organization does not provide such services as provided for under the contract.

(2) INTERMEDIATE SANCTIONS.—The sanctions described in this paragraph are as follows:

(A) Civil money penalties as follows:

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

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

(iii) With respect to a determination under paragraph (1)(A)(ii), double the excess amount charged in violation of such subsection (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned).

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

(B) The appointment of temporary management—

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

(ii) to assure the health of the organization's enrollees, if there is a need for temporary management while—

(I) there is an orderly termination or reorganization of the organization; or

(II) improvements are made to remedy the violations found under paragraph (1), except that temporary management under this subparagraph may not be terminated until the State has determined that the medicaid managed care organization has the capability to ensure that the violations shall not recur.

(C) Permitting individuals enrolled with the managed care entity to terminate enrollment without cause, and notifying such individuals of such right to terminate enrollment.

(D) Suspension or default of all enrollment of individuals under this title after the date the Secretary or the State

notifies the entity of a determination of a violation of any requirement of section 1903(m) or this section.

(E) Suspension of payment to the entity under this title for individuals enrolled after the date the Secretary or State notifies the entity of such a determination and until the Secretary or State is satisfied that the basis for such determination has been corrected and is not likely to recur.

(3) TREATMENT OF CHRONIC SUBSTANDARD ENTITIES.—In the case of a medicaid managed care organization which has repeatedly failed to meet the requirements of section 1903(m) and this section, the State shall (regardless of what other sanctions are provided) impose the sanctions described in subparagraphs (B) and (C) of paragraph (2).

(4) AUTHORITY TO TERMINATE CONTRACT.—

(A) IN GENERAL.—In the case of a managed care entity which has failed to meet the requirements of this part or a contract under section 1903(m) or 1905(t)(3), the State shall have the authority to terminate such contract with the entity and to enroll such entity's enrollees with other managed care entities (or to permit such enrollees to receive medical assistance under the State plan under this title other than through a managed care entity).

(B) AVAILABILITY OF HEARING PRIOR TO TERMINATION OF CONTRACT.—A State may not terminate a contract with a managed care entity under subparagraph (A) unless the entity is provided with a hearing prior to the termination.

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

(i) notify individuals enrolled with a managed care entity which is the subject of a hearing to terminate the entity's contract with the State of the hearing, and

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

(5) OTHER PROTECTIONS FOR MANAGED CARE ENTITIES AGAINST SANCTIONS IMPOSED BY STATE.—Before imposing any sanction against a managed care entity other than termination of the entity's contract, the State shall provide the entity with notice and such other due process protections as the State may provide, except that a State may not provide a managed care entity with a pre–termination hearing before imposing the sanction described in paragraph (2)(B).

(f) TIMELINESS OF PAYMENT.—A contract under section 1903(m) with a medicaid managed care organization shall provide that the organization shall make payment to health care providers for items and services which are subject to the contract and that are furnished to individuals eligible for medical assistance under the State plan under this title who are enrolled with the organization on a timely basis consistent with the claims payment procedures described in section 1902(a)(37)(A), unless the health care provider and the organization agree to an alternate payment schedule.

(g) IDENTIFICATION OF PATIENTS FOR PURPOSES OF MAKING DSH PAYMENTS.— Each contract with a managed care entity under section 1903(m) or under section 1905(t)(3) shall require the entity either—

(1) to report to the State information necessary to determine the hospital services provided under the contract (and the identity of hospitals providing such services) for purposes of applying sections 1886(d)(5)(F) and 1923; or

(2) to include a sponsorship code in the identification card issued to individuals covered under this title in order that a hospital may identify a patient as being entitled to benefits under this title.

STATE COVERAGE OF MEDICARE COST–SHARING FOR ADDITIONAL LOW–INCOME MEDICARE BENEFICIARIES [172]

SEC. 1933. [42 U.S.C. 1396u–3] (a) IN GENERAL.—A State plan under this title shall provide, under section 1902(a)(10)(E)(iv) and subject to the succeeding provisions of this section and through a plan amendment, for medical assistance for payment of the cost of medicare cost–sharing described in such section on behalf of all individuals described in such section (in this section referred to as "qualifying individuals") who are selected to receive such assistance under subsection (b).

(b) SELECTION OF QUALIFYING INDIVIDUALS.—A State shall select qualifying individuals, and provide such individuals with assistance, under this section consistent with the following:

(1) ALL QUALIFYING INDIVIDUALS MAY APPLY.—The State shall permit all qualifying individuals to apply for assistance during a calendar year.

(2) SELECTION ON FIRST–COME, FIRST–SERVED BASIS.—

(A) IN GENERAL.—For each calendar year (beginning with 1998), from (and to the extent of) the amount of the allocation under subsection (c) for the State for the fiscal year ending in such calendar year, the State shall select qualifying individuals who apply for the assistance in the order in which they apply.

(B) CARRYOVER.—For calendar years after 1998, the State shall give preference to individuals who were provided such assistance (or other assistance described in section 1902(a)(10)(E)) in the last month of the previous year and who continue to be (or become) qualifying individuals.

(3) LIMIT ON NUMBER OF INDIVIDUALS BASED ON ALLOCATION.—The State shall limit the number of qualifying individuals selected with respect to assistance in a calendar year so that the aggregate amount of such assistance provided to such individuals in such year is estimated to be equal to (but not exceed) the State's allocation under subsection (c) for the fiscal year ending in such calendar year.

(4) RECEIPT OF ASSISTANCE DURING DURATION OF YEAR.—If a qualifying individual is selected to receive assistance under this section for a month in a year, the individual is entitled to receive such assistance for the remainder of the year if the individual continues to be a qualifying individual. The fact that an individual is selected to receive assistance under this section at any time during a year does not entitle the individual to continued assistance for any succeeding year.

[172] P.L. 105–33, §4732(c), added this §1933, effective August 5, 1997. See Vol. II, P.L. 105–33, §4759, with respect to an extension of the effective date if State legislation is required.

(c) ALLOCATION.—

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

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

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

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

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

(E) each of fiscal years 2002 and 2003[173] is $400,000,000.

(2) ALLOCATION TO STATES.—The Secretary shall provide for the allocation of the total amount described in paragraph (1) for a fiscal year, among the States that executed a plan amendment in accordance with subsection (a), based upon the Secretary's estimate of the ratio of—

(A) an amount equal to the total number of individuals described in section 1902(a)(10)(E)(iv) in the State; to[174]

(B) the sum of the amounts computed under subparagraph (A) for all eligible States.

(d) APPLICABLE FMAP.—With respect to assistance described in section 1902(a)(10)(E)(iv) furnished in a State for calendar quarters in a calendar year—

(1) to the extent that such assistance does not exceed the State's allocation under subsection (c) for the fiscal year ending in the calendar year, the Federal medical assistance percentage shall be equal to 100 percent; and

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

(e) LIMITATION ON ENTITLEMENT.—Except as specifically provided under this section, nothing in this title shall be construed as establishing any entitlement of individuals described in section 1902(a)(10)(E)(iv) to assistance described in such section.

(f) COVERAGE OF COSTS THROUGH PART B OF THE MEDICARE PROGRAM.—For each fiscal year, the Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund under section 1841 to the appropriate account in the Treasury that provides for payments under section 1903(a) with respect to medical assistance provided under this section, of an amount equivalent to the total of the amount of payments made under such section that is attributable to this section and such transfer shall be treated as an expenditure from such Trust Fund for purposes of section 1839.

(g)[175] SPECIAL RULES—

(1) IN GENERAL—With respect to each period described in paragraph (2), a State shall select qualifying individuals, subject to paragraph (3), and provide such individuals with assistance, in accordance with the provisions of this section as in ef-

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[173] P.L. 108–89, §401(b)(1), struck out "fiscal year 2002" and substituted "each of fiscal years 2002 and 2003", effective October 1, 2003.

[174] P.L. 108–89, §401(b)(2), struck out "the sum of—

(i) twice the total number of individuals described in section 1902(a)(10)(E)(iv)(I) in the State, and

(ii) the total number of individuals described in section 1902(a)(10)(E)(iv)(II) in the State; to" and substituted "the total number of individuals described in section 1902(a)(10)(E)(iv) in the State; to", effective October 1, 2003.

[175] P.L. 108-89, §401(c), added subsection (g), effective October 1, 2003.

P.L. 108-448, §1(b), amended subsection (g) in its entirety, effective December 8, 2004. For subsection (g) as it formerly read, see Vol. II, Appendix I, Superseded Provisions, P.L. 108-448.

fect with respect to calendar year 2003, except that for such purpose—

(A) references in the preceding subsections of this section to a year, whether fiscal or calendar, shall be deemed to be references to such period; and

(B) the total allocation amount under subsection (c) for such period shall be the amount described in paragraph (2) for that period.

(2) PERIODS AND TOTAL ALLOCATION AMOUNTS DESCRIBED-For purposes of this subsection--

(A) for the period that begins on January 1, 2004, and ends on September 30, 2004, the total allocation amount is $300,000,000;

(B) for the period that begins on October 1, 2004, and ends on December 31, 2004, the total allocation amount is $100,000,000; and

(C) for the period that begins on January 1, 2005, and ends on September 30, 2005, the total allocation amount is $300,000,000.

PROGRAM OF ALL–INCLUSIVE CARE FOR THE ELDERLY (PACE)[176]

SEC. 1934. [42 U.S.C. 1396u–4] (a) STATE OPTION.—

(1) IN GENERAL.—A State may elect to provide medical assistance under this section with respect to PACE program services to PACE program eligible individuals who are eligible for medical assistance under the State plan and who are enrolled in a PACE program under a PACE program agreement. Such individuals need not be eligible for benefits under part A, or enrolled under part B, of title XVIII to be eligible to enroll under this section. In the case of an individual enrolled with a PACE program pursuant to such an election—

(A) the individual shall receive benefits under the plan solely through such program, and

(B) the PACE provider shall receive payment in accordance with the PACE program agreement for provision of such benefits.

A State may establish a numerical limit on the number of individuals who may be enrolled in a PACE program under a PACE program agreement.

(2) PACE PROGRAM DEFINED.—For purposes of this section, the term "PACE program" means a program of all–inclusive care for the elderly that meets the following requirements:

(A) OPERATION.—The entity operating the program is a PACE provider (as defined in paragraph (3)).

(B) COMPREHENSIVE BENEFITS.—The program provides comprehensive health care services to PACE program eligible individuals in accordance with the PACE program agreement and regulations under this section.

(C) TRANSITION.—In the case of an individual who is enrolled under the program under this section and whose enrollment ceases for any reason (including that the individual no longer qualifies as a PACE program eligible individual, the termination of a PACE program agreement, or

[176] P.L. 105–33, §4802(a)(3), added this §1934, effective August 5, 1997. See Vol. II, P.L. 105–33, §4759, with respect to an extension of the effective date if State legislation is required.

otherwise), the program provides assistance to the individual in obtaining necessary transitional care through appropriate referrals and making the individual's medical records available to new providers.

(3) PACE PROVIDER DEFINED.—

(A) IN GENERAL.—For purposes of this section, the term "PACE provider" means an entity that—

(i) subject to subparagraph (B), is (or is a distinct part of) a public entity or a private, nonprofit entity organized for charitable purposes under section 501(c)(3) of the Internal Revenue Code of 1986, and

(ii) has entered into a PACE program agreement with respect to its operation of a PACE program.

(B) TREATMENT OF PRIVATE, FOR–PROFIT PROVIDERS.—Clause (i) of subparagraph (A) shall not apply—

(i) to entities subject to a demonstration project waiver under subsection (h); and

(ii) after the date the report under section 4804(b) of the Balanced Budget Act of 1997 is submitted, unless the Secretary determines that any of the findings described in subparagraph (A), (B), (C), or (D) of paragraph (2) of such section are true.

(4) PACE PROGRAM AGREEMENT DEFINED.—For purposes of this section, the term "PACE program agreement" means, with respect to a PACE provider, an agreement, consistent with this section, section 1894 (if applicable), and regulations promulgated to carry out such sections, among the PACE provider, the Secretary, and a State administering agency for the operation of a PACE program by the provider under such sections.

(5) PACE PROGRAM ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, the term "PACE program eligible individual" means, with respect to a PACE program, an individual who—

(A) is 55 years of age or older;

(B) subject to subsection (c)(4), is determined under subsection (c) to require the level of care required under the State medicaid plan for coverage of nursing facility services;

(C) resides in the service area of the PACE program; and

(D) meets such other eligibility conditions as may be imposed under the PACE program agreement for the program under subsection (e)(2)(A)(ii).

(6) PACE PROTOCOL.—For purposes of this section, the term "PACE protocol" means the Protocol for the Program of All–inclusive Care for the Elderly (PACE), as published by On Lok, Inc., as of April 14, 1995, or any successor protocol that may be agreed upon between the Secretary and On Lok, Inc.

(7) PACE DEMONSTRATION WAIVER PROGRAM DEFINED.—For purposes of this section, the term "PACE demonstration waiver program" means a demonstration program under either of the following sections (as in effect before the date of their repeal):

(A) Section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21), as extended by section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272).

(B) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509).

(8) STATE ADMINISTERING AGENCY DEFINED.—For purposes of this section, the term "State administering agency" means, with respect to the operation of a PACE program in a State, the agency of that State (which may be the single agency responsible for administration of the State plan under this title in the State) responsible for administering PACE program agreements under this section and section 1894 in the State.

(9) TRIAL PERIOD DEFINED.—

(A) IN GENERAL.—For purposes of this section, the term "trial period" means, with respect to a PACE program operated by a PACE provider under a PACE program agreement, the first 3 contract years under such agreement with respect to such program.

(B) TREATMENT OF ENTITIES PREVIOUSLY OPERATING PACE DEMONSTRATION WAIVER PROGRAMS.—Each contract year (including a year occurring before the effective date of this section) during which an entity has operated a PACE demonstration waiver program shall be counted under subparagraph (A) as a contract year during which the entity operated a PACE program as a PACE provider under a PACE program agreement.

(10) REGULATIONS.—For purposes of this section, the term "regulations" refers to interim final or final regulations promulgated under subsection (f) to carry out this section and section 1894.

(b) SCOPE OF BENEFITS; BENEFICIARY SAFEGUARDS.—

(1) IN GENERAL.—Under a PACE program agreement, a PACE provider shall—

(A) provide to PACE program eligible individuals, regardless of source of payment and directly or under contracts with other entities, at a minimum—

(i) all items and services covered under title XVIII (for individuals enrolled under section 1894) and all items and services covered under this title, but without any limitation or condition as to amount, duration, or scope and without application of deductibles, copayments, coinsurance, or other cost–sharing that would otherwise apply under such title or this title, respectively; and

(ii) all additional items and services specified in regulations, based upon those required under the PACE protocol;

(B) provide such enrollees access to necessary covered items and services 24 hours per day, every day of the year;

(C) provide services to such enrollees through a comprehensive, multidisciplinary health and social services delivery system which integrates acute and long–term care services pursuant to regulations; and

(D) specify the covered items and services that will not be provided directly by the entity, and to arrange for delivery of those items and services through contracts meeting the requirements of regulations.

(2) QUALITY ASSURANCE; PATIENT SAFEGUARDS.—The PACE program agreement shall require the PACE provider to have in effect at a minimum—

(A) a written plan of quality assurance and improvement, and procedures implementing such plan, in accordance with regulations, and

(B) written safeguards of the rights of enrolled participants (including a patient bill of rights and procedures for grievances and appeals) in accordance with regulations and with other requirements of this title and Federal and State law designed for the protection of patients.

(3)[177] TREATMENT OF MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—

(A) APPLICATION OF MEDICARE ADVANTAGE REQUIREMENT WITH RESPECT TO MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—Section 1852(k)(1) (relating to limitations on balance billing against MA organizations for noncontract physicians and other entities with respect to services covered under title XVIII) shall apply to PACE providers, PACE program eligible individuals enrolled with such PACE providers, and physicians and other entities that do not have a contract or other agreement establishing payment amounts for services furnished to such an individual in the same manner as such section applies to MA organizations, individuals enrolled with such organizations, and physicians and other entities referred to in such section.

(B) REFERENCE TO RELATED PROVISION FOR NONCONTRACT PROVIDERS OF SERVICES.—For the provision relating to limitations on balance billing against PACE providers for services covered under title XVIII furnished by noncontract providers of services, see section 1866(a)(1)(O).

(4) REFERENCE TO RELATED PROVISION FOR SERVICES COVERED UNDER THIS TITLE BUT NOT UNDER TITLE XVIII.—For provisions relating to limitations on payments to providers participating under the State plan under this title that do not have a contract or other agreement with a PACE provider establishing payment amounts for services covered under such plan (but not under title XVIII) when such services are furnished to enrollees of that PACE provider, see section 1902(a)(67).

(c) ELIGIBILITY DETERMINATIONS.—

(1) IN GENERAL.—The determination of—

(A) whether an individual is a PACE program eligible individual shall be made under and in accordance with the PACE program agreement, and

(B) who is entitled to medical assistance under this title shall be made (or who is not so entitled, may be made) by the State administering agency.

(2) CONDITION.—An individual is not a PACE program eligible individual (with respect to payment under this section) unless the individual's health status has been determined by the Secretary or the State administering agency, in accordance with regulations, to be comparable to the health status of indi-

[177] P.L. 108–173, §236(b)(2), added paragraphs (3) and (4), effective December 8, 2003, applicable to services furnished on or after January 1, 2004.

viduals who have participated in the PACE demonstration waiver programs. Such determination shall be based upon information on health status and related indicators (such as medical diagnoses and measures of activities of daily living, instrumental activities of daily living, and cognitive impairment) that are part of a uniform minimum data set collected by PACE providers on potential eligible individuals.

(3) ANNUAL ELIGIBILITY RECERTIFICATIONS.—

(A) IN GENERAL.—Subject to subparagraph (B), the determination described in subsection (a)(5)(B) for an individual shall be reevaluated at least annually.

(B) EXCEPTION.—The requirement of annual reevaluation under subparagraph (A) may be waived during a period in accordance with regulations in those cases in which the State administering agency determines that there is no reasonable expectation of improvement or significant change in an individual's condition during the period because of the severity of chronic condition, or degree of impairment of functional capacity of the individual involved.

(4) CONTINUATION OF ELIGIBILITY.—An individual who is a PACE program eligible individual may be deemed to continue to be such an individual notwithstanding a determination that the individual no longer meets the requirement of subsection (a)(5)(B) if, in accordance with regulations, in the absence of continued coverage under a PACE program the individual reasonably would be expected to meet such requirement within the succeeding 6–month period.

(5) ENROLLMENT; DISENROLLMENT.—

(A) VOLUNTARY DISENROLLMENT AT ANY TIME.—The enrollment and disenrollment of PACE program eligible individuals in a PACE program shall be pursuant to regulations and the PACE program agreement and shall permit enrollees to voluntarily disenroll without cause at any time.

(B) LIMITATIONS ON DISENROLLMENT.—

(i) IN GENERAL.—Regulations promulgated by the Secretary under this section and section 1894, and the PACE program agreement, shall provide that the PACE program may not disenroll a PACE program eligible individual except—

(I) for nonpayment of premiums (if applicable) on a timely basis; or

(II) for engaging in disruptive or threatening behavior, as defined in such regulations (developed in close consultation with State administering agencies).

(ii) NO DISENROLLMENT FOR NONCOMPLIANT BEHAVIOR.—Except as allowed under regulations promulgated to carry out clause (i)(II), a PACE program may not disenroll a PACE program eligible individual on the ground that the individual has engaged in noncompliant behavior if such behavior is related to a mental or physical condition of the individual. For purposes of the preceding sentence, the term "noncompliant behavior" includes repeated noncompliance with medical

advice and repeated failure to appear for appointments.

(iii) TIMELY REVIEW OF PROPOSED NONVOLUNTARY DISENROLLMENT.—A proposed disenrollment, other than a voluntary disenrollment, shall be subject to timely review and final determination by the Secretary or by the State administering agency (as applicable), prior to the proposed disenrollment becoming effective.

(d) PAYMENTS TO PACE PROVIDERS ON A CAPITATED BASIS.—

(1) IN GENERAL.—In the case of a PACE provider with a PACE program agreement under this section, except as provided in this subsection or by regulations, the State shall make prospective monthly payments of a capitation amount for each PACE program eligible individual enrolled under the agreement under this section.

(2) CAPITATION AMOUNT.—The capitation amount to be applied under this subsection for a provider for a contract year shall be an amount specified in the PACE program agreement for the year. Such amount shall be an amount, specified under the PACE agreement, which is less than the amount that would otherwise have been made under the State plan if the individuals were not so enrolled and shall be adjusted to take into account the comparative frailty of PACE enrollees and such other factors as the Secretary determines to be appropriate. The payment under this section shall be in addition to any payment made under section 1894 for individuals who are enrolled in a PACE program under such section.

(e) PACE PROGRAM AGREEMENT.—

(1) REQUIREMENT.—

(A) IN GENERAL.—The Secretary, in close cooperation with the State administering agency, shall establish procedures for entering into, extending, and terminating PACE program agreements for the operation of PACE programs by entities that meet the requirements for a PACE provider under this section, section 1894, and regulations.

(B) NUMERICAL LIMITATION.—

(i) IN GENERAL.—The Secretary shall not permit the number of PACE providers with which agreements are in effect under this section or under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 to exceed—

(I) 40 as of the date of the enactment of this section, or

(II) as of each succeeding anniversary of such date, the numerical limitation under this subparagraph for the preceding year plus 20.

Subclause (II) shall apply without regard to the actual number of agreements in effect as of a previous anniversary date.

(ii) TREATMENT OF CERTAIN PRIVATE, FOR–PROFIT PROVIDERS.—The numerical limitation in clause (i) shall not apply to a PACE provider that—

(I) is operating under a demonstration project waiver under subsection (h), or

(II) was operating under such a waiver and subsequently qualifies for PACE provider status pursuant to subsection (a)(3)(B)(ii).

(2) SERVICE AREA AND ELIGIBILITY.—

(A) IN GENERAL.—A PACE program agreement for a PACE program—

(i) shall designate the service area of the program;

(ii) may provide additional requirements for individuals to qualify as PACE program eligible individuals with respect to the program;

(iii) shall be effective for a contract year, but may be extended for additional contract years in the absence of a notice by a party to terminate, and is subject to termination by the Secretary and the State administering agency at any time for cause (as provided under the agreement);

(iv) shall require a PACE provider to meet all applicable State and local laws and requirements; and

(v) shall contain such additional terms and conditions as the parties may agree to, so long as such terms and conditions are consistent with this section and regulations.

(B) SERVICE AREA OVERLAP.—In designating a service area under a PACE program agreement under subparagraph (A)(i), the Secretary (in consultation with the State administering agency) may exclude from designation an area that is already covered under another PACE program agreement, in order to avoid unnecessary duplication of services and avoid impairing the financial and service viability of an existing program.

(3) DATA COLLECTION; DEVELOPMENT OF OUTCOME MEASURES.—

(A) DATA COLLECTION.—

(i) IN GENERAL.—Under a PACE program agreement, the PACE provider shall—

(I) collect data;

(II) maintain, and afford the Secretary and the State administering agency access to, the records relating to the program, including pertinent financial, medical, and personnel records; and

(III) submit to the Secretary and the State administering agency such reports as the Secretary finds (in consultation with State administering agencies) necessary to monitor the operation, cost, and effectiveness of the PACE program.

(ii) REQUIREMENTS DURING TRIAL PERIOD.—During the first 3 years of operation of a PACE program (either under this section or under a PACE demonstration waiver program), the PACE provider shall provide such additional data as the Secretary specifies in regulations in order to perform the oversight required under paragraph (4)(A).

(B) DEVELOPMENT OF OUTCOME MEASURES.—Under a PACE program agreement, the PACE provider, the Secretary, and the State administering agency shall jointly co-

operate in the development and implementation of health status and quality of life outcome measures with respect to PACE program eligible individuals.

(4) OVERSIGHT.—

(A) ANNUAL, CLOSE OVERSIGHT DURING TRIAL PERIOD.—During the trial period (as defined in subsection (a)(9)) with respect to a PACE program operated by a PACE provider, the Secretary (in cooperation with the State administering agency) shall conduct a comprehensive annual review of the operation of the PACE program by the provider in order to assure compliance with the requirements of this section and regulations. Such a review shall include—

(i) an onsite visit to the program site;

(ii) comprehensive assessment of a provider's fiscal soundness;

(iii) comprehensive assessment of the provider's capacity to provide all PACE services to all enrolled participants;

(iv) detailed analysis of the entity's substantial compliance with all significant requirements of this section and regulations; and

(v) any other elements the Secretary or the State administering agency considers necessary or appropriate.

(B) CONTINUING OVERSIGHT.—After the trial period, the Secretary (in cooperation with the State administering agency) shall continue to conduct such review of the operation of PACE providers and PACE programs as may be appropriate, taking into account the performance level of a provider and compliance of a provider with all significant requirements of this section and regulations.

(C) DISCLOSURE.—The results of reviews under this paragraph shall be reported promptly to the PACE provider, along with any recommendations for changes to the provider's program, and shall be made available to the public upon request.

(5) TERMINATION OF PACE PROVIDER AGREEMENTS.—

(A) IN GENERAL.—Under regulations—

(i) the Secretary or a State administering agency may terminate a PACE program agreement for cause, and

(ii) a PACE provider may terminate such an agreement after appropriate notice to the Secretary, the State administering agency, and enrollees.

(B) CAUSES FOR TERMINATION.—In accordance with regulations establishing procedures for termination of PACE program agreements, the Secretary or a State administering agency may terminate a PACE program agreement with a PACE provider for, among other reasons, the fact that—

(i) the Secretary or State administering agency determines that—

(I) there are significant deficiencies in the quality of care provided to enrolled participants; or

(II) the provider has failed to comply substantially with conditions for a program or provider under this section or section 1894; and

(ii) the entity has failed to develop and successfully initiate, within 30 days of the date of the receipt of written notice of such a determination, a plan to correct the deficiencies, or has failed to continue implementation of such a plan.

(C) TERMINATION AND TRANSITION PROCEDURES.—An entity whose PACE provider agreement is terminated under this paragraph shall implement the transition procedures required under subsection (a)(2)(C).

(6) SECRETARY'S OVERSIGHT; ENFORCEMENT AUTHORITY.—

(A) IN GENERAL.—Under regulations, if the Secretary determines (after consultation with the State administering agency) that a PACE provider is failing substantially to comply with the requirements of this section and regulations, the Secretary (and the State administering agency) may take any or all of the following actions:

(i) Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.

(ii) Withhold some or all further payments under the PACE program agreement under this section or section 1894 with respect to PACE program services furnished by such provider until the deficiencies have been corrected.

(iii) Terminate such agreement.

(B) APPLICATION OF INTERMEDIATE SANCTIONS.—Under regulations, the Secretary may provide for the application against a PACE provider of remedies described in section 1857(g)(2) (or, for periods before January 1, 1999, section 1876(i)(6)(B)) or 1903(m)(5)(B) in the case of violations by the provider of the type described in section 1857(g)(1) (or 1876(i)(6)(A) for such periods) or 1903(m)(5)(A), respectively (in relation to agreements, enrollees, and requirements under section 1894 or this section, respectively).

(7) PROCEDURES FOR TERMINATION OR IMPOSITION OF SANCTIONS.—Under regulations, the provisions of section 1857(h) (or for periods before January 1, 1999, section 1876(i)(9)) shall apply to termination and sanctions respecting a PACE program agreement and PACE provider under this subsection in the same manner as they apply to a termination and sanctions with respect to a contract and a Medicare+Choice organization under part C of title XVIII (or for such periods an eligible organization under section 1876).

(8) TIMELY CONSIDERATION OF APPLICATIONS FOR PACE PROGRAM PROVIDER STATUS.—In considering an application for PACE provider program status, the application shall be deemed approved unless the Secretary, within 90 days after the date of the submission of the application to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information that is needed in order to make a final determination with respect to the application. After the date the Secretary receives such additional information, the application shall be deemed approved

unless the Secretary, within 90 days of such date, denies such request.

(f) REGULATIONS.—

(1) IN GENERAL.—The Secretary shall issue interim final or final regulations to carry out this section and section 1894.

(2) USE OF PACE PROTOCOL.—

(A) IN GENERAL.—In issuing such regulations, the Secretary shall, to the extent consistent with the provisions of this section, incorporate the requirements applied to PACE demonstration waiver programs under the PACE protocol.

(B) FLEXIBILITY.—In order to provide for reasonable flexibility in adapting the PACE service delivery model to the needs of particular organizations (such as those in rural areas or those that may determine it appropriate to use nonstaff physicians according to State licensing law requirements) under this section and section 1894, the Secretary (in close consultation with State administering agencies) may modify or waive provisions of the PACE protocol so long as any such modification or waiver is not inconsistent with and would not impair the essential elements, objectives, and requirements of this section, but may not modify or waive any of the following provisions:

(i) The focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility.

(ii) The delivery of comprehensive, integrated acute and long–term care services.

(iii) The interdisciplinary team approach to care management and service delivery.

(iv) Capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals.

(v) The assumption by the provider of full financial risk.

(C) CONTINUATION OF MODIFICATIONS OR WAIVERS OF OPERATIONAL REQUIREMENTS UNDER DEMONSTRATION STATUS.—If a PACE program operating under demonstration authority has contractual or other operating arrangements which are not otherwise recognized in regulation and which were in effect on July 1, 2000, the Secretary (in close consultation with, and with the concurrence of, the State administering agency) shall permit any such program to continue such arrangements so long as such arrangements are found by the Secretary and the State to be reasonably consistent with the objectives of the PACE program[178].

(3) APPLICATION OF CERTAIN ADDITIONAL BENEFICIARY AND PROGRAM PROTECTIONS.—

(A) IN GENERAL.—In issuing such regulations and subject to subparagraph (B), the Secretary may apply with respect to PACE programs, providers, and agreements such requirements of part C of title XVIII (or, for periods before January 1, 1999, section 1876) and sections 1903(m) and 1932 relating to protection of beneficiaries and program in-

[178] See Vol. II, P.L. 106-554, §903, with respect to flexibility in exercising waiver authority.

tegrity as would apply to Medicare+Choice organizations under such part C (or for such periods eligible organizations under risk–sharing contracts under section 1876) and to medicaid managed care organizations under prepaid capitation agreements under section 1903(m).

(B) CONSIDERATIONS.—In issuing such regulations, the Secretary shall—

(i) take into account the differences between populations served and benefits provided under this section and under part C of title XVIII (or, for periods before January 1, 1999, section 1876) and section 1903(m);

(ii) not include any requirement that conflicts with carrying out PACE programs under this section; and

(iii) not include any requirement restricting the proportion of enrollees who are eligible for benefits under this title or title XVIII.

(4) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the Secretary from including in regulations provisions to ensure the health and safety of individuals enrolled in a PACE program under this section that are in addition to those otherwise provided under paragraphs (2) and (3).

(g) WAIVERS OF REQUIREMENTS.—With respect to carrying out a PACE program under this section, the following requirements of this title (and regulations relating to such requirements) shall not apply:

(1) Section 1902(a)(1), relating to any requirement that PACE programs or PACE program services be provided in all areas of a State.

(2) Section 1902(a)(10), insofar as such section relates to comparability of services among different population groups.

(3) Sections 1902(a)(23) and 1915(b)(4), relating to freedom of choice of providers under a PACE program.

(4) Section 1903(m)(2)(A), insofar as it restricts a PACE provider from receiving prepaid capitation payments.

(5) Such other provisions of this title that, as added or amended by the Balanced Budget Act of 1997, the Secretary determines are inapplicable to carrying out a PACE program under this section.

(h) DEMONSTRATION PROJECT FOR FOR–PROFIT ENTITIES.—

(1) IN GENERAL.—In order to demonstrate the operation of a PACE program by a private, for–profit entity, the Secretary (in close consultation with State administering agencies) shall grant waivers from the requirement under subsection (a)(3) that a PACE provider may not be a for–profit, private entity.

(2) SIMILAR TERMS AND CONDITIONS.—

(A) IN GENERAL.—Except as provided under subparagraph (B), and paragraph (1), the terms and conditions for operation of a PACE program by a provider under this subsection shall be the same as those for PACE providers that are nonprofit, private organizations.

(B) NUMERICAL LIMITATION.—The number of programs for which waivers are granted under this subsection shall not exceed 10. Programs with waivers granted under this subsection shall not be counted against the numerical limitation specified in subsection (e)(1)(B).

(i) POST–ELIGIBILITY TREATMENT OF INCOME.—A State may provide for post–eligibility treatment of income for individuals enrolled in PACE programs under this section in the same manner as a State treats post–eligibility income for individuals receiving services under a waiver under section 1915(c).

(j) MISCELLANEOUS PROVISIONS.—Nothing in this section or section 1894 shall be construed as preventing a PACE provider from entering into contracts with other governmental or nongovernmental payers for the care of PACE program eligible individuals who are not eligible for benefits under part A, or enrolled under part B, of title XVIII or eligible for medical assistance under this title.

SPECIAL PROVISIONS RELATING TO MEDICARE PRESCRIPTION DRUG BENEFIT

SEC. 1935.[179] [42 U.S.C. 1396u-5] (a) REQUIREMENTS RELATING TO MEDICARE PRESCRIPTION DRUG LOW-INCOME SUBSIDIES AND MEDICARE TRANSITIONAL PRESCRIPTION DRUG ASSISTANCE.—As a condition of its State plan under this title under section 1902(a)(66) and receipt of any Federal financial assistance under section 1903(a) subject to subsection (e)[180], a State shall do the following:

(1) INFORMATION FOR TRANSITIONAL PRESCRIPTION DRUG ASSISTANCE VERIFICATION.—The State shall provide the Secretary with information to carry out section 1860D-31(f)(3)(B)(i).

(2) ELIGIBILITY DETERMINATIONS FOR LOW-INCOME SUBSIDIES.—The State shall—

(A) make determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D-14;

(B) inform the Secretary of such determinations in cases in which such eligibility is established; and

(C) otherwise provide the Secretary with such information as may be required to carry out part D, other than subpart 4, of title XVIII (including section 1860D-14).

(3) SCREENING FOR ELIGIBILITY, AND ENROLLMENT OF, BENEFICIARIES FOR MEDICARE COST-SHARING.—As part of making an eligibility determination required under paragraph (2) for an individual, the State shall make a determination of the individual's eligibility for medical assistance for any medicare cost-sharing described in section 1905(p)(3) and, if the individual is eligible for any such medicare cost-sharing, offer enrollment to the individual under the State plan (or under a waiver of such plan).

(b) REGULAR FEDERAL SUBSIDY OF ADMINISTRATIVE COSTS.—The amounts expended by a State in carrying out subsection (a) are expenditures reimbursable under the appropriate paragraph of section 1903(a).

(c)[181] FEDERAL ASSUMPTION OF MEDICAID PRESCRIPTION DRUG COSTS FOR DUALLY ELIGIBLE INDIVIDUALS.—

(1) PHASED-DOWN STATE CONTRIBUTION.—

(A) IN GENERAL.—Each of the 50 States and the District of Columbia for each month beginning with January 2006

[179] P.L. 108-173, §103(a)(2)(B), added §1935(a) and (b), effective December 8, 2003.
[180] P.L. 108-173, §103(d)(1)(A), inserted "subject to subsection (e)", effective December 8, 2003.
[181] P.L. 108-173, §103(b), added subsection (c), effective December 8, 2003.

shall provide for payment under this subsection to the Secretary of the product of—

(i) the amount computed under paragraph (2)(A) for the State and month;

(ii) the total number of full-benefit dual eligible individuals (as defined in paragraph (6)) for such State and month; and

(iii) the factor for the month specified in paragraph (5).

(B) FORM AND MANNER OF PAYMENT.—Payment under subparagraph (A) shall be made in a manner specified by the Secretary that is similar to the manner in which State payments are made under an agreement entered into under section 1843, except that all such payments shall be deposited into the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund.

(C) COMPLIANCE.—If a State fails to pay to the Secretary an amount required under subparagraph (A), interest shall accrue on such amount at the rate provided under section 1903(d)(5). The amount so owed and applicable interest shall be immediately offset against amounts otherwise payable to the State under section 1903(a) subject to subsection (e)[182], in accordance with the Federal Claims Collection Act of 1996 and applicable regulations.

(D) DATA MATCH.—The Secretary shall perform such periodic data matches as may be necessary to identify and compute the number of full-benefit dual eligible individuals for purposes of computing the amount under subparagraph (A).

(2) AMOUNT.—

(A) IN GENERAL.—The amount computed under this paragraph for a State described in paragraph (1) and for a month in a year is equal to—

(i) 1/12 of the product of—

(I) the base year State medicaid per capita expenditures for covered part D drugs for full-benefit dual eligible individuals (as computed under paragraph (3)); and

(II) a proportion equal to 100 percent minus the Federal medical assistance percentage (as defined in section 1905(b)) applicable to the State for the fiscal year in which the month occurs; and

(ii) increased for each year (beginning with 2004 up to and including the year involved) by the applicable growth factor specified in paragraph (4) for that year.

(B) NOTICE.—The Secretary shall notify each State described in paragraph (1) not later than October 15 before the beginning of each year (beginning with 2006) of the amount computed under subparagraph (A) for the State for that year.

(3) BASE YEAR STATE MEDICAID PER CAPITA EXPENDITURES FOR COVERED PART D DRUGS FOR FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—

[182] P.L. 108-173, §103(d)(1)(B), inserted "subject to subsection (e)", effective December 8, 2003. §103(d)(1)(B), indicated the clause should be inserted after "1903(a)(1)". Executed as if the insertion should have been after "1903(a)".

(A) IN GENERAL—For purposes of paragraph (2)(A), the "base year State medicaid per capita expenditures for covered part D drugs for full-benefit dual eligible individuals" for a State is equal to the weighted average (as weighted under subparagraph (C)) of—

(i) the gross per capita medicaid expenditures for prescription drugs for 2003, determined under subparagraph (B); and

(ii) the estimated actuarial value of prescription drug benefits provided under a capitated managed care plan per full-benefit dual eligible individual for 2003, as determined using such data as the Secretary determines appropriate.

(B) GROSS PER CAPITA MEDICAID EXPENDITURES FOR PRESCRIPTION DRUGS.—

(i) IN GENERAL.—The gross per capita medicaid expenditures for prescription drugs for 2003 under this subparagraph is equal to the expenditures, including dispensing fees, for the State under this title during 2003 for covered outpatient drugs, determined per full-benefit-dual-eligible-individual for such individuals not receiving medical assistance for such drugs through a medicaid managed care plan.

(ii) DETERMINATION.—In determining the amount under clause (i), the Secretary shall—

(I) use data from the Medicaid Statistical Information System (MSIS) and other available data;

(II) exclude expenditures attributable to covered outpatient prescription drugs that are not covered part D drugs (as defined in section 1860D-2(e)); and

(III) reduce such expenditures by the product of such portion and the adjustment factor (described in clause (iii)).

(iii) ADJUSTMENT FACTOR.—The adjustment factor described in this clause for a State is equal to the ratio for the State for 2003 of—

(I) aggregate payments under agreements under section 1927; to

(II) the gross expenditures under this title for covered outpatient drugs referred to in clause (i).

Such factor shall be determined based on information reported by the State in the medicaid financial management reports (form CMS-64) for the 4 quarters of calendar year 2003 and such other data as the Secretary may require.

(C) WEIGHTED AVERAGE.—The weighted average under subparagraph (A) shall be determined taking into account—

(i) with respect to subparagraph (A)(i), the average number of full-benefit dual eligible individuals in 2003 who are not described in clause (ii); and

(ii) with respect to subparagraph (A)(ii), the average number of full-benefit dual eligible individuals in such year who received in 2003 medical assistance for cov-

ered outpatient drugs through a medicaid managed care plan.

(4) APPLICABLE GROWTH FACTOR.—The applicable growth factor under this paragraph for—

(A) each of 2004, 2005, and 2006, is the average annual percent change (to that year from the previous year) of the per capita amount of prescription drug expenditures (as determined based on the most recent National Health Expenditure projections for the years involved); and

(B) a succeeding year, is the annual percentage increase specified in section 1860D-2(b)(6) for the year.

(5) FACTOR.—The factor under this paragraph for a month—

(A) in 2006 is 90 percent;

(B) in 2007 is 88 ⅓ percent;

(C) in 2008 is 86 ⅔ percent;

(D) in 2009 is 85 percent;

(E) in 2010 is 83 ⅓ percent;

(F) in 2011 is 81 ⅔ percent;

(G) in 2012 is 80 percent;

(H) in 2013 is 78 ⅓ percent;

(I) in 2014 is 76 ⅔ percent; or

(J) after December 2014, is 75 percent.

(6) FULL-BENEFIT DUAL ELIGIBLE INDIVIDUAL DEFINED—

(A) IN GENERAL.—For purposes of this section, the term "full-benefit dual eligible individual" means for a State for a month an individual who—

(i) has coverage for the month for covered part D drugs under a prescription drug plan under part D of title XVIII, or under an MA-PD plan under part C of such title; and

(ii) is determined eligible by the State for medical assistance for full benefits under this title for such month under section 1902(a)(10)(A) or 1902(a)(10)(C), by reason of section 1902(f), or under any other category of eligibility for medical assistance for full benefits under this title, as determined by the Secretary.

(B) TREATMENT OF MEDICALLY NEEDY AND OTHER INDIVIDUALS REQUIRED TO SPEND DOWN.—In applying subparagraph (A) in the case of an individual determined to be eligible by the State for medical assistance under section 1902(a)(10)(C) or by reason of section 1902(f), the individual shall be treated as meeting the requirement of subparagraph (A)(ii) for any month if such medical assistance is provided for in any part of the month.

(d)[183] COORDINATION OF PRESCRIPTION DRUG BENEFITS.—

(1) MEDICARE AS PRIMARY PAYOR.—In the case of a part D eligible individual (as defined in section 1860D-1(a)(3)(A)) who is described in subsection (c)(6)(A)(ii), notwithstanding any other provision of this title, medical assistance is not available under this title for such drugs (or for any cost-sharing respecting such drugs), and the rules under this title relating to the provision of medical assistance for such drugs shall not apply. The provision of benefits with respect to such drugs shall not be considered as the provision of care or services under the plan

[183] P.L. 108-173, §103(c), added subsection (d), effective December 8, 2003.

under this title. No payment may be made under section 1903(a) for prescribed drugs for which medical assistance is not available pursuant to this paragraph.

(2) COVERAGE OF CERTAIN EXCLUDABLE DRUGS.— In the case of medical assistance under this title with respect to a covered outpatient drug (other than a covered part D drug) furnished to an individual who is enrolled in a prescription drug plan under part D of title XVIII or an MA-PD plan under part C of such title, the State may elect to provide such medical assistance in the manner otherwise provided in the case of individuals who are not full-benefit dual eligible individuals or through an arrangement with such plan.

(e)[184] TREATMENT OF TERRITORIES.—

(1) IN GENERAL.—In the case of a State, other than the 50 States and the District of Columbia—

(A) the previous provisions of this section shall not apply to residents of such State; and

(B) if the State establishes and submits to the Secretary a plan described in paragraph (2) (for providing medical assistance with respect to the provision of prescription drugs to part D eligible individuals), the amount otherwise determined under section 1108(f) (as increased under section 1108(g)) for the State shall be increased by the amount for the fiscal period specified in paragraph (3).

(2) PLAN.—The Secretary shall determine that a plan is described in this paragraph if the plan—

(A) provides medical assistance with respect to the provision of covered part D drugs (as defined in section 1860D-2(e)) to low-income part D eligible individuals;

(B) provides assurances that additional amounts received by the State that are attributable to the operation of this subsection shall be used only for such assistance and related administrative expenses and that no more than 10 percent of the amount specified in paragraph (3)(A) for the State for any fiscal period shall be used for such administrative expenses; and

(C) meets such other criteria as the Secretary may establish.

(3) INCREASED AMOUNT.—

(A) IN GENERAL.—The amount specified in this paragraph for a State for a year is equal to the product of—

(i) the aggregate amount specified in subparagraph (B); and

(ii) the ratio (as estimated by the Secretary) of—

(I) the number of individuals who are entitled to benefits under part A or enrolled under part B and who reside in the State (as determined by the Secretary based on the most recent available data before the beginning of the year); to

(II) the sum of such numbers for all States that submit a plan described in paragraph (2).

(B) AGGREGATE AMOUNT.— The aggregate amount specified in this subparagraph for—

[184] P.L. 108-173, §103(d)(1)(C), added subsection (e), effective December 8, 2003.

(i) the last 3 quarters of fiscal year 2006, is equal to $28,125,000;

(ii) fiscal year 2007, is equal to $37,500,000; or

(iii) a subsequent year, is equal to the aggregate amount specified in this subparagraph for the previous year increased by annual percentage increase specified in section 1860D-2(b)(6) for the year involved.

(4) REPORT.—The Secretary shall submit to Congress a report on the application of this subsection and may include in the report such recommendations as the Secretary deems appropriate.

REFERENCES TO LAWS DIRECTLY AFFECTING MEDICAID PROGRAM [185]

SEC. 1936. [42 U.S.C. 1396v] (a) AUTHORITY OR REQUIREMENTS TO COVER ADDITIONAL INDIVIDUALS.—For provisions of law which make additional individuals eligible for medical assistance under this title, see the following:

(1) AFDC.—(A) Section 402(a)(32) of this Act (relating to individuals who are deemed recipients of aid but for whom a payment is not made).

(B) Section 402(a)(37) of this Act (relating to individuals who lose AFDC eligibility due to increased earnings).

(C) Section 406(h) of this Act (relating to individuals who lose AFDC eligibility due to increased collection of child or spousal support).

(D) Section 482(e)(6) of this Act (relating to certain individuals participating in work supplementation programs).

(2) SSI.—(A) Section 1611(e) of this Act (relating to treatment of couples sharing an accommodation in a facility).

(B) Section 1619 of this Act (relating to benefits for individuals who perform substantial gainful activity despite severe medical impairment).

(C) Section 1634(b) of this Act (relating to preservation of benefit status for disabled widows and widowers who lost SSI benefits because of 1983 changes in actuarial reduction formula).

(D) Section 1634(c) of this Act (relating to individuals who lose eligibility for SSI benefits due to entitlement to child's insurance benefits under section 202(d) of this Act).

(E) Section 1634(d) of this Act (relating to individuals who lose eligibility for SSI benefits due to entitlement to early widow's or widower's insurance benefits under section 202(e) or (f) of this Act).

(3) FOSTER CARE AND ADOPTION ASSISTANCE.—Sections 472(h) and 473(b) of this Act (relating to medical assistance for children in foster care and for adopted children).

(4) REFUGEE ASSISTANCE.—Section 412(e)(5) of the Immigration and Nationality Act [186] (relating to medical assistance for certain refugees).

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[185] P.L. 108–173, §103(a)(2)(A), redesignated the former §1935 as §1936, effective December 8, 2003.

[186] See Vol. II, P.L. 82-414.

(5)[187] MISCELLANEOUS.—(A) Section 230 of Public Law 93–66 (relating to deeming eligible for medical assistance certain essential persons).

(B) Section 231 of Public Law 93–66 (relating to deeming eligible for medical assistance certain persons in medical institutions).

(C) Section 232 of Public Law 93–66 (relating to deeming eligible for medical assistance certain blind and disabled medically indigent persons).

(D) Section 13(c) of Public Law 93–233 (relating to deeming eligible for medical assistance certain individuals receiving mandatory State supplementary payments).

(E) Section 503 of Public Law 94–566 (relating to deeming eligible for medical assistance certain individuals who would be eligible for supplemental security income benefits but for cost-of-living increases in social security benefits).

(F) Section 310(b)(1) of Public Law 96–272 (relating to continuing medicaid eligibility for certain recipients of Department of Veterans Affairs pensions).

(b) ADDITIONAL STATE PLAN REQUIREMENTS.—For other provisions of law that establish additional requirements for State plans to be approved under this title, see the following:

(1) Section 1618 of this Act (relating to requirement for operation of certain State supplementation programs).

(2) Section 212(a) of Public Law 93–66[188] (relating to requiring mandatory minimum State supplementation of SSI benefits program).

[187] See Vol. II, P.L. 93-66, P.L. 93-233, P.L. 94-566, and P.L. 96-272.
[188] See Vol. II, P.L. 93–66, §212(a).

TITLE XX—BLOCK GRANTS TO STATES FOR SOCIAL SERVICES [1]

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PURPOSES OF TITLE; AUTHORIZATION OF APPROPRIATIONS

SEC. 2001. [42 U.S.C. 1397] For the purposes of consolidating Federal assistance to States for social services into a single grant, increasing State flexibility in using social service grants, and encouraging each State, as far as practicable under the conditions in that State, to furnish services directed at the goals of—

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

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

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

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

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[1] Title XX of the Social Security Act is administered by the Office of Community Services, Administration for Children and Families, Department of Health and Human Services.

Title XX appears in the United States Code as §§1397–1397f, subchapter XX, chapter 7, Title 42.

Regulations of the Secretary of Health and Human Services relating to Title XX are contained in part 96, subtitle A, Title 45, Code of Federal Regulations.

See Vol. II, 31 U.S.C. 7501–7507, with respect to uniform audit requirements for State and local governments receiving Federal financial assistance.

See Vol. II, P.L. 79–396, §17(p), with respect to proprietary title XX center and §17(q), with respect to demonstration projects.

See Vol. II, P.L. 88–352, §601, for prohibition against discrimination in federally assisted programs.

See Vol. II, P.L. 95–521, §102(i), with respect to reporting of benefits received under the Social Security Act.

See Vol. II, P.L. 99–425, Title VI, with respect to grants for awarding scholarships to certain eligible individuals.

See Vol. II, P.L. 100–383, §§105(f)(2) and 206(d)(2), with respect to exclusion from income and resources of certain payments to certain individuals. See Vol. II, 31 U.S.C. 3803(c)(2)(C), with respect to benefits not affected by P.L. 100–383.

See Vol. II, P.L. 101–239, §10405, with respect to Agent Orange settlement payments excluded from countable income and resources under Federal means-tested programs.

[2] This table of contents does not appear in the law.

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

there are authorized to be appropriated for each fiscal year such sums as may be necessary to carry out the purposes of this title.

PAYMENTS TO STATES

SEC. 2002. [42 U.S.C. 1397a] (a)(1) Each State shall be entitled to payment under this title for each fiscal year in an amount equal to its allotment for such fiscal year, to be used by such State for services directed at the goals set forth in section 2001, subject to the requirements of this title.

(2) For purposes of paragraph (1)—

(A) services which are directed at the goals set forth in section 2001 include, but are not limited to, child care services, protective services for children and adults, services for children and adults in foster care, services related to the management and maintenance of the home, day care services for adults, transportation services, family planning services, training and related services, employment services, information, referral, and counseling services, the preparation and delivery of meals, health support services and appropriate combinations of services designed to meet the special needs of children, the aged, the mentally retarded, the blind, the emotionally disturbed, the physically handicapped, and alcoholics and drug addicts; and

(B) expenditures for such services may include expenditures for—

(i) administration (including planning and evaluation);

(ii) personnel training and retraining directly related to the provision of those services (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions); and

(iii) conferences or workshops, and training or retraining through grants to nonprofit organizations within the meaning of section 501(c)(3) of the Internal Revenue Code of 1954[3] or to individuals with social services expertise, or through financial assistance to individuals participating in such conferences, workshops, and training or retraining (and this clause shall apply with respect to all persons involved in the delivery of such services).

(b) The Secretary shall make payments in accordance with section 6503 of title 31, United States Code[4], to each State from its allotment for use under this title.

(c) Payments to a State from its allotment for any fiscal year must be expended by the State in such fiscal year or in the succeeding fiscal year.

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[3] See Vol. II, P.L. 83–591.
[4] See Vol. II, title 31.

(d) A State may transfer up to 10 percent of its allotment under section 2003 for any fiscal year for its use for that year under other provisions of Federal law providing block grants for support of health services, health promotion and disease prevention activities, or low-income home energy assistance (or any combination of those activities). Amounts allotted to a State under any provisions of Federal law referred to in the preceding sentence and transferred by a State for use in carrying out the purposes of this title shall be treated as if they were paid to the State under this title but shall not affect the computation of the State's allotment under this title. The State shall inform the Secretary of any such transfer of funds.

(e) A State may use a portion of the amounts described in subsection (a) for the purpose of purchasing technical assistance from public or private entities if the State determines that such assistance is required in developing, implementing, or administering programs funded under this title.

(f) A State may use funds provided under this title to provide vouchers, for services directed at the goals set forth in section 2001, to families, including—

(1) families who have become ineligible for assistance under a State program funded under part A of title IV by reason of a durational limit on the provision of such assistance; and

(2) families denied cash assistance under the State program funded under part A of title IV for a child who is born to a member of the family who is—

(A) a recipient of assistance under the program; or

(B) a person who received such assistance at any time during the 10–month period ending with the birth of the child.

ALLOTMENTS

SEC. 2003. [42 U.S.C. 1397b] (a) The allotment for any fiscal year to each of the jurisdictions of Puerto Rico, Guam, the Virgin Islands, and the Northern Mariana Islands shall be an amount which bears the same ratio to the amount specified in subsection (c) as the amount which was specified for allocation to the particular jurisdiction involved for the fiscal year 1981 under section 2002(a)(2)(C) of this Act (as in effect prior to the enactment of this section[5]) bore to $2,900,000,000. The allotment for fiscal year 1989 and each succeeding fiscal year to American Samoa shall be an amount which bears the same ratio to the amount allotted to the Northern Mariana Islands for that fiscal year as the population of American Samoa bears to the population of the Northern Mariana Islands determined on the basis of the most recent data available at the time such allotment is determined.

(b) The allotment for any fiscal year for each State other than the jurisdictions of Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands shall be an amount which bears the same ratio to—

(1) the amount specified in subsection (c), reduced by

(2) the total amount allotted to those jurisdictions for that fiscal year under subsection (a),

[5] August 13, 1981 [P.L. 97–35; 95 Stat. 357].

as the population of that State bears to the population of all the States (other than Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands) as determined by the Secretary (on the basis of the most recent data available from the Department of Commerce) and promulgated prior to the first day of the third month of the preceding fiscal year.

(c) The amount specified for purposes of subsections (a) and (b) shall be—

(1) $2,400,000,000 for the fiscal year 1982;

(2) $2,450,000,000 for the fiscal year 1983;

(3) $2,700,000,000 for the fiscal years 1984, 1985, 1986, 1987, and 1989;

(4) $2,750,000,000 for the fiscal year 1988;

(5) $2,800,000,000 for each of the fiscal years 1990 through 1995;

(6) $2,381,000,000 for the fiscal year 1996;

(7) $2,380,000,000 for the fiscal years 1997;

(8) $2,299,000,000 for the fiscal year 1998;

(9) $2,380,000,000 for the fiscal year 1999;

(10) $2,380,000,000 for the fiscal year 2000; and

(11) $1,700,000,000 for the fiscal year 2001 and each fiscal year thereafter.

STATE ADMINISTRATION

SEC. 2004. [42 U.S.C. 1397c] Prior to expenditure by a State of payments made to it under section 2002 for any fiscal year, the State shall report on the intended use of the payments the State is to receive under this title, including information on the types of activities to be supported and the categories or characteristics of individuals to be served. The report shall be transmitted to the Secretary and made public within the State in such manner as to facilitate comment by any person (including any Federal or other public agency) during development of the report and after its completion. The report shall be revised throughout the year as may be necessary to reflect substantial changes in the activities assisted under this title, and any revision shall be subject to the requirements of the previous sentence.

LIMITATIONS ON USE OF GRANTS

SEC. 2005. [42 U.S.C. 1397d] (a) Except as provided in subsection (b), grants made under this title may not be used by the State, or by any other person with which the State makes arrangements to carry out the purposes of this title—

(1) for the purchase or improvement of land, or the purchase, construction, or permanent improvement (other than minor remodeling) of any building or other facility;

(2) for the provision of cash payments for costs of subsistence or for the provision of room and board (other than costs of subsistence during rehabilitation, room and board provided for a short term as an integral but subordinate part of a social service, or temporary emergency shelter provided as a protective service);

(3) for payment of the wages of any individual as a social service (other than payment of the wages of welfare recipients employed in the provision of child day care services);

(4) for the provision of medical care (other than family planning services, rehabilitation services, or initial detoxification of an alcoholic or drug dependent individual) unless it is an integral but subordinate part of a social service for which grants may be used under this title;

(5) for social services (except services to an alcoholic or drug dependent individual or rehabilitation services) provided in and by employees of any hospital, skilled nursing facility, intermediate care facility, or prison, to any individual living in such institution;

(6) for the provision of any educational service which the State makes generally available to its residents without cost and without regard to their income;

(7) for any child day care services unless such services meet applicable standards of State and local law;

(8) for the provision of cash payments as a service (except as otherwise provided in this section);

(9) for payment for any item or service (other than an emergency item or service) furnished—

(A) by an individual or entity during the period when such individual or entity is excluded under this title or title V, XVIII, or XIX pursuant to section 1128, 1128A, 1156, or 1842(j)(2), or

(B) at the medical direction or on the prescription of a physician during the period when the physician is excluded under this title or title V, XVIII, or XIX pursuant to section 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person); or

(10) in a manner inconsistent with the Assisted Suicide Funding Restriction Act of 1997.

(b) The Secretary may waive the limitation contained in subsection (a)(1) and (4) upon the State's request for such a waiver if he finds that the request describes extraordinary circumstances to justify the waiver and that permitting the waiver will contribute to the State's ability to carry out the purposes of this title.

REPORTS AND AUDITS

SEC. 2006. [42 U.S.C. 1397e] (a) Each State shall prepare reports on its activities carried out with funds made available (or transferred for use) under this title. Reports shall be prepared annually, covering the most recently completed fiscal year, and shall be in such form and contain such information (including but not limited to the information specified in subsection (c)) as the State finds necessary to provide an accurate description of such activities, to secure a complete record of the purposes for which funds were spent, and to determine the extent to which funds were spent in a manner consistent with the reports required by section 2004. The State shall make copies of the reports required by this section available for public inspection within the State and shall transmit a copy to the Secretary. Copies shall also be provided, upon request, to any interested public agency, and each such agency may provide its views on these reports to the Congress.

(b) Each State shall, not less often than every two years, audit its expenditures from amounts received (or transferred for use) under this title. Such State audits shall be conducted by an entity independent of any agency administering activities funded under this title, in accordance with generally accepted auditing principles. Within 30 days following the completion of each audit, the State shall submit a copy of that audit to the legislature of the State and to the Secretary. Each State shall repay to the United States amounts ultimately found not to have been expended in accordance with this title, or the Secretary may offset such amounts against any other amount to which the State is or may become entitled under this title.

(c) Each report prepared and transmitted by a State under subsection (a) shall set forth (with respect to the fiscal year covered by the report)—

(1) the number of individuals who received services paid for in whole or in part with funds made available under this title, showing separately the number of children and the number of adults who received such services, and broken down in each case to reflect the types of services and circumstances involved;

(2) the amount spent in providing each such type of service, showing separately for each type of service the amount spent per child recipient and the amount spent per adult recipient;

(3) the criteria applied in determining eligibility for services (such as income eligibility guidelines, sliding fee scales, the effect of public assistance benefits, and any requirements for enrollment in school or training programs); and

(4) the methods by which services were provided, showing separately the services provided by public agencies and those provided by private agencies, and broken down in each case to reflect the types of services and circumstances involved.

The Secretary shall establish uniform definitions of services for use by the States in preparing the information required by this subsection, and make such other provision as may be necessary or appropriate to assure that compliance with the requirements of this subsection will not be unduly burdensome on the States.

(d) For other provisions requiring States to account for Federal grants, see section 6503 of title 31, United States Code[6].

ADDITIONAL GRANTS

SEC. 2007. [42 U.S.C 1397f] (a) ENTITLEMENT.—

(1) IN GENERAL.—In addition to any payment under section 2002, each State shall be entitled to—

(A) 2 grants under this section for each qualified empowerment zone in the State; and

(B) 1 grant under this section for each qualified enterprise community in the State.

(2) AMOUNT OF GRANTS.—

(A) EMPOWERMENT GRANTS.—The amount of each grant to a State under this section for a qualified empowerment zone shall be—

[6] See Vol. II, title 31.

(i) if the zone is designated in an urban area, $50,000,000, multiplied by that proportion of the population of the zone that resides in the State; or

(ii) if the zone is designated in a rural area, $20,000,000, multiplied by such proportion.

(B) ENTERPRISE GRANTS.—The amount of the grant to a State under this section for a qualified enterprise community shall be 1/95 of $280,000,000, multiplied by that proportion of the population of the community that resides in the State.

(C) POPULATION DETERMINATIONS.—The Secretary shall make population determinations for purposes of this paragraph based on the most recent decennial census data available.

(3) TIMING OF GRANTS.—

(A) QUALIFIED EMPOWERMENT ZONES.—With respect to each qualified empowerment zone, the Secretary shall make—

(i) 1 grant under this section to each State in which the zone lies, on the date of the designation of the zone under part I of subchapter U of chapter 1 of the Internal Revenue Code of 1986; and

(ii) 1 grant under this section to each such State, on the 1st day of the 1st fiscal year that begins after the date of the designation.

(B) QUALIFIED ENTERPRISE COMMUNITIES.—With respect to each qualified enterprise community, the Secretary shall make 1 grant under this section to each State in which the community lies, on the date of the designation of the community under part I of subchapter U of chapter 1 of the Internal Revenue Code of 1986.

(4) FUNDING.—$1,000,000,000 shall be made available to the Secretary for grants under this section.

(b) PROGRAM OPTIONS.—Notwithstanding section 2005(a):

(1) In order to prevent and remedy the neglect and abuse of children, a State may use amounts paid under this section to make grants to, or enter into contracts with, entities to provide residential or nonresidential drug and alcohol prevention and treatment programs that offer comprehensive services for pregnant women and mothers, and their children.

(2) In order to prevent to assist disadvantaged adults and youths in achieving and maintaining self–sufficiency, a State may use amounts paid under this section to make grants to, or enter into contracts with—

(A) organizations operated for profit or not for profit, for the purpose of training and employing disadvantaged adults and youths in construction, rehabilitation, or improvement of affordable housing, public infrastructure, and community facilities; and

(B) nonprofit organizations and community or junior colleges, for the purpose of enabling such entities to provide short–term training courses in entrepreneurism and self–employment, and other training that will promote individual self–sufficiency and the interests of the community.

(3) A State may use amounts paid under this section to make grants to, or enter into contracts with, nonprofit community–

based organizations to enable such organizations to provide activities designed to promote and protect the interests of children and families, outside of school hours, including keeping schools open during evenings and weekends for mentoring and study.

(4) In order to assist disadvantaged adults and youths in achieving and maintain economic self–support, a State may use amounts paid under this section to—

(A) fund services designed to promote community and economic development in qualified empowerment zones and qualified enterprise communities, such as skills training, job counseling, transportation services, housing counseling, financial management, and business counseling;

(B) assist in emergency and transitional shelter for disadvantaged families and individuals; or

(C) support programs that promote home ownership, education, or other routes to economic independence for low–income families and individuals.

(c) USE OF GRANTS.—

(1) IN GENERAL.—Subject to subsection (d) of this section, each State that receives a grant under this section with respect to an area shall use the grant—

(A) for services directed only at the goals set forth in paragraphs (1), (2), and (3) of section 2001;

(B) in accordance with the strategic plan for the area; and

(C) for activities that benefit residents of the area for which the grant is made.

(2) TECHNICAL ASSISTANCE.—A State may use a portion of any grant made under this section in the manner described in section 2002(e).

(d) REMITTANCE OF CERTAIN AMOUNTS.—

(1) PORTION OF GRANT UPON TERMINATION OF DESIGNATION.—Each State to which an amount is paid under this subsection during a fiscal year with respect to an area the designation of which under part I of subchapter U of chapter 1 of the Internal Revenue Code of 1986 ends before the end of the fiscal year shall remit to the Secretary an amount equal to the total of the amounts so paid with respect to the area, multiplied by that proportion of the fiscal year remaining after the designation ends.

(2) AMOUNTS PAID TO THE STATES AND NOT OBLIGATED WITHIN 2 YEARS.—Each State shall remit to the Secretary any amount paid to the State under this section that is not obligated by the end of the 2–year period that begins with the date of the payment.

(e) REALLOCATION OF REMAINING FUNDS.—

(1) REMITTED AMOUNTS.—The amount specified in section 2003(c) for any fiscal year is hereby increased by the total of the amounts remitted during the fiscal year pursuant to subsection (d) of this section.

(2) AMOUNTS NOT PAID TO THE STATES.—The amount specified in section 2003(c) for fiscal year 1998 is hereby increased by the amount made available for grants under this section that has not been paid to any State by the end of fiscal year 1997.

(f) DEFINITIONS.—AS USED IN THIS SECTION:

(1) QUALIFIED EMPOWERMENT ZONE.—The term "qualified empowerment zone" means, with respect to a State, an area—

(A) which has been designated (other than by the Secretary of the Interior) as an empowerment zone under part I of subchapter U of chapter 1 of the Internal Revenue Code of 1986;

(B) with respect to which the designation is in effect;

(C) the strategic plan for which is a qualified plan; and

(D) part or all of which is in the State.

(2) QUALIFIED ENTERPRISE COMMUNITY.—The term "qualified enterprise community" means, with respect to a State, an area—

(A) which has been designated (other than by the Secretary of the Interior) as an enterprise community under part I of subchapter U of chapter 1 of the Internal Revenue Code of 1986;

(B) with respect to which the designation is in effect;

(C) the strategic plan for which is a qualified plan; and

(D) part or all of which is in the State.

(3) STRATEGIC PLAN.—The term "strategic plan" means, with respect to an area, the plan contained in the application for designation of the area under part I of subchapter U of chapter 1 of the Internal Revenue Code of 1986.

(4) QUALIFIED PLAN.—The term "qualified plan" means, with respect to an area, a plan that—

(A) includes a detailed description of the activities proposed for the area that are to be funded with amounts provided under this section;

(B) contains a commitment that the amounts provided under this section to any State for the area will not be used to supplant Federal or non–Federal funds for services and activities which promote the purposes of this section;

(C) was developed in cooperation with the local government or governments with jurisdiction over the area; and

(D) to the extent that any State will not use the amounts provided under this section for the area in the manner described in subsection (b), explains the reasons why not.

(5) RURAL AREA.—The term "rural area" has the meaning given such term in section 1393(a)(2) of the Internal Revenue Code of 1986.

(6) URBAN AREA.—The term "urban area" has the meaning given such term in section 1393(a)(3) of the Internal Revenue Code of 1986.

TITLE XXI–STATE CHILDREN'S HEALTH INSURANCE PROGRAM [1]

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PURPOSE; STATE CHILD HEALTH PLANS

SEC. 2101. [42 U.S.C. 1397aa] (a) PURPOSE.—The purpose of this title is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low–income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children. Such assistance shall be provided primarily for obtaining health benefits coverage through—

(1) obtaining coverage that meets the requirements of section 2103, or

(2) providing benefits under the State's medicaid plan under title XIX, or a combination of both.

(b) STATE CHILD HEALTH PLAN REQUIRED.—A State is not eligible for payment under section 2105 unless the State has submitted to the Secretary under section 2106 a plan that—

(1) sets forth how the State intends to use the funds provided under this title to provide child health assistance to needy children consistent with the provisions of this title, and

(2) has been approved under section 2106.

(c) STATE ENTITLEMENT.—This title constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided under section 2104.

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[1] Title XXI appears in the United States Code as §§1397aa–1397jj, subchapter XXI, chapter 7, Title 42.

See Vol. II, P.L. 106–113, Appendix F, Title VII, §704, with respect to references to SCHIP and State Children's Health Insurance Program.

See Vol. II, P.L. 106–554, §1(a)(6)[802(c)], with respect to the elimination of the requirement to reduce Title XXI allotment by Medicaid expansion SCHIP costs.

[2] This table of contents does not appear in the law.

(d) EFFECTIVE DATE.—No State is eligible for payments under section 2105 for child health assistance for coverage provided for periods beginning before October 1, 1997.

GENERAL CONTENTS OF STATE CHILD HEALTH PLAN; ELIGIBILITY; OUTREACH

SEC. 2102. [42 U.S.C. 1397bb] (a) GENERAL BACKGROUND AND DESCRIPTION.—A State child health plan shall include a description, consistent with the requirements of this title, of—

(1) the extent to which, and manner in which, children in the State, including targeted low–income children and other classes of children classified by income and other relevant factors, currently have creditable health coverage (as defined in section 2110(c)(2));

(2) current State efforts to provide or obtain creditable health coverage for uncovered children, including the steps the State is taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs and health insurance programs that involve public–private partnerships;

(3) how the plan is designed to be coordinated with such efforts to increase coverage of children under creditable health coverage;

(4) the child health assistance provided under the plan for targeted low–income children, including the proposed methods of delivery, and utilization control systems;

(5) eligibility standards consistent with subsection (b);

(6) outreach activities consistent with subsection (c); and

(7) methods (including monitoring) used—

(A) to assure the quality and appropriateness of care, particularly with respect to well–baby care, well–child care, and immunizations provided under the plan, and

(B) to assure access to covered services, including emergency services.

(b) GENERAL DESCRIPTION OF ELIGIBILITY STANDARDS AND METHODOLOGY.—

(1) ELIGIBILITY STANDARDS.—

(A) IN GENERAL.—The plan shall include a description of the standards used to determine the eligibility of targeted low–income children for child health assistance under the plan. Such standards may include (to the extent consistent with this title) those relating to the geographic areas to be served by the plan, age, income and resources (including any standards relating to spenddowns and disposition of resources), residency, disability status (so long as any standard relating to such status does not restrict eligibility), access to or coverage under other health coverage, and duration of eligibility. Such standards may not discriminate on the basis of diagnosis.

(B) LIMITATIONS ON ELIGIBILITY STANDARDS.—Such eligibility standards—

(i) shall, within any defined group of covered targeted low–income children, not cover such children with higher family income without covering children with a lower family income, and

(ii) may not deny eligibility based on a child having a preexisting medical condition.

(2) METHODOLOGY.—The plan shall include a description of methods of establishing and continuing eligibility and enrollment.

(3) ELIGIBILITY SCREENING; COORDINATION WITH OTHER HEALTH COVERAGE PROGRAMS.—The plan shall include a description of procedures to be used to ensure—

(A) through both intake and followup screening, that only targeted low–income children are furnished child health assistance under the State child health plan;

(B) that children found through the screening to be eligible for medical assistance under the State medicaid plan under title XIX are enrolled for such assistance under such plan;

(C) that the insurance provided under the State child health plan does not substitute for coverage under group health plans;

(D) the provision of child health assistance to targeted low–income children in the State who are Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c)); and

(E) coordination with other public and private programs providing creditable coverage for low–income children.

(4) NONENTITLEMENT.—Nothing in this title shall be construed as providing an individual with an entitlement to child health assistance under a State child health plan.

(c) OUTREACH AND COORDINATION.—A State child health plan shall include a description of the procedures to be used by the State to accomplish the following:

(1) OUTREACH.—Outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs to inform these families of the availability of, and to assist them in enrolling their children in, such a program.

(2) COORDINATION WITH OTHER HEALTH INSURANCE PROGRAMS.—Coordination of the administration of the State program under this title with other public and private health insurance programs.

COVERAGE REQUIREMENTS FOR CHILDREN'S HEALTH INSURANCE

SEC. 2103. [42 U.S.C. 1397cc] (a) REQUIRED SCOPE OF HEALTH INSURANCE COVERAGE.—The child health assistance provided to a targeted low–income child under the plan in the form described in paragraph (1) of section 2101(a) shall consist, consistent with subsection (c)(5), of any of the following:

(1) BENCHMARK COVERAGE.—Health benefits coverage that is equivalent to the benefits coverage in a benchmark benefit package described in subsection (b).

(2) BENCHMARK–EQUIVALENT COVERAGE.—Health benefits coverage that meets the following requirements:

(A) INCLUSION OF BASIC SERVICES.—The coverage includes benefits for items and services within each of the categories of basic services described in subsection (c)(1).

(B) AGGREGATE ACTUARIAL VALUE EQUIVALENT TO BENCHMARK PACKAGE.—The coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages.

(C) SUBSTANTIAL ACTUARIAL VALUE FOR ADDITIONAL SERVICES INCLUDED IN BENCHMARK PACKAGE.—With respect to each of the categories of additional services described in subsection (c)(2) for which coverage is provided under the benchmark benefit package used under subparagraph (B), the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the coverage of that category of services in such package.

(3) EXISTING COMPREHENSIVE STATE–BASED COVERAGE.—Health benefits coverage under an existing comprehensive State–based program, described in subsection (d)(1).

(4) SECRETARY–APPROVED COVERAGE.—Any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage for the population of targeted low–income children proposed to be provided such coverage.

(b) BENCHMARK BENEFIT PACKAGES.—The benchmark benefit packages are as follows:

(1) FEHBP–EQUIVALENT CHILDREN'S HEALTH INSURANCE COVERAGE.—The standard Blue Cross/Blue Shield preferred provider option service benefit plan, described in and offered under section 8903(1) of title 5, United States Code.

(2) STATE EMPLOYEE COVERAGE.—A health benefits coverage plan that is offered and generally available to State employees in the State involved.

(3) COVERAGE OFFERED THROUGH HMO.—The health insurance coverage plan that—

(A) is offered by a health maintenance organization (as defined in section 2791(b)(3) of the Public Health Service Act), and

(B) has the largest insured commercial, non–medicaid enrollment of covered lives of such coverage plans offered by such a health maintenance organization in the State involved.

(c) CATEGORIES OF SERVICES; DETERMINATION OF ACTUARIAL VALUE OF COVERAGE.—

(1) CATEGORIES OF BASIC SERVICES.—For purposes of this section, the categories of basic services described in this paragraph are as follows:

(A) Inpatient and outpatient hospital services.

(B) Physicians surgical and medical services.

(C) Laboratory and x–ray services.

(D) Well–baby and well–child care, including age–appropriate immunizations.

(2) CATEGORIES OF ADDITIONAL SERVICES.—For purposes of this section, the categories of additional services described in this paragraph are as follows:

(A) Coverage of prescription drugs.

(B) Mental health services.

(C) Vision services.

(D) Hearing services.

(3) TREATMENT OF OTHER CATEGORIES.—Nothing in this subsection shall be construed as preventing a State child health plan from providing coverage of benefits that are not within a category of services described in paragraph (1) or (2).

(4) DETERMINATION OF ACTUARIAL VALUE.—The actuarial value of coverage of benchmark benefit packages, coverage offered under the State child health plan, and coverage of any categories of additional services under benchmark benefit packages and under coverage offered by such a plan, shall be set forth in an actuarial opinion in an actuarial report that has been prepared—

(A) by an individual who is a member of the American Academy of Actuaries;

(B) using generally accepted actuarial principles and methodologies;

(C) using a standardized set of utilization and price factors;

(D) using a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan;

(E) applying the same principles and factors in comparing the value of different coverage (or categories of services);

(F) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and

(G) taking into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage.

The actuary preparing the opinion shall select and specify in the memorandum the standardized set and population to be used under subparagraphs (C) and (D).

(5) CONSTRUCTION ON PROHIBITED COVERAGE.—Nothing in this section shall be construed as requiring any health benefits coverage offered under the plan to provide coverage for items or services for which payment is prohibited under this title, notwithstanding that any benchmark benefit package includes coverage for such an item or service.

(d) DESCRIPTION OF EXISTING COMPREHENSIVE STATE–BASED COVERAGE.—

(1) IN GENERAL.—A program described in this paragraph is a child health coverage program that—

(A) includes coverage of a range of benefits;

(B) is administered or overseen by the State and receives funds from the State;

(C) is offered in New York, Florida, or Pennsylvania; and

(D) was offered as of the date of the enactment of this title.

(2) MODIFICATIONS.—A State may modify a program described in paragraph (1) from time to time so long as it continues to meet the requirement of subparagraph (A) and does not reduce the actuarial value of the coverage under the program below the lower of—

(A) the actuarial value of the coverage under the program as of the date of the enactment of this title, or

(B) the actuarial value described in subsection (a)(2)(B), evaluated as of the time of the modification.

(e) COST–SHARING.—

(1) DESCRIPTION; GENERAL CONDITIONS.—

(A) DESCRIPTION.—A State child health plan shall include a description, consistent with this subsection, of the amount (if any) of premiums, deductibles, coinsurance, and other cost sharing imposed. Any such charges shall be imposed pursuant to a public schedule.

(B) PROTECTION FOR LOWER INCOME CHILDREN.—The State child health plan may only vary premiums, deductibles, coinsurance, and other cost sharing based on the family income of targeted low–income children in a manner that does not favor children from families with higher income over children from families with lower income.

(2) NO COST SHARING ON BENEFITS FOR PREVENTIVE SERVICES.—The State child health plan may not impose deductibles, coinsurance, or other cost sharing with respect to benefits for services within the category of services described in subsection (c)(1)(D).

(3) LIMITATIONS ON PREMIUMS AND COST–SHARING.—

(A) CHILDREN IN FAMILIES WITH INCOME BELOW 150 PERCENT OF POVERTY LINE .—In the case of a targeted low–income child whose family income is at or below 150 percent of the poverty line, the State child health plan may not impose—

(i) an enrollment fee, premium, or similar charge that exceeds the maximum monthly charge permitted consistent with standards established to carry out section 1916(b)(1) (with respect to individuals described in such section); and

(ii) a deductible, cost sharing, or similar charge that exceeds an amount that is nominal (as determined consistent with regulations referred to in section 1916(a)(3), with such appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable).

(B) OTHER CHILDREN.—For children not described in subparagraph (A), subject to paragraphs (1)(B) and (2), any premiums, deductibles, cost sharing or similar charges imposed under the State child health plan may be imposed on a sliding scale related to income, except that the total annual aggregate cost–sharing with respect to all targeted low–income children in a family under this title may not exceed 5 percent of such family's income for the year involved.

(4) RELATION TO MEDICAID REQUIREMENTS.—Nothing in this subsection shall be construed as affecting the rules relating to the use of enrollment fees, premiums, deductions, cost sharing, and similar charges in the case of targeted low–income children who are provided child health assistance in the form of coverage under a medicaid program under section 2101(a)(2).

(f) APPLICATION OF CERTAIN REQUIREMENTS.—

(1) RESTRICTION ON APPLICATION OF PREEXISTING CONDITION EXCLUSIONS.—

(A) IN GENERAL.—Subject to subparagraph (B), the State child health plan shall not permit the imposition of any preexisting condition exclusion for covered benefits under the plan.

(B) GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.—If the State child health plan provides for benefits through payment for, or a contract with, a group health plan or group health insurance coverage, the plan may permit the imposition of a preexisting condition exclusion but only insofar as it is permitted under the applicable provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and title XXVII of the Public Health Service Act.

(2) COMPLIANCE WITH OTHER REQUIREMENTS.—Coverage offered under this section shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act insofar as such requirements apply with respect to a health insurance issuer that offers group health insurance coverage.

ALLOTMENTS

SEC. 2104. [42 U.S.C. 1397dd] (a) APPROPRIATION; TOTAL ALLOTMENT.—For the purpose of providing allotments to States under this section, there is appropriated, out of any money in the Treasury not otherwise appropriated—

(1) for fiscal year 1998, $4,295,000,000;
(2) for fiscal year 1999, $4,275,000,000;
(3) for fiscal year 2000, $4,275,000,000;
(4) for fiscal year 2001, $4,275,000,000;
(5) for fiscal year 2002, $3,150,000,000;
(6) for fiscal year 2003, $3,150,000,000;
(7) for fiscal year 2004, $3,150,000,000;
(8) for fiscal year 2005, $4,050,000,000;
(9) for fiscal year 2006, $4,050,000,000; and
(10) for fiscal year 2007, $5,000,000,000.

(b) ALLOTMENTS TO 50 STATES AND DISTRICT OF COLUMBIA.—

(1) IN GENERAL.—Subject to paragraph (4), of the amount available for allotment under subsection (a) for a fiscal year, reduced by the amount of allotments made under subsection (c) (determined without regard to paragraph (4) thereof) for the fiscal year, the Secretary shall allot to each State (other than a State described in such subsection) with a State child health plan approved under this title the same proportion as the ratio of—

(A) the product of (i) the number of children described in paragraph (2) for the State for the fiscal year and (ii) the State cost factor for that State (established under paragraph (3)); to

(B) the sum of the products computed under subparagraph (A).

(2) NUMBER OF CHILDREN.—

(A) IN GENERAL.—The number of children described in this paragraph for a State for—

(i) each of fiscal years 1998 and 1999 is equal to the number of low–income children in the State with no health insurance coverage for the fiscal year;

(ii) fiscal year 2000 is equal to—

(I) 75 percent of the number of low–income children in the State for the fiscal year with no health insurance coverage, plus

(II) 25 percent of the number of low–income children in the State for the fiscal year; and

(iii) each succeeding fiscal year is equal to—

(I) 50 percent of the number of low–income children in the State for the fiscal year with no health insurance coverage, plus

(II) 50 percent of the number of low–income children in the State for the fiscal year.

(B) DETERMINATION OF NUMBER OF CHILDREN.—For purposes of subparagraph (A), a determination of the number of low–income children (and of such children who have no health insurance coverage) for a State for a fiscal year shall be made on the basis of the arithmetic average of the number of such children, as reported and defined in the 3 most recent March supplements to the Current Population Survey of the Bureau of the Census before the beginning of the calendar year in which such fiscal year begins.

(3) ADJUSTMENT FOR GEOGRAPHIC VARIATIONS IN HEALTH COSTS.—

(A) IN GENERAL.—For purposes of paragraph (1)(A)(ii), the State cost factor for a State for a fiscal year equal to the sum of—

(i) 0.15, and

(ii) 0.85 multiplied by the ratio of—

(I) the annual average wages per employee for the State for such year (as determined under subparagraph (B)), to

(II) the annual average wages per employee for the 50 States and the District of Columbia.

(B) ANNUAL AVERAGE WAGES PER EMPLOYEE.—For purposes of subparagraph (A), the "annual average wages per employee" for a State, or for all the States, for a fiscal year is equal to the average of the annual wages per employee for the State or for the 50 States and the District of Columbia for employees in the health services industry (SIC code 8000), as reported by the Bureau of Labor Statistics of the Department of Labor for each of the most recent 3 years before the beginning of the calendar year in which such fiscal year begins.

(4) FLOORS AND CEILINGS IN STATE ALLOTMENTS.—

(A) IN GENERAL.—The proportion of the allotment under this subsection for a subsection (b) State (as defined in subparagraph (D)) for fiscal year 2000 and each fiscal year thereafter shall be subject to the following floors and ceilings:

(i) FLOOR OF $2,000,000.—A floor equal to $2,000,000 divided by the total of the amount available under this subsection for all such allotments for the fiscal year.

(ii) ANNUAL FLOOR OF 10 PERCENT BELOW PRECEDING FISCAL YEAR'S PROPORTION.—A floor of 90 percent of the proportion for the State for the preceding fiscal year.

(iii) CUMULATIVE FLOOR OF 30 PERCENT BELOW THE FY 1999 PROPORTION.—A floor of 70 percent of the proportion for the State for fiscal year 1999.

(iv) CUMULATIVE CEILING OF 45 PERCENT ABOVE FY 1999 PROPORTION.—A ceiling of 145 percent of the proportion for the State for fiscal year 1999.

(B) RECONCILIATION.—

(i) ELIMINATION OF ANY DEFICIT BY ESTABLISHING A PERCENTAGE INCREASE CEILING FOR STATES WITH HIGHEST ANNUAL PERCENTAGE INCREASES.—To the extent that the application of subparagraph (A) would result in the sum of the proportions of the allotments for all subsection (b) States exceeding 1.0, the Secretary shall establish a maximum percentage increase in such proportions for all subsection (b) States for the fiscal year in a manner so that such sum equals 1.0.

(ii) ALLOCATION OF SURPLUS THROUGH PRO RATA INCREASE.—To the extent that the application of subparagraph (A) would result in the sum of the proportions of the allotments for all subsection (b) States being less than 1.0, the proportions of such allotments (as computed before the application of floors under clauses (i), (ii), and (iii) of subparagraph (A)) for all subsection (b) States shall be increased in a pro rata manner (but not to exceed the ceiling established under subparagraph (A)(iv)) so that (after the application of such floors and ceiling) such sum equals 1.0.

(C) CONSTRUCTION.—This paragraph shall not be construed as applying to (or taking into account) amounts of allotments redistributed under subsection (f).

(D) DEFINITIONS.—In this paragraph:

(i) PROPORTION OF ALLOTMENT.—The term "proportion" means, with respect to the allotment of a subsection (b) State for a fiscal year, the amount of the allotment of such State under this subsection for the fiscal year divided by the total of the amount available under this subsection for all such allotments for the fiscal year.

(ii) SUBSECTION (B) STATE.—The term "subsection (b) State" means one of the 50 States or the District of Columbia.

(c) ALLOTMENTS TO TERRITORIES.—

(1) IN GENERAL.—Of the amount available for allotment under subsection (a) for a fiscal year, the Secretary shall allot 0.25 percent among each of the commonwealths and territories described in paragraph (3) in the same proportion as the percentage specified in paragraph (2) for such commonwealth or territory bears to the sum of such percentages for all such commonwealths or territories so described.

(2) PERCENTAGE.—The percentage specified in this paragraph for—

(A) Puerto Rico is 91.6 percent,

(B) Guam is 3.5 percent,

(C) the Virgin Islands is 2.6 percent,

(D) American Samoa is 1.2 percent, and

(E) the Northern Mariana Islands is 1.1 percent.

(3) COMMONWEALTHS AND TERRITORIES.—A commonwealth or territory described in this paragraph is any of the following if it has a State child health plan approved under this title:

(A) Puerto Rico.

(B) Guam.

(C) The Virgin Islands.

(D) American Samoa.

(E) The Northern Mariana Islands.

(4) ADDITIONAL ALLOTMENT.—

(A) IN GENERAL.—In additional to the allotment under paragraph (1), the Secretary shall allot each commonwealth and territory described in paragraph (3) the applicable percentage specified in paragraph (2) of the amount appropriated under subparagraph (B).

(B) APPROPRIATIONS.—For purposes of providing allotments pursuant to subparagraph (A), there is appropriated, out of any money in the Treasury not otherwise appropriated $32,000,000 for fiscal year 1999, $34,200,000 for each of fiscal years 2000 and 2001, $25,200,000 for each of fiscal years 2002 through 2004, $32,400,000 for each of fiscal years 2005 and 2006, and $40,000,000 for fiscal year 2007.[3]

(d) [Stricken.[4]]

(e) 3–YEAR AVAILABILITY OF AMOUNTS ALLOTTED.—Amounts allotted to a State pursuant to this section for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year; except that amounts reallotted to a State under subsection (f) shall be available for expenditure by the State through the end of the fiscal year in which they are reallotted.

(f) PROCEDURE FOR REDISTRIBUTION OF UNUSED ALLOTMENTS.—The Secretary shall determine an appropriate procedure for redistribution of allotments from States that were provided allotments under this section for a fiscal year but that do not expend all of the amount of such allotments during the period in which such allotments are available for expenditure under subsection (e), to States that have fully expended the amount of their allotments under this section.

(g) [5]Rule for Redistribution and Extended Availability of Fiscal Years 1998, 1999, 2000, and 2001[6] Allotments.—

(1) AMOUNT REDISTRIBUTED.—

(A) IN GENERAL.—In the case of a State that expends all of its allotment under subsection (b) or (c) for fiscal year

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[3] See Vol. II, P.L. 105–277, §707, with respect to the determination of number of children and State cost factors for fiscal years 1998 and 1999.

[4] P.L.106–554, §1(a)(6)[802(b)]; 114 Stat. 2763A-581.

[5] See Vol. II, P.L. 108-74, §1(a)(4), for the effective date for the amendments to §2104(g) made by subsection (a) of P.L. 108-74, §1.

[6] P.L. 108-74, §1(a)(2)(C)(i), struck out "and 1999" and substituted ", 1999 and 2000".
P.L. 108-74, §1(a)(3)(C)(i), struck out "and 2000" and substituted "2000, and 2001".

1998 by the end of fiscal year 2000, or for fiscal year 1999 by the end of fiscal year 2001, or for fiscal year 2000 by the end of fiscal year 2002,[7] or for fiscal year 2001 by the end of fiscal year 2003,[8] the Secretary shall redistribute to the State under subsection (f) (from the fiscal year 1998, 1999, 2000, or 2001[9] allotments of other States, respectively, as determined by the application of paragraphs (2) and (3) with respect to the respective fiscal year) the following amount:

(i) STATE.—In the case of one of the 50 States or the District of Columbia, with respect to—

(I) the fiscal year 1998 allotment, the amount by which the State's expenditures under this title in fiscal years 1998, 1999, and 2000 exceed the State's allotment for fiscal year 1998 under subsection (b);[10]

(II) the fiscal year 1999 allotment, the amount by which the State's expenditures under this title in fiscal years 1999, 2000, and 2001 exceed the State's allotment for fiscal year 1999 under subsection (b);[11]

(III)[12] the fiscal year 2000 allotment, the amount specified in subparagraph (C)(i) (less the total of the amounts under clause (ii) for such fiscal year), multiplied by the ratio of the amount specified in subparagraph (C)(ii) for the State to the amount specified in subparagraph (C)(iii); or[13]

(IV) the fiscal year 2001 allotment, the amount specified in subparagraph (D)(i) (less the total of the amounts under clause (ii) for such fiscal year), multiplied by the ratio of the amount specified in subparagraph (D)(ii) for the State to the amount specified in subparagraph (D)(iii)[14].

(ii) TERRITORY.—In the case of a commonwealth or territory described in subsection (c)(3), an amount that bears the same ratio to 1.05 percent of the total amount described in paragraph (2)(B)(i)(I) as the ratio of the commonwealth's or territory's fiscal year 1998, 1999, 2000, or 2001[15], allotment under subsection (c) (as the case may be) bears to the total of all such allotments for such fiscal year under such subsection.

(B) EXPENDITURE RULES.—An amount redistributed to a State under this paragraph[16] —

(i) shall not be included in the determination of the State's allotment for any fiscal year under this section;

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[7] P.L. 108-74, §1(a)(2)(B)(i), inserted "or for fiscal year 2000 by the end of fiscal year 2002,".
[8] P.L. 108-74, §1(a)(3)(B)(i), inserted "or fiscal year 2001 by the end of fiscal year 2003."
[9] P.L. 108-74, §1(a)(2)(B)(ii), struck out "1998 or 1999: and substituted "1998, 1999, or 2000". P.L. 108-74, §1(a)(3)(B)(ii), struck out "1999, or 2000" and substituted "1999, 2000, or 2001".
[10] P.L. 108-74, §1(a)(2)(B)(iii)(I), struck out "or" .
[11] P.L. 108-74, §1(a)(2)(B)(iii)(II), struck out the period and substituted "; or".
[12] P.L. 108-74, §1(a)(2)(B)(iii)(III), added subclause (III).
[13] P.L. 108-74, §1(a)(3)(B)(iii)(II), struck out the period at the end of subclause (II) and inserted "; or".
[14] P.L. 108-74, §1(a)(3)(B)(iii)(III), added subclause (IV).
[15] P.L. 108-74, §1(a)(2)(B)(iv), struck out "or 1999" and substituted ", 1999 or 2000". P.L. 108-74, §1(a)(3)(B)(iv), struck out "or 2000" and substituted "2000, or 2001".
[16] P.L. 108-74, §1(a)(2)(B)(v), struck out "with respect to fiscal year 1998 or 1999".

(ii) notwithstanding subsection (e), with respect to fiscal year 1998, 1999, or 2000,[17] shall remain available for expenditure by the State through the end of fiscal year 2004[18];

(iii)[19] notwithstanding subsection (e), with respect to fiscal year 2001, shall remain available for expenditure by the State through the end of fiscal year 2005; and

(iv)[20] shall be counted as being expended with respect to a fiscal year allotment in accordance with applicable regulations of the Secretary.

(C) [21]Amounts used in computing redistributions for fiscal year 2000.—For purposes of subparagraph (A)(i)(III)—

(i) the amount specified in this clause is the amount specified in paragraph (2)(B)(i)(I) for fiscal year 2000, less the total amount remaining available pursuant to paragraph (2)(A)(iii);

(ii) the amount specified in this clause for a State is the amount by which the State's expenditures under this title in fiscal years 2000, 2001, and 2002 exceed the State's allotment for fiscal year 2000 under subsection (b); and

(iii) the amount specified in this clause is the sum, for all States entitled to a redistribution under subparagraph (A) from the allotments for fiscal year 2000, of the amounts specified in clause (ii).

(D)[22] Amounts used in computing redistributions for fiscal year 2001.—For purposes of subparagraph (A)(i)(IV)—

(i) the amount specified in this clause is the amount specified in paragraph (2)(B)(i)(I) for fiscal year 2001, less the total amount remaining available pursuant to paragraph (2)(A)(iv);

(ii) the amount specified in this clause for a State is the amount by which the State's expenditures under this title in fiscal years 2001, 2002, and 2003 exceed the State's allotment for fiscal year 2001 under subsection (b); and

(iii) the amount specified in this clause is the sum, for all States entitled to a redistribution under subparagraph (A) from the allotments for fiscal year 2001, of the amounts specified in clause (ii).

(2) EXTENSION OF AVAILABILITY OF PORTION OF UNEXPENDED FISCAL YEARS 1998 AND THROUGH 2001[23] allotments.—

(A) IN GENERAL.—Notwithstanding subsection (e):

(i) FISCAL YEAR 1998 ALLOTMENT.—Of the amounts allotted to a State pursuant to this section for fiscal year 1998 that were not expended by the State by the end of fiscal year 2000, the amount specified in subparagraph (B) for fiscal year 1998 for such State shall

[17] P.L. 108-74, §1(a)(2)(B)(vi)(I), inserted "with respect to fiscal year 1998, 1999, or 2000,".
[18] P.L 108-74, §1(a)(2)(B)(vi)(II), struck out "2002" and substituted "2004".
P.L 108-74, §1(a)(3)(B)(v)(I), struck out "and".
[19] P.L 108-74, §1(a)(3)(B)(v)(III), added a new clause (iii).
[20] P.L 108-74, §1(a)(3)(B)(v)(II), redesignated the former clause (iii) as clause (iv).
[21] P.L. 108-74, §1(a)(2)(B)(vii), added subparagraph (C).
[22] P.L 108-74, §1(a)(3)(B)(vi), added subparagraph (D).
[23] P.L. 108-74, §1(a)(2)(A)(i), struck out "and 1999" and substituted "through 2000".

remain available for expenditure by the State through the end of fiscal year 2002 or for fiscal year 2001 by the end of fiscal year 2004[24].

(ii) FISCAL YEAR 2001[25] allotment.—Of the amounts allotted to a State pursuant to this subsection for fiscal year 1999 that were not expended by the State by the end of fiscal year 2001, the amount specified in subparagraph (B) for fiscal year 1999 for such State shall remain available for expenditure by the State through the end of fiscal year 2004[26].

(iii) FISCAL YEAR 2000 ALLOTMENT.—Of the amounts allotted to a State pursuant to this section for fiscal year 2001[27] that were not expended by the State by the end of fiscal year 2002, 50 percent of that amount shall remain available for expenditure by the State through the end of fiscal year 2004[28].

(iv) FISCAL YEAR 2001 ALLOTMENT.—Of the amounts allotted to a State pursuant to this section for fiscal year 2001 that were not expended by the State by the end of fiscal year 2003, 50 percent of that amount shall remain available for expenditure by the State through the end of fiscal year 2005[29].

(B) AMOUNT REMAINING AVAILABLE FOR EXPENDITURE.—The amount specified in this subparagraph for a State for a fiscal year is equal to—

(i) the amount by which (I) the total amount available for redistribution under subsection (f) from the allotments for that fiscal year, exceeds (II) the total amounts redistributed under paragraph (1) for that fiscal year; multiplied by

(ii) the ratio of the amount of such State's unexpended allotment for that fiscal year to the total amount described in clause (i)(I) for that fiscal year.

(C) USE OF UP TO 10 PERCENT OF RETAINED 1998 ALLOTMENTS FOR OUTREACH ACTIVITIES.—Notwithstanding section 2105(c)(2)(A), with respect to any State described in subparagraph (A)(i), the State may use up to 10 percent of the amount specified in subparagraph (B) for fiscal year 1998 for expenditures for outreach activities approved by the Secretary.

(3) DETERMINATION OF AMOUNTS.—For purposes of calculating the amounts described in paragraphs (1) and (2) relating to the allotment for fiscal year 1998, fiscal year 1999, fiscal year 2000, or fiscal year 2001[30], the Secretary shall use the amounts reported by the States not later than December 15, 2000, November 30, 2002, or November 30, 2003[31], respec-

[24] P.L. 108-74, §1(a)(1), struck out "fiscal year 2002", substituted "fiscal year 2004".
[25] P.L. 108-74, §1(a)(3)(A)(i), struck out "2000" and substitituted "2001".
[26] P.L. 108-74, §1(a)(1), struck out "fiscal year 2002" and substituted "fiscal year 2004".
[27] P.L. 108-74, §1(a)(3)(A)(i), struck-out "2000" and substituted "2001".
[28] P.L. 108-74, §1(a)(2)(A)(ii), added clause (iii).
[29] added clause (iv).
[30] P.L. 108-74, §1(a)(2)(C)(ii)(I), struck out "or fiscal year 1999" and substituted "fiscal year 1999, or fiscal year 2000".
P.L. 108-74, §1(a)(3)(C)(ii)(I), struck out "or fiscal year 2000" and substituted "fiscal year 2000, or fiscal year 2001".
[31] P.L. 108-74, §1(a)(2)(C)((ii)(II), struck out "or November 30, 2001" and substituted "November 30, 2001, or November 30, 2002".

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tively, on HCFA Form 64 or HCFA Form 21 or CMS Form 64 or CMS Form 21, as the case may be,[32] as approved by the Secretary.

PAYMENTS TO STATES

SEC. 2105. [42 U.S.C. 1397ee] (a) PAYMENTS.—

(1) IN GENERAL.—Subject to the succeeding provisions of this section, the Secretary shall pay to each State with a plan approved under this title, from its allotment under section 2104, an amount for each quarter equal to the enhanced FMAP (or, in the case of expenditures described in subparagraph (B), the Federal medical assistance percentage (as defined in the first sentence of section 1905(b))) of expenditures in the quarter—

(A) for child health assistance under the plan for targeted low–income children in the form of providing medical assistance for which payment is made on the basis of an enhanced FMAP under the fourth sentence of section 1905(b);

(B) for the provision of medical assistance on behalf of a child during a presumptive eligibility period under section 1920A;

(C) for child health assistance under the plan for targeted low–income children in the form of providing health benefits coverage that meets the requirements of section 2103; and

(D) only to the extent permitted consistent with subsection (c)—

(i) for payment for other child health assistance for targeted low–income children;

(ii) for expenditures for health services initiatives under the plan for improving the health of children (including targeted low–income children and other low–income children);

(iii) for expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and

(iv) for other reasonable costs incurred by the State to administer the plan.

(b) ENHANCED FMAP.—For purposes of subsection (a), the "enhanced FMAP", for a State for a fiscal year, is equal to the Federal medical assistance percentage (as defined in the first sentence of section 1905(b)) for the State increased by a number of percentage points equal to 30 percent of the number of percentage points by which (1) such Federal medical assistance percentage for the State, is less than (2) 100 percent; but in no case shall the enhanced FMAP for a State exceed 85 percent.

(c) LIMITATION ON CERTAIN PAYMENTS FOR CERTAIN EXPENDITURES.—

(1) GENERAL LIMITATIONS.—Funds provided to a State under this title shall only be used to carry out the purposes of this title (as described in section 2101), and any health insurance

P.L. 108-74, §1(a)(3)(C)((ii)(II), struck out "or November 30, 2002," and substituted "November 30, 2002, or November 30, 2003,".

[32] P.L. 108-173, §900(e)(1)(M), inserted "or CMS Form 64 or CMS Form 21, as the case may be,", effective December 8, 2003.

coverage provided with such funds may include coverage of abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

(2) LIMITATION ON EXPENDITURES NOT USED FOR MEDICAID OR HEALTH INSURANCE ASSISTANCE.—

(A) IN GENERAL.—Except as provided in this paragraph, the amount of payment that may be made under subsection (a) for a fiscal year for expenditures for items described in paragraph (1)(D) of such subsection shall not exceed 10 percent of the total amount of expenditures for which payment is made under subparagraphs (A), (C), and (D) of paragraph (1) of such subsection.

(B) WAIVER AUTHORIZED FOR COST–EFFECTIVE ALTERNATIVE.—The limitation under subparagraph (A) on expenditures for items described in subsection (a)(1)(D) shall not apply to the extent that a State establishes to the satisfaction of the Secretary that—

(i) coverage provided to targeted low–income children through such expenditures meets the requirements of section 2103;

(ii) the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under section 2103; and

(iii) such coverage is provided through the use of a community–based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923.

(3) WAIVER FOR PURCHASE OF FAMILY COVERAGE.—Payment may be made to a State under subsection (a)(1) for the purchase of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low–income children only if the State establishes to the satisfaction of the Secretary that—

(A) purchase of such coverage is cost–effective relative to the amounts that the State would have paid to obtain comparable coverage only of the targeted low–income children involved, and

(B) such coverage shall not be provided if it would otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage.

(4) USE OF NON–FEDERAL FUNDS FOR STATE MATCHING REQUIREMENT.—Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of non–Federal contributions required under subsection (a).

(5) OFFSET OF RECEIPTS ATTRIBUTABLE TO PREMIUMS AND OTHER COST–SHARING.—For purposes of subsection (a), the amount of the expenditures under the plan shall be reduced by the amount of any premiums and other cost–sharing received by the State.

(6) PREVENTION OF DUPLICATIVE PAYMENTS.—

(A) OTHER HEALTH PLANS.—No payment shall be made to a State under this section for expenditures for child health assistance provided for a targeted low–income child under its plan to the extent that a private insurer (as defined by the Secretary by regulation and including a group health plan (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), a service benefit plan, and a health maintenance organization) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided child health assistance under the plan.

(B) OTHER FEDERAL GOVERNMENTAL PROGRAMS.—Except as provided in subparagraph (A) or (B) of subsection (a)(1) or any other provision of law, no payment shall be made to a State under this section for expenditures for child health assistance provided for a targeted low–income child under its plan to the extent that payment has been made or can reasonably be expected to be made promptly (as determined in accordance with regulations) under any other federally operated or financed health care insurance program, other than an insurance program operated or financed by the Indian Health Service, as identified by the Secretary. For purposes of this paragraph, rules similar to the rules for overpayments under section 1903(d)(2) shall apply.

(7) LIMITATION ON PAYMENT FOR ABORTIONS.—

(A) IN GENERAL.—Payment shall not be made to a State under this section for any amount expended under the State plan to pay for any abortion or to assist in the purchase, in whole or in part, of health benefit coverage that includes coverage of abortion.

(B) EXCEPTION.—Subparagraph (A) shall not apply to an abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

(C) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as affecting the expenditure by a State, locality, or private person or entity of State, local, or private funds (other than funds expended under the State plan) for any abortion or for health benefits coverage that includes coverage of abortion.

(d) MAINTENANCE OF EFFORT.—

(1) IN MEDICAID ELIGIBILITY STANDARDS.—No payment may be made under subsection (a) with respect to child health assistance provided under a State child health plan if the State adopts income and resource standards and methodologies for purposes of determining a child's eligibility for medical assistance under the State plan under title XIX that are more restrictive than those applied as of June 1, 1997.

(2) IN AMOUNTS OF PAYMENT EXPENDED FOR CERTAIN STATE–FUNDED HEALTH INSURANCE PROGRAMS FOR CHILDREN.—

(A) IN GENERAL.—The amount of the allotment for a State in a fiscal year (beginning with fiscal year 1999) shall be reduced by the amount by which—

(i) the total of the State children's health insurance expenditures in the preceding fiscal year, is less than

(ii) the total of such expenditures in fiscal year 1996.

(B) STATE CHILDREN'S HEALTH INSURANCE EXPENDITURES.—The term State children's health insurance expenditures means the following:

(i) The State share of expenditures under this title.

(ii) The State share of expenditures under title XIX that are attributable to an enhanced FMAP under the fourth sentence of section 1905(b).

(iii) State expenditures under health benefits coverage under an existing comprehensive State–based program, described in section 2103(d).

(e) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The Secretary may make payments under this section for each quarter on the basis of advance estimates of expenditures submitted by the State and such other investigation as the Secretary may find necessary, and may reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior quarters.

(f) FLEXIBILITY IN SUBMITTAL OF CLAIMS.—Nothing in this section or subsections (e) and (f) of section 2104 shall be construed as preventing a State from claiming as expenditures in the quarter expenditures that were incurred in a previous quarter.

(g) [33]Authority for Qualifying States To Use Certain Funds for Medicaid Expenditures.—

(1) STATE OPTION.—

(A) IN GENERAL.—Notwithstanding any other provision of law, a qualifying State (as defined in paragraph (2)) may elect to use not more than 20 percent of any allotment under section 2104 for fiscal year 1998, 1999, 2000, or 2001 (insofar as it is available under subsections (e) and (g) of such section) for payments under title XIX in accordance with subparagraph (B), instead of for expenditures under this title.

(B) PAYMENTS TO STATES.—

(i) IN GENERAL.—In the case of a qualifying State that has elected the option described in subparagraph (A), subject to the availability of funds under such subparagraph with respect to the State, the Secretary shall pay the State an amount each quarter equal to the additional amount that would have been paid to the State under title XIX with respect to expenditures described in clause (ii) if the enhanced FMAP (as determined under subsection (b)) had been substituted for the Federal medical assistance percentage (as defined in section 1905(b)).

(ii) EXPENDITURES DESCRIBED.—For purposes of this subparagraph, the expenditures described in this clause are expenditures, made after the date of the enactment of this subsection and during the period in which funds are available to the qualifying State for use under subparagraph (A), for medical assistance under title XIX to individuals who have not attained

[33] P.L. 108-74, §1(b), added subsection (g), effective August 15, 2003.

age 19 and whose family income exceeds 150 percent of the poverty line.

(iii) NO IMPACT ON DETERMINATION OF BUDGET NEUTRALITY FOR WAIVERS.—In the case of a qualifying State that uses amounts paid under this subsection for expenditures described in clause (ii) that are incurred under a waiver approved for the State, any budget neutrality determinations with respect to such waiver shall be determined without regard to such amounts paid.

(2) QUALIFYING STATE.—In this subsection, the term 'qualifying State' means a State that, on and after April 15, 1997, has an income eligibility standard that is at least 184[34] percent of the poverty line with respect to any 1 or more categories of children (other than infants) who are eligible for medical assistance under section 1902(a)(10)(A) or, in the case of a State that has a statewide waiver in effect under section 1115 with respect to title XIX that was first implemented on August 1, 1994, or[35]July 1, 1995, has an income eligibility standard under such waiver for children that is at least 185 percent of the poverty line, or, in the case of a State that has a statewide waiver in effect under section 1115 with respect to title XIX that was first implemented on January 1, 1994, has an income eligibility standard under such waiver for children who lack health insurance that is at least 185 percent of the poverty line, or, in the case of a State that had a statewide waiver in effect under section 1115 with respect to title XIX that was first implemented on October 1, 1993, had an income eligibility standard under such waiver for children that was at least 185 percent of the poverty line and on and after July 1, 1998, has an income eligibility standard for children under section 1902(a)(10)(A) or a statewide waiver in effect under section 1115 with respect to title XIX that is at least 185 percent of the poverty line.[36]

(3) CONSTRUCTION.—Nothing in paragraphs (1) and (2) shall be construed as modifying the requirements applicable to States implementing State child health plans under this title.

PROCESS FOR SUBMISSION, APPROVAL, AND AMENDMENT OF STATE CHILD HEALTH PLANS

SEC. 2106. [42 U.S.C. 1397ff] (a) INITIAL PLAN.—

(1) IN GENERAL.—As a condition of receiving payment under section 2105, a State shall submit to the Secretary a State child health plan that meets the applicable requirements of this title.

(2) APPROVAL.—Except as the Secretary may provide under subsection (e), a State plan submitted under paragraph (1)—

[34] P.L. 108-127, §1(1), struck out "185" and substituted "184", effective as if included in P.L. 108-74, §1(b), as enacted August 15, 2003.

[35] P.L. 108-127, §1(2), inserted "August 1, 1994, or", effective as if included in P.L. 108-74, §1(b) as enacted August 15, 2003.

[36] P.L. 108-127, §1(3), inserted ", or, in the case of a State that had a statewide waiver in effect under section 1115 with respect to title XIX that was first implemented on October 1, 1993, had an income eligibility standard under such waiver for children that was at least 185 percent of the poverty line and on and after July 1, 1998, has an income eligibility standard for children under section 1902(a)(10)(A) or a statewide waiver in effect under section 1115 with respect to title XIX that is at least 185 percent of the poverty line", effective as if included in P.L. 108-74, §1(b), as enacted August 15, 2003.

(A) shall be approved for purposes of this title, and

(B) shall be effective beginning with a calendar quarter that is specified in the plan, but in no case earlier than October 1, 1997.

(b) PLAN AMENDMENTS.—

(1) IN GENERAL.—A State may amend, in whole or in part, its State child health plan at any time through transmittal of a plan amendment.

(2) APPROVAL.—Except as the Secretary may provide under subsection (e), an amendment to a State plan submitted under paragraph (1)—

(A) shall be approved for purposes of this title, and

(B) shall be effective as provided in paragraph (3).

(3) EFFECTIVE DATES FOR AMENDMENTS.—

(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, an amendment to a State plan shall take effect on one or more effective dates specified in the amendment.

(B) AMENDMENTS RELATING TO ELIGIBILITY OR BENEFITS.—

(i) NOTICE REQUIREMENT.—Any plan amendment that eliminates or restricts eligibility or benefits under the plan may not take effect unless the State certifies that it has provided prior public notice of the change, in a form and manner provided under applicable State law.

(ii) TIMELY TRANSMITTAL.—Any plan amendment that eliminates or restricts eligibility or benefits under the plan shall not be effective for longer than a 60–day period unless the amendment has been transmitted to the Secretary before the end of such period.

(C) OTHER AMENDMENTS.—Any plan amendment that is not described in subparagraph (B) and that becomes effective in a State fiscal year may not remain in effect after the end of such fiscal year (or, if later, the end of the 90–day period on which it becomes effective) unless the amendment has been transmitted to the Secretary.

(c) DISAPPROVAL OF PLANS AND PLAN AMENDMENTS.—

(1) PROMPT REVIEW OF PLAN SUBMITTALS.—The Secretary shall promptly review State plans and plan amendments submitted under this section to determine if they substantially comply with the requirements of this title.

(2) 90–DAY APPROVAL DEADLINES.—A State plan or plan amendment is considered approved unless the Secretary notifies the State in writing, within 90 days after receipt of the plan or amendment, that the plan or amendment is disapproved (and the reasons for disapproval) or that specified additional information is needed.

(3) CORRECTION.—In the case of a disapproval of a plan or plan amendment, the Secretary shall provide a State with a reasonable opportunity for correction before taking financial sanctions against the State on the basis of such disapproval.

(d) PROGRAM OPERATION.—

(1) IN GENERAL.—The State shall conduct the program in accordance with the plan (and any amendments) approved under subsection (c) and with the requirements of this title.

(2) VIOLATIONS.—The Secretary shall establish a process for enforcing requirements under this title. Such process shall provide for the withholding of funds in the case of substantial noncompliance with such requirements. In the case of an enforcement action against a State under this paragraph, the Secretary shall provide a State with a reasonable opportunity for correction before taking financial sanctions against the State on the basis of such an action.

(e) CONTINUED APPROVAL.—An approved State child health plan shall continue in effect unless and until the State amends the plan under subsection (b) or the Secretary finds, under subsection (d), substantial noncompliance of the plan with the requirements of this title.

STRATEGIC OBJECTIVES AND PERFORMANCE GOALS; PLAN ADMINISTRATION

SEC. 2107. [42 U.S.C. 1397gg] (a) STRATEGIC OBJECTIVES AND PERFORMANCE GOALS.—

(1) DESCRIPTION.—A State child health plan shall include a description of—

(A) the strategic objectives,

(B) the performance goals, and

(C) the performance measures, the State has established for providing child health assistance to targeted low–income children under the plan and otherwise for maximizing health benefits coverage for other low–income children and children generally in the State.

(2) STRATEGIC OBJECTIVES.—Such plan shall identify specific strategic objectives relating to increasing the extent of creditable health coverage among targeted low–income children and other low–income children.

(3) PERFORMANCE GOALS.—Such plan shall specify one or more performance goals for each such strategic objective so identified.

(4) PERFORMANCE MEASURES.—Such plan shall describe how performance under the plan will be—

(A) measured through objective, independently verifiable means, and

(B) compared against performance goals, in order to determine the State's performance under this title.

(b) RECORDS, REPORTS, AUDITS, AND EVALUATION.—

(1) DATA COLLECTION, RECORDS, AND REPORTS.—A State child health plan shall include an assurance that the State will collect the data, maintain the records, and furnish the reports to the Secretary, at the times and in the standardized format the Secretary may require in order to enable the Secretary to monitor State program administration and compliance and to evaluate and compare the effectiveness of State plans under this title.

(2) STATE ASSESSMENT AND STUDY.—A State child health plan shall include a description of the State's plan for the annual assessments and reports under section 2108(a) and the evaluation required by section 2108(b).

(3) AUDITS.—A State child health plan shall include an assurance that the State will afford the Secretary access to any

records or information relating to the plan for the purposes of review or audit.

(c) PROGRAM DEVELOPMENT PROCESS.—A State child health plan shall include a description of the process used to involve the public in the design and implementation of the plan and the method for ensuring ongoing public involvement.

(d) PROGRAM BUDGET.—A State child health plan shall include a description of the budget for the plan. The description shall be updated periodically as necessary and shall include details on the planned use of funds and the sources of the non–Federal share of plan expenditures, including any requirements for cost–sharing by beneficiaries.

(e) APPLICATION OF CERTAIN GENERAL PROVISIONS.—The following sections of this Act shall apply to States under this title in the same manner as they apply to a State under title XIX:

(1) TITLE XIX PROVISIONS.—

(A) Section 1902(a)(4)(C) (relating to conflict of interest standards).

(B) Paragraphs (2), (16), and (17) of section 1903(i) (relating to limitations on payment).

(C) Section 1903(w) (relating to limitations on provider taxes and donations).

(D) Section 1920A (relating to presumptive eligibility for children).

(2) TITLE XI PROVISIONS.—

(A) Section 1115 (relating to waiver authority).

(B) Section 1116 (relating to administrative and judicial review), but only insofar as consistent with this title.

(C) Section 1124 (relating to disclosure of ownership and related information).

(D) Section 1126 (relating to disclosure of information about certain convicted individuals).

(E) Section 1128A (relating to civil monetary penalties).

(F) Section 1128B(d) (relating to criminal penalties for certain additional charges).

(G) Section 1132 (relating to periods within which claims must be filed).

ANNUAL REPORTS; EVALUATIONS

SEC. 2108. [42 U.S.C. 1397hh] (a) ANNUAL REPORT.—The State shall—

(1) assess the operation of the State plan under this title in each fiscal year, including the progress made in reducing the number of uncovered low–income children; and

(2) report to the Secretary, by January 1 following the end of the fiscal year, on the result of the assessment.

(b) STATE EVALUATIONS.—

(1) IN GENERAL.—By March 31, 2000, each State that has a State child health plan shall submit to the Secretary an evaluation that includes each of the following:

(A) An assessment of the effectiveness of the State plan in increasing the number of children with creditable health coverage.

(B) A description and analysis of the effectiveness of elements of the State plan, including—

(i) the characteristics of the children and families assisted under the State plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the State plan and after eligibility for the State plan ends,

(ii) the quality of health coverage provided including the types of benefits provided,

(iii) the amount and level (including payment of part or all of any premium) of assistance provided by the State,

(iv) the service area of the State plan,

(v) the time limits for coverage of a child under the State plan,

(vi) the State's choice of health benefits coverage and other methods used for providing child health assistance, and

(vii) the sources of non–Federal funding used in the State plan.

(C) An assessment of the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children.

(D) A review and assessment of State activities to coordinate the plan under this title with other public and private programs providing health care and health care financing, including medicaid and maternal and child health services.

(E) An analysis of changes and trends in the State that affect the provision of accessible, affordable, quality health insurance and health care to children.

(F) A description of any plans the State has for improving the availability of health insurance and health care for children.

(G) Recommendations for improving the program under this title.

(H) Any other matters the State and the Secretary consider appropriate.

(2) REPORT OF THE SECRETARY.—The Secretary shall submit to Congress and make available to the public by December 31, 2001, a report based on the evaluations submitted by States under paragraph (1), containing any conclusions and recommendations the Secretary considers appropriate.

(c) FEDERAL EVALUATION.—

(1) IN GENERAL.—The Secretary, directly or through contracts or interagency agreements, shall conduct an independent evaluation of 10 States with approved child health plans.

(2) SELECTION OF STATES.—In selecting States for the evaluation conducted under this subsection, the Secretary shall choose 10 States that utilize diverse approaches to providing child health assistance, represent various geographic area (including a mix of rural and urban areas), and contain a significant portion of uncovered children.

(3) MATTERS INCLUDED.—In addition to the elements described in subsection (b)(1), the evaluation conducted under this subsection shall include each of the following:

(A) Surveys of the target population (enrollees, disenrollees, and individuals eligible for but not enrolled in the program under this title).

(B) Evaluation of effective and ineffective outreach and enrollment practices with respect to children (for both the program under this title and the medicaid program under title XIX), and identification of enrollment barriers and key elements of effective outreach and enrollment practices, including practices that have successfully enrolled hard-to-reach populations such as children who are eligible for medical assistance under title XIX but have not been enrolled previously in the medicaid program under that title.

(C) Evaluation of the extent to which State medicaid eligibility practices and procedures under the medicaid program under title XIX are a barrier to the enrollment of children under that program, and the extent to which coordination (or lack of coordination) between that program and the program under this title affects the enrollment of children under both programs.

(D) An assessment of the effect of cost-sharing on utilization, enrollment, and coverage retention.

(E) Evaluation of disenrollment or other retention issues, such as switching to private coverage, failure to pay premiums, or barriers in the recertification process.

(4) SUBMISSION TO CONGRESS.—Not later than December 31, 2001, the Secretary shall submit to Congress the results of the evaluation conducted under this subsection.

(5) FUNDING.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated $10,000,000 for fiscal year 2000 for the purpose of conducting the evaluation authorized under this subsection. Amounts appropriated under this paragraph shall remain available for expenditure through fiscal year 2002.

(d) INSPECTOR GENERAL AUDIT AND GAO REPORT.—

(1) AUDIT.—Beginning with fiscal year 2000, and every third fiscal year thereafter, the Secretary, through the Inspector General of the Department of Health and Human Services, shall audit a sample from among the States described in paragraph (2) in order to—

(A) determine the number, if any, of enrollees under the plan under this title who are eligible for medical assistance under title XIX (other than as optional targeted low-income children under section 1902(a)(10)(A)(ii)(XIV)); and

(B) assess the progress made in reducing the number of uncovered low–income children, including the progress made to achieve the strategic objectives and performance goals included in the State child health plan under section 2107(a).

(2) STATE DESCRIBED.—A State described in this paragraph is a State with an approved State child health plan under this title that does not, as part of such plan, provide health benefits coverage under the State's medicaid program under title XIX.

(3) MONITORING AND REPORT FROM GAO.—The Comptroller General of the United States shall monitor the audits conducted under this subsection and, not later than March 1 of

each fiscal year after a fiscal year in which an audit is conducted under this subsection, shall submit a report to Congress on the results of the audit conducted during the prior fiscal year.

MISCELLANEOUS PROVISIONS

SEC. 2109. [42 U.S.C. 1397ii] (a) RELATION TO OTHER LAWS.—

(1) HIPAA.—Health benefits coverage provided under section 2101(a)(1) (and coverage provided under a waiver under section 2105(c)(2)(B)) shall be treated as creditable coverage for purposes of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, title XXVII of the Public Health Service Act, and subtitle K of the Internal Revenue Code of 1986.

(2) ERISA.—Nothing in this title shall be construed as affecting or modifying section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) with respect to a group health plan (as defined in section 2791(a)(1) of the Public Health Service Act (42 U.S.C. 300gg– 91(a)(1))).

(b) ADJUSTMENT TO CURRENT POPULATION SURVEY TO INCLUDE STATE-BY–STATE DATA RELATING TO CHILDREN WITHOUT HEALTH INSURANCE COVERAGE.—

(1) IN GENERAL.—The Secretary of Commerce shall make appropriate adjustments to the annual Current Population Survey conducted by the Bureau of the Census in order to produce statistically reliable annual State data on the number of low–income children who do not have health insurance coverage, so that real changes in the uninsurance rates of children can reasonably be detected. The Current Population Survey should produce data under this subsection that categorizes such children by family income, age, and race or ethnicity. The adjustments made to produce such data shall include, where appropriate, expanding the sample size used in the State sampling units, expanding the number of sampling units in a State, and an appropriate verification element.

(2) APPROPRIATION.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated $10,000,000 for fiscal year 2000 and each fiscal year thereafter for the purpose of carrying out this subsection.

DEFINITIONS

SEC. 2110. [42 U.S.C. 1397jj] (a) CHILD HEALTH ASSISTANCE.—For purposes of this title, the term "child health assistance" means payment for part or all of the cost of health benefits coverage for targeted low–income children that includes any of the following (and includes, in the case described in section 2105(a)(1)(D)(i), payment for part or all of the cost of providing any of the following), as specified under the State plan:

(1) Inpatient hospital services.

(2) Outpatient hospital services.

(3) Physician services.

(4) Surgical services.

(5) Clinic services (including health center services) and other ambulatory health care services.

(6) Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.

(7) Over–the–counter medications.

(8) Laboratory and radiological services.

(9) Prenatal care and prepregnancy family planning services and supplies.

(10) Inpatient mental health services, other than services described in paragraph (18) but including services furnished in a State–operated mental hospital and including residential or other 24–hour therapeutically planned structured services.

(11) Outpatient mental health services, other than services described in paragraph (19) but including services furnished in a State–operated mental hospital and including community–based services.

(12) Durable medical equipment and other medically–related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).

(13) Disposable medical supplies.

(14) Home and community–based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home).

(15) Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting.

(16) Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

(17) Dental services.

(18) Inpatient substance abuse treatment services and residential substance abuse treatment services.

(19) Outpatient substance abuse treatment services.

(20) Case management services.

(21) Care coordination services.

(22) Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

(23) Hospice care.

(24) Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is—

(A) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,

(B) performed under the general supervision or at the direction of a physician, or

(C) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

(25) Premiums for private health care insurance coverage.

(26) Medical transportation.

(27) Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low–income individuals.

(28) Any other health care services or items specified by the Secretary and not excluded under this section.

(b) TARGETED LOW–INCOME CHILD DEFINED.—For purposes of this title—

(1) IN GENERAL.—Subject to paragraph (2), the term "targeted low–income child" means a child—

(A) who has been determined eligible by the State for child health assistance under the State plan;

(B)(i) who is a low–income child, or

(ii) is a child—

(I) whose family income (as determined under the State child health plan) exceeds the medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50 percentage points above the medicaid applicable income level;

(II) whose family income (as so determined) does not exceed the medicaid applicable income level (as defined in paragraph (4) but determined as if "June 1, 1997" were substituted for "March 31, 1997"); or

(III) who resides in a State that does not have a medicaid applicable income level (as defined in paragraph (4)); and

(C) who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in section 2791 of the Public Health Service Act).

(2) CHILDREN EXCLUDED.—Such term does not include—

(A) a child who is an inmate of a public institution or a patient in an institution for mental diseases; or

(B) a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.

(3) SPECIAL RULE.—A child shall not be considered to be described in paragraph (1)(C) notwithstanding that the child is covered under a health insurance coverage program that has been in operation since before July 1, 1997, and that is offered by a State which receives no Federal funds for the program's operation.

(4) MEDICAID APPLICABLE INCOME LEVEL.—The term "medicaid applicable income level" means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under section 1902(r)(2)), as of March 31, 1997, for the child to be eligible for medical assistance under section 1902(l)(2) or 1905(n)(2) (as selected by a State) for the age of such child.

(c) ADDITIONAL DEFINITIONS.—For purposes of this title:

(1) CHILD.—The term child means an individual under 19 years of age.

(2) CREDITABLE HEALTH COVERAGE.—The term "creditable health coverage" has the meaning given the term "creditable

coverage" under section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage that meets the requirements of section 2103 provided to a targeted low–income child under this title or under a waiver approved under section 2105(c)(2)(B) (relating to a direct service waiver).

(3) GROUP HEALTH PLAN; HEALTH INSURANCE COVERAGE; ETC.—The terms "group health plan", "group health insurance coverage", and "health insurance coverage" have the meanings given such terms in section 2791 of the Public Health Service Act.

(4) LOW–INCOME.—The term "low–income child" means a child whose family income is at or below 200 percent of the poverty line for a family of the size involved.

(5) POVERTY LINE DEFINED.—The term "poverty line" has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

(6) PREEXISTING CONDITION EXCLUSION.—The term "preexisting condition exclusion" has the meaning given such term in section 2701(b)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(b)(1)(A)).

(7) STATE CHILD HEALTH PLAN; PLAN.—Unless the context otherwise requires, the terms "State child health plan" and "plan" mean a State child health plan approved under section 2106.

(8) UNCOVERED CHILD.—The term "uncovered child" means a child that does not have creditable health coverage.

SELECTED PROVISIONS OF THE INTERNAL REVENUE CODE OF 1986 [1]

(P.L. 83-591, Approved August 16, 1954)

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Subtitle A—Income Taxes

CHAPTER 2—TAX ON SELF–EMPLOYMENT INCOME

SEC. 1401. RATE OF TAX.

(a) OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE.—In addition to other taxes, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax equal to the following percent of the amount of the self-employment income for such taxable year:

In the case of a taxable year		
Beginning after:	**And before:**	**Percent:**
December 31, 1983	January 1, 1988	11.40
December 31, 1987	January 1, 1990	12.12
December 31, 1989	January 1, 1993	12.40*

*As in original. No punctuation.

(b) HOSPITAL INSURANCE.—In addition to the tax imposed by the preceding subsection, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax equal to the following percent of the amount of the self-employment income for such taxable year:

[1] To locate in U.S. Code, look for identical section number in Title 26, Internal Revenue Code. P.L. 99-514, §2(a), provides that the Internal Revenue Title enacted August 14, 1954, may be cited as the "Internal Revenue Code of 1986" and §2(b) provides, except when inappropriate, any reference to the Internal Revenue Code of 1954 shall include a reference to the Internal Revenue Code of 1986 and any reference to the Internal Revenue Code of 1986 shall include a reference to the provisions of the Internal Revenue Code of 1954.

In the case of a taxable year		
Beginning after:	**And before:**	**Percent:**
December 31, 1983	January 1, 1985	2.60
December 31, 1984	January 1, 1986	2.70
December 31, 1985	January 1, 1987	2.90.

(c) RELIEF FROM TAXES IN CASES COVERED BY CERTAIN INTERNATIONAL AGREEMENTS.—During any period in which there is in effect an agreement entered into pursuant to section 233 of the Social Security Act with any foreign country, the self-employment income of an individual shall be exempt from the taxes imposed by this section to the extent that such self-employment income is subject under such agreement exclusively to the laws applicable to[2] the social security system of such foreign country.

SEC. 1402. DEFINITIONS.

(a) NET EARNINGS FROM SELF-EMPLOYMENT.—The term "net earnings from self-employment" means the gross income derived by an individual from any trade or business carried on by such individual, less the deductions allowed by this subtitle which are attributable to such trade or business, plus his distributive share (whether or not distributed) of income or loss described in section 702(a)(8) from any trade or business carried on by a partnership of which he is a member; except that in computing such gross income and deductions and such distributive share of partnership ordinary income or loss—

(1) there shall be excluded rentals from real estate and from personal property leased with the real estate (including such rentals paid in crop shares) together with the deductions attributable thereto, unless such rentals are received in the course of a trade or business as a real estate dealer; except that the preceding provisions of this paragraph shall not apply to any income derived by the owner or tenant of land if (A) such income is derived under an arrangement, between the owner or tenant and another individual, which provides that such other individual shall produce agricultural or horticultural commodities (including livestock, bees, poultry, and fur-bearing animals and wildlife) on such land, and that there shall be material participation by the owner or tenant (as determined without regard to any activities of an agent of such owner or tenant) in the production or the management of the production of such agricultural or horticultural commodities, and (B) there is material participation by the owner or tenant (as determined without regard to any activities of an agent of such owner or tenant) with respect to any such agricultural or horticultural commodity;

(2) there shall be excluded dividends on any share of stock, and interest on any bond, debenture, note, or certificate, or other evidence of indebtedness, issued with interest coupons or in registered form by any corporation (including one issued by a government or political subdivision thereof), unless such dividends and interest are received in the course of a trade or business as a dealer in stocks or securities;

[2] P.L. 108-203, §415, struck out "to taxes or contributions for similar purposes under" and substitutes "exclusively to the laws applicable to".

(3) there shall be excluded any gain or loss—

(A) which is considered as gain or loss from the sale or exchange of a capital asset,

(B) from the cutting of timber, or the disposal of timber, coal, or iron ore, if section 631 applies to such gain or loss, or

(C) from the sale, exchange, involuntary conversion, or other disposition of property if such property is neither—

(i) stock in trade or other property of a kind which would properly be includible in inventory if on hand at the close of the taxable year, nor

(ii) property held primarily for sale to customers in the ordinary course of the trade or business;

(4) the deduction for net operating losses provided in section 172 shall not be allowed;

(5) if—

(A) any of the income derived from a trade or business (other than a trade or business carried on by a partnership) is community income under community property laws applicable to such income, the gross income and deductions attributable to such trade or business shall be treated as the gross income and deductions of the spouse carrying on such trade or business or, if such trade or business is jointly operated, treated as the gross income and deductions of each spouse on the basis of their respective distributive share of the gross income and deductions; and [3]

(B) any portion of a partner's distributive share of the ordinary income or loss from a trade or business carried on by a partnership is community income or loss under the community property laws applicable to such share, all of such distributive share shall be included in computing the net earnings from self-employment of such partner, and no part of such share shall be taken into account in computing the net earnings from self-employment of the spouse of such partner;

(6) a resident of Puerto Rico shall compute his net earnings from self-employment in the same manner as a citizen of the United States but without regard to section 933;

(7) the deduction for personal exemptions provided in section 151 shall not be allowed;

(8) an individual who is a duly ordained, commissioned, or licensed minister of a church or a member of a religious order shall compute his net earnings from self-employment derived from the performance of service described in subsection (c)(4) without regard to section 107 (relating to rental value of parsonages), section 119 (relating to meals and lodging furnished for the convenience of the employer), and section 911 (relating to citizens or residents of the United States living abroad), but

[3] P.L.108-203, §425(b), struck out "all of the gross income and deductions attributable to such trade or business shall be treated as the gross income and deduction of the husband unless the wife exercises substantially all of the management and control of such trade or business, in which case all of such gross income and deductions shall be treated as the gross income and deductions of the wife"; and substituted "the gross income and deductions attributable to such trade or business shall be treated as the gross income and deductions of the spouse carrying on such trade or business or, if such trade or business is jointly operated, treated as the gross income and deductions of each spouse on the basis of their respective distributive share of the gross income and deductions; and".

shall not include in such net earnings from self –employment the rental value of any parsonage or any parsonage allowance (whether or not excludable under section 107) provided after the individual retires, or any other retirement benefit received by such individual from a church plan (as defined in section 414(e)) after the individual retires;

(9) the exclusion from gross income provided by section 931 shall not apply;

(10) there shall be excluded amounts received by a partner pursuant to a written plan of the partnership, which meets such requirements as are prescribed by the Secretary, and which provides for payments on account of retirement, on a periodic basis, to partners generally or to a class or classes of partners, such payments to continue at least until such partner's death, if—

(A) such partner rendered no services with respect to any trade or business carried on by such partnership (or its successors) during the taxable year of such partnership (or its successors), ending within or with his taxable year, in which such amounts were received, and

(B) no obligation exists (as of the close of the partnership's taxable year referred to in subparagraph (A)) from the other partners to such partner except with respect to retirement payments under such plan, and

(C) such partner's share, if any, of the capital of the partnership has been paid to him in full before the close of the partnership's taxable year referred to in subparagraph (A);

(11) the exclusion from gross income provided by section 911(a)(1) shall not apply;

(12) in lieu of the deduction provided by section 164(f) (relating to deduction for one-half of self-employment taxes), there shall be allowed a deduction equal to the product of—

(A) the taxpayer's net earnings from self-employment for the taxable year (determined without regard to this paragraph), and

(B) one-half of the sum of the rates imposed by subsections (a) and (b) of section 1401 for such year;

(13) there shall be excluded the distributive share of any item of income or loss of a limited partner, as such, other than guaranteed payments described in section 707(c) to that partner for services actually rendered to or on behalf of the partnership to the extent that those payments are established to be in the nature of remuneration for those services;

(14) in the case of church employee income, the special rules of subsection (j)(1) shall apply;[4]

(15) in the case of a member of an Indian tribe, the special rules of section 7873 (relating to income derived by Indians from exercise of fishing rights) shall apply; and[5]

(16) the deduction provided by section 199 shall not be allowed.[6]

If the taxable year of a partner is different from that of the partnership, the distributive share which he is required to include in

[4] P.L. 108-357, §102(d)(7), struck out "and".
[5] P.L. 108-357, §102(d)(7), struck out the period and substituted "; and".
[6] P.L. 108-357, §102(d)(7), added paragraph (16).

computing his net earnings from self-employment shall be based on the ordinary income or loss of the partnership for any taxable year of the partnership ending within or with his taxable year. In the case of any trade or business which is carried on by an individual or by a partnership and in which, if such trade or business were carried on exclusively by employees, the major portion of the services would constitute agricultural labor as defined in section 3121(g)—

(i) in the case of an individual, if the gross income derived by him from such trade or business is not more than $2,400, the net earnings from self-employment derived by him from such trade or business may, at his option, be deemed to be 66 ⅔ percent of such gross income; or

(ii) in the case of an individual, if the gross income derived by him from such trade or business is more than $2,400 and the net earnings from self-employment derived by him from such trade or business (computed under this subsection without regard to this sentence) are less than $1,600, the net earnings from self-employment derived by him from such trade or business may, at his option, be deemed to be $1,600; and

(iii) in the case of a member of a partnership, if his distributive share of the gross income of the partnership derived from such trade or business (after such gross income has been reduced by the sum of all payments to which section 707(c) applies) is not more than $2,400, his distributive share of income described in section 702(a)(8) derived from such trade or business may, at his option, be deemed to be an amount equal to 66 ⅔ percent of his distributive share of such gross income (after such gross income has been so reduced); or

(iv) in the case of a member of a partnership, if his distributive share of the gross income of the partnership derived from such trade or business (after such gross income has been reduced by the sum of all payments to which section 707(c) applies) is more than $2,400 and his distributive share (whether or not distributed) of income described in section 702(a)(8) derived from such trade or business (computed under this subsection without regard to this sentence) is less than $1,600, his distributive share of income described in section 702(a)(8) derived from such trade or business may, at his option, be deemed to be $1,600.

For purposes of the preceding sentence, gross income means—

(v) in the case of any such trade or business in which the income is computed under a cash receipts and disbursements method, the gross receipts from such trade or business reduced by the cost or other basis of property which was purchased and sold in carrying on such trade or business, adjusted (after such reduction) in accordance with the provisions of paragraphs (1) through (7) and paragraph (9) of this subsection; and

(vi) in the case of any such trade or business in which the income is computed under an accrual method, the gross income from such trade or business, adjusted in accordance with the provisions of paragraphs (1) through (7) and paragraph (9) of this subsection;

and, for purposes of such sentence, if an individual (including a member of a partnership) derives gross income from more than one such trade or business, such gross income (including his distribu-

tive share of the gross income of any partnership derived from any such trade or business) shall be deemed to have been derived from one trade or business.

The preceding sentence and clauses (i) through (iv) of the second preceding sentence shall also apply in the case of any trade or business (other than a trade or business specified in such second preceding sentence) which is carried on by an individual who is self-employed on a regular basis as defined in subsection (h), or by a partnership of which an individual is a member on a regular basis as defined in subsection (h), but only if such individual's net earnings from self-employment as determined without regard to this sentence in the taxable year are less than $1,600 and less than 66 ⅔ percent of the sum (in such taxable year) of such individual's gross income derived from all trades or businesses carried on by him and his distributive share of the income or loss from all trades or businesses carried on by all the partnerships of which he is a member; except that this sentence shall not apply to more than 5 taxable years in the case of any individual, and in no case in which an individual elects to determine the amount of his net earnings from self-employment for a taxable year under the provisions of the two preceding sentences with respect to a trade or business to which the second preceding sentence applies and with respect to a trade or business to which this sentence applies shall such net earnings for such year exceed $1,600.

(b) SELF-EMPLOYMENT INCOME.—The term "self-employment income" means the net earnings from self-employment derived by an individual (other than a nonresident alien individual, except as provided by an agreement under section 233 of the Social Security Act) during any taxable year; except that such term shall not include—

(1) in the case of the tax imposed by section 1401(a), that part of the net earnings from self-employment which is in excess of (i) an amount equal to the contribution and benefit base (as determined under section 230 of the Social Security Act) which is effective for the calendar year in which such taxable year begins, minus (ii) the amount of the wages paid to such individual during such taxable years; or

(2) the net earnings from self-employment, if such net earnings for the taxable year are less than $400.

For purposes of paragraph (1), the term "wages" (A) includes such remuneration paid to an employee for services included under an agreement entered into pursuant to the provisions of section 3121(l) (relating to coverage of citizens of the United States who are employees of foreign affiliates of American employers), as would be wages under section 3121(a) if such services constituted employment under section 3121(b), and (B) includes compensation which is subject to the tax imposed by section 3201 or 3211,[7]. An individual who is not a citizen of the United States but who is a resident of the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa shall not, for purposes of this chapter be considered to be a nonresident alien individual. In the case of church employee income, the special rules of subsection (j)(2) shall apply for purposes of paragraph (2).

[7] As in original. Comma should be deleted.

(c) TRADE OR BUSINESS.—The term "trade or business", when used with reference to self-employment income or net earnings from self-employment, shall have the same meaning as when used in section 162 (relating to trade or business expenses), except that such term shall not include—

(1) the performance of the functions of a public office, other than the functions of a public office of a State or a political subdivision thereof with respect to fees received in any period in which the functions are performed in a position compensated solely on a fee basis and in which such functions are not covered under an agreement entered into by such State and the Commissioner of Social Security pursuant to section 218 of the Social Security Act;

(2) the performance of service by an individual as an employee, other than—

(A) service described in section 3121(b)(14)(B) performed by an individual who has attained the age of 18,

(B) service described in section 3121(b)(16),

(C) service described in section 3121(b)(11), (12), or (15) performed in the United States (as defined in section 3121(e)(2)) by a citizen of the United States except service which constitutes "employment" under section 3121(y),

(D) service described in paragraph (4) of this subsection,

(E) service performed by an individual as an employee of a State or a political subdivision thereof in a position compensated solely on a fee basis with respect to fees received in any period in which such service is not covered under an agreement entered into by such State and the Secretary of Health and Human Services pursuant to section 218 of the Social Security Act,

(F) service described in section 3121(b)(20), and

(G) service described in section 3121(b)(8)(B);

(3) the performance of service by an individual as an employee or employee representative as defined in section 3231;

(4) the performance of service by a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry or by a member of a religious order in the exercise of duties required by such order;

(5) the performance of service by an individual in the exercise of his profession as a Christian Science practitioner; or

(6) the performance of service by an individual during the period for which an exemption under subsection (g) is effective with respect to him.

The provisions of paragraph (4) or (5) shall not apply to service (other than service performed by a member of a religious order who has taken a vow of poverty as a member of such order) performed by an individual unless an exemption under subsection (e) is effective with respect to him.

(d) EMPLOYEE AND WAGES.—The term "employee" and the term "wages" shall have the same meaning as when used in chapter 21 (sec. 3101 and following, relating to Federal Insurance Contributions Act).

(e) MINISTERS, MEMBERS OF RELIGIOUS ORDERS, AND CHRISTIAN SCIENCE PRACTITIONERS.—[8]

(1) EXEMPTION.—Subject to paragraph (2), any individual who is (A) a duly ordained, commissioned, or licensed minister of a church or a member of a religious order (other than a member of a religious order who has taken a vow of poverty as a member of such order) or (B) a Christian Science practitioner, upon filing an application (in such form and manner, and with such official, as may be prescribed by regulations made under this chapter) together with a statement that either he is conscientiously opposed to, or because of religious principles he is opposed to, the acceptance (with respect to services performed by him as such minister, member, or practitioner) of any public insurance which makes payments in the event of death, disability, old age, or retirement or makes payments toward the cost of, or provides services for, medical care (including the benefits of any insurance system established by the Social Security Act) and, in the case of an individual described in subparagraph (A), that he has informed the ordaining, commissioning, or licensing body of the church or order that he is opposed to such insurance, shall receive an exemption from the tax imposed by this chapter with respect to services performed by him as such minister, member, or practitioner. Notwithstanding the preceding sentence, an exemption may not be granted to an individual under this subsection if he had filed an effective waiver certificate under this section as it was in effect before its amendment in 1967.

(2) VERIFICATION OF APPLICATION.—The Secretary may approve an application for an exemption filed pursuant to paragraph (1) only if the Secretary has verified that the individual applying for the exemption is aware of the grounds on which the individual may receive an exemption pursuant to this subsection and that the individual seeks exemption on such grounds. The Secretary (or the Commissioner of Social Security under an agreement with the Secretary) shall make such verification by such means as prescribed in regulations.

(3) TIME FOR FILING APPLICATION.—Any individual who desires to file an application pursuant to paragraph (1) must file such application on or before whichever of the following dates is later: (A) the due date of the return (including any extension thereof) for the second taxable year for which he has net earnings from self-employment (computed without regard to subsections (c)(4) and (c)(5)) of $400 or more, any part of which was derived from the performance of service described in subsection (c)(4) or (c)(5); or (B) the due date of the return (including any extension thereof) for his second taxable year ending after 1967.

(4) EFFECTIVE DATE OF EXEMPTION.—An exemption received by an individual pursuant to this subsection shall be effective for the first taxable year for which he has net earnings from self-employment (computed without regard to subsections (c)(4) and (c)(5)) of $400 or more, any part of which was derived from the performance of service described in subsection (c)(4) or

[8] See Vol. II, P.L. 106-170, §403, with respect to revocation by members of the clergy of exemption from Social Security coverage.

(c)(5), and for all succeeding taxable years. An exemption received pursuant to this subsection shall be irrevocable.

(f) PARTNER'S TAXABLE YEAR ENDING AS THE RESULT OF DEATH.—In computing a partner's net earnings from self-employment for his taxable year which ends as a result of his death (but only if such taxable year ends within, and not with, the taxable year of the partnership), there shall be included so much of the deceased partner's distributive share of the partnership's ordinary income or loss for the partnership taxable year as is not attributable to an interest in the partnership during any period beginning on or after the first day of the first calendar month following the month in which such partner died. For purposes of this subsection—

(1) in determining the portion of the distributive share which is attributable to any period specified in the preceding sentence, the ordinary income or loss of the partnership shall be treated as having been realized or sustained ratably over the partnership taxable year; and

(2) the term "deceased partner's distributive share " includes the share of his estate or of any other person succeeding, by reason of his death, to rights with respect to his partnership interest.

(g) MEMBERS OF CERTAIN RELIGIOUS FAITHS.—

(1) EXEMPTION.—Any individual may file an application (in such form and manner, and with such official, as may be prescribed by regulations under this chapter) for an exemption from the tax imposed by this chapter if he is a member of a recognized religious sect or division thereof and is an adherent of established tenets or teachings of such sect or division by reason of which he is conscientiously opposed to acceptance of the benefits of any private or public insurance which makes payments in the event of death, disability, old-age, or retirement or makes payments toward the cost of, or provides services for, medical care (including the benefits of any insurance system established by the Social Security Act). Such exemption may be granted only if the application contains or is accompanied by—

(A) such evidence of such individual's membership in, and adherence to the tenets or teachings of, the sect or division thereof as the Secretary may require for purposes of determining such individual's compliance with the preceding sentence, and

(B) his waiver of all benefits and other payments under titles II and XVIII of the Social Security Act on the basis of his wages and self-employment income as well as all such benefits and other payments to him on the basis of the wages and self-employment income of any other person,

and only if the Commissioner of Social Security finds that—

(C) such sect or division thereof has the established tenets or teachings referred to in the preceding sentence,

(D) it is the practice, and has been for a period of time which he deems to be substantial, for members of such sect or division thereof to make provision for their dependent members which in his judgment is reasonable in view of their general level of living, and

(E) such sect or division thereof has been in existence at all times since December 31, 1950.

An exemption may not be granted to any individual if any benefit or other payment referred to in subparagraph (B) became payable (or, but for section 203 or 222(b) of the Social Security Act, would have become payable) at or before the time of the filing of such waiver.

(2) PERIOD FOR WHICH EXEMPTION EFFECTIVE.—An exemption granted to any individual pursuant to this subsection shall apply with respect to all taxable years beginning after December 31, 1950, except that such exemption shall not apply for any taxable year—

(A) beginning (i) before the taxable year in which such individual first met the requirements of the first sentence of paragraph (1), or (ii) before the time as of which the Commissioner of Social Security finds that the sect or division thereof of which such individual is a member met the requirements of subparagraphs (C) and (D), or

(B) ending (i) after the time such individual ceases to meet the requirements of the first sentence of paragraph (1), or (ii) after the time as of which the Commissioner of Social Security finds that the sect or division thereof of which he is a member ceases to meet the requirements of subparagraph (C) or (D).

(3) SUBSECTION TO APPLY TO CERTAIN CHURCH EMPLOYEES.—This subsection shall apply with respect to services which are described in subparagraph (B) of section 3121(b)(8) (and are not described in subparagraph (A) of such section).

(h) REGULAR BASIS.—An individual shall be deemed to be self-employed on a regular basis in a taxable year, or to be a member of a partnership on a regular basis in such year, if he had net earnings from self-employment, as defined in the first sentence of subsection (a), of not less than $400 in at least two of the three consecutive taxable years immediately preceding such taxable year from trades or businesses carried on by such individual or such partnership.

(i) SPECIAL RULES FOR OPTIONS AND COMMODITIES DEALERS.—

(1) IN GENERAL.—Notwithstanding subsection (a)(3)(A), in determining the net earnings from self-employment of any options dealer or commodities dealer, there shall not be excluded any gain or loss (in the normal course of the taxpayer's activity of dealing in or trading section 1256 contracts) from section 1256 contracts or property related to such contracts.

(2) DEFINITIONS.—For purposes of this subsection—

(A) OPTIONS DEALER.—The term "options dealer" has the meaning given such term by section 1256(g)(8).

(B) COMMODITIES DEALER.—The term "commodities dealer" means a person who is actively engaged in trading section 1256 contracts and is registered with a domestic board of trade which is designated as a contract market by the Commodities Futures Trading Commission.

(C) SECTION 1256 CONTRACTS.—The term "section 1256 contract" has the meaning given to such term by section 1256(b).

(j) SPECIAL RULES FOR CERTAIN CHURCH EMPLOYEE INCOME.—

(1) COMPUTATION OF NET EARNINGS.—In applying subsection (a)—

(A) church employee income shall not be reduced by any deduction;

(B) church employee income and deductions attributable to such income shall not be taken into account in determining the amount of other net earnings from self-employment.

(2) COMPUTATION OF SELF-EMPLOYMENT INCOME.—

(A) SEPARATE APPLICATION OF SUBSECTION (B)(2).—Paragraph (2) of subsection (b) shall be applied separately—

(i) to church employee income, and

(ii) to other net earnings from self-employment.

(B) $100 FLOOR.—In applying paragraph (2) of subsection (b) to church employee income, "$100" shall be substituted for "$400".

(3) COORDINATION WITH SUBSECTION(a)(12).—Paragraph (1) shall not apply to any amount allowable as a deduction under subsection (a)(12), and paragraph (1) shall be applied before determining the amount so allowable.

(4) CHURCH EMPLOYEE INCOME DEFINED.—For purposes of this section, the term "church employee income" means gross income for services which are described in section 3121(b)(8)(B) (and are not described in section 3121(b)(8)(A)).

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Subtitle C—Employment Taxes

CHAPTER 21—FEDERAL INSURANCE CONTRIBUTIONS ACT

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Subchapter A—Tax on Employees

SEC. 3101. RATE OF TAX.

(a) OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE.—In addition to other taxes, there is hereby imposed on the income of every individual a tax equal to the following percentages of the wages (as defined in section 3121(a)) received by him with respect to employment (as defined in section 3121(b))—

In cases of wages during:	**The rate received shall be:**
1984, 1985, 1986, or 1987	5.7 percent
1988 or 1989	6.06 percent
1990 or thereafter	6.2 percent.

(b) HOSPITAL INSURANCE.—In addition to the tax imposed by the preceding subsection, there is hereby imposed on the income of every individual a tax equal to the following percentages of the

wages (as defined in section 3121(a)) received by him with respect to employment (as defined in section 3121(b))—

(1) with respect to wages received during the calendar years 1974 through 1977, the rate shall be 0.90 percent;

(2) with respect to wages received during the calendar year 1978, the rate shall be 1.00 percent;

(3) with respect to wages received during the calendar years 1979 and 1980, the rate shall be 1.05 percent;

(4) with respect to wages received during the calendar years 1981 through 1984, the rate shall be 1.30 percent;

(5) with respect to wages received during the calendar year 1985, the rate shall be 1.35 percent; and

(6) with respect to wages received after December 31, 1985, the rate shall be 1.45 percent.

(c) RELIEF FROM TAXES IN CASES COVERED BY CERTAIN INTERNATIONAL AGREEMENTS.—During any period in which there is in effect an agreement entered into pursuant to section 233 of the Social Security Act with any foreign country, wages received by or paid to an individual shall be exempt from the taxes imposed by this section to the extent that such wages are subject under such agreement exclusively to the laws applicable to[9] the social security system of such foreign country.

SEC. 3102. DEDUCTION OF TAX FROM WAGES.

(a) REQUIREMENT.—The tax imposed by section 3101 shall be collected by the employer of the taxpayer, by deducting the amount of the tax from the wages as and when paid. An employer who in any calendar year pays to an employee cash remuneration to which paragraph (7)(B) of section 3121(a) is applicable may deduct an amount equivalent to such tax from any such payment of remuneration, even though at the time of payment the total amount of such remuneration paid to the employee by the employer in the calendar year is less than the applicable dollar threshold (as defined in section 3121(x)) for such year; and an employer who in any calendar year pays to an employee cash remuneration to which paragraph (7)(C) or (10) of section 3121(a) is applicable may deduct an amount equivalent to such tax from any such payment of remuneration, even though at the time of payment the total amount of such remuneration paid to the employee by the employer in the calendar year is less than $100; and an employer who in any calendar year pays to an employee cash remuneration to which paragraph (8)(B) of section 3121(a) is applicable may deduct an amount equivalent to such tax from any such payment of remuneration, even though at the time of payment the total amount of such remuneration paid to the employee by the employer in the calendar year is less than $150[10] and an employer who is furnished by an employee a written statement of tips (received in a calendar month) pursuant to section 6053(a) to which paragraph (12)(B) of section 3121(a) is applicable may deduct an amount equivalent to such tax with respect to such tips from any wages of the employee (exclusive of tips) under his control, even though at the time such statement is

[9] P.L.108-203, §415, struck out "to taxes of contributions for similar purposes under" and substituted "exclusively to the laws applicable to".

[10] P.L. 108-203, §424(b), struck out "and the employee has not performed agricultural labor for the employer on 20 days or more in the calendar year for cash remuneration computed on a time basis".

furnished the total amount of the tips included in statements furnished to the employer as having been received by the employee in such calendar month in the course of his employment by such employer is less than $20.

(b) INDEMNIFICATION OF EMPLOYER.—Every employer required so to deduct the tax shall be liable for the payment of such tax, and shall be indemnified against the claims and demands of any person for the amount of any such payment made by such employer.

(c) SPECIAL RULE FOR TIPS.—

(1) In the case of tips which constitute wages, subsection (a) shall be applicable only to such tips as are included in a written statement furnished to the employer pursuant to section 6053(a), and only to the extent that collection can be made by the employer, at or after the time such statement is so furnished and before the close of the 10th day following the calendar month (or, if paragraph (3) applies, the 30th day following the year) in which the tips were deemed paid, by deducting the amount of the tax from such wages of the employee (excluding tips, but including funds turned over by the employee to the employer pursuant to paragraph (2)) as are under control of the employer.

(2) If the tax imposed by section 3101, with respect to tips which are included in written statements furnished in any month to the employer pursuant to section 6053(a), exceeds the wages of the employee (excluding tips) from which the employer is required to collect the tax under paragraph (1), the employee may furnish to the employer on or before the 10th day of the following month (or, if paragraph (3) applies, on or before the 30th day of the following year) an amount of money equal to the amount of the excess.

(3) The Secretary may, under regulations prescribed by him, authorize employers—

(A) to estimate the amount of tips that will be reported by the employee pursuant to section 6053(a) in any calendar year,

(B) to determine the amount to be deducted upon each payment of wages (exclusive of tips) during such year as if the tips so estimated constituted the actual tips so reported, and

(C) to deduct upon any payment of wages (other than tips, but including funds turned over by the employee to the employer pursuant to paragraph (2)) to such employee during such year (and within 30 days thereafter) such amount as may be necessary to adjust the amount actually deducted upon such wages of the employee during the year to the amount required to be deducted in respect of tips included in written statements furnished to the employer during the year.

(4) If the tax imposed by section 3101 with respect to tips which constitute wages exceeds the portion of such tax which can be collected by the employer from the wages of the employee pursuant to paragraph (1) or paragraph (3), such excess shall be paid by the employee.

(d) SPECIAL RULE FOR CERTAIN TAXABLE GROUP-TERM LIFE INSURANCE BENEFITS.—

(1) IN GENERAL.—In the case of any payment for group-term life insurance to which this subsection applies—

(A) subsection (a) shall not apply,

(B) the employer shall separately include on the statement required under section 6051—

(i) the portion of the wages which consists of payments for group-term life insurance to which this subsection applies, and

(ii) the amount of the tax imposed by section 3101 on such payments, and

(C) the tax imposed by section 3101 on such payments shall be paid by the employee.

(2) BENEFITS TO WHICH SUBSECTION APPLIES.—This subsection shall apply to any payment for group-term life insurance to the extent—

(A) such payment constitutes wages, and

(B) such payment is for coverage for periods during which an employment relationship no longer exists between the employee and the employer.

(e) SPECIAL RULE FOR CERTAIN TRANSFERRED FEDERAL EMPLOYEES.—In the case of any payments of wages for service performed in the employ of an international organization pursuant to a transfer to which the provisions of section 3121(y) are applicable—

(1) subsection (a) shall not apply,

(2) the head of the Federal agency from which the transfer was made shall separately include on the statement required under section 6051—

(A) the amount determined to be the amount of the wages for such service, and

(B) the amount of the tax imposed by section 3101 on such payments, and

(3) the tax imposed by section 3101 on such payments shall be paid by the employee.

Subchapter B—Tax on Employers

SEC. 3111. RATE OF TAX.

(a) OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE.—In addition to other taxes, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to the following percentages of the wages (as defined in section 3121(a)) paid by him with respect to employment (as defined in section 3121(b))—

In cases of wages paid during:	**The rate shall be:**
1984, 1985, 1986, or 1987	5.7 percent
1988 or 1989	6.06 percent
1990 or thereafter	6.2 percent.

(b) HOSPITAL INSURANCE.—In addition to the tax imposed by the preceding subsection, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to the following percentages of the wages (as defined in sec-

tion 3121(a)) paid by him with respect to employment (as defined in section 3121(b))—

(1) with respect to wages paid during the calendar years 1974 through 1977, the rate shall be 0.90 percent;

(2) with respect to wages paid during the calendar year 1978, the rate shall be 1.00 percent;

(3) with respect to wages paid during the calendar years 1979 and 1980, the rate shall be 1.05 percent;

(4) with respect to wages paid during the calendar years 1981 through 1984, the rate shall be 1.30 percent;

(5) with respect to wages paid during the calendar year 1985, the rate shall be 1.35 percent; and

(6) with respect to wages paid after December 31, 1985, the rate shall be 1.45 percent.

(c) RELIEF FROM TAXES IN CASES COVERED BY CERTAIN INTERNATIONAL AGREEMENTS.—During any period in which there is in effect an agreement entered into pursuant to section 233 of the Social Security Act with any foreign country, wages received by or paid to an individual shall be exempt from the taxes imposed by this section to the extent that such wages are subject under such agreement exclusively to the laws applicable to[11] the social security system of such foreign country.

SEC. 3112. INSTRUMENTALITIES OF THE UNITED STATES.

Notwithstanding any other provision of law (whether enacted before or after the enactment of this section) which grants to any instrumentality of the United States an exemption from taxation, such instrumentality shall not be exempt from the tax imposed by section 3111 unless such other provision of law grants a specific exemption, by reference to section 3111 (or the corresponding section of prior law), from the tax imposed by such section.

Subchapter C—General Provisions

SEC. 3121. DEFINITIONS.

(a) WAGES.—For purposes of this chapter, the term "wages" means all remuneration for employment, including the cash value of all remuneration (including benefits) paid in any medium other than cash; except that such term shall not include—

(1) in the case of the taxes imposed by sections 3101(a) and 3111(a) that part of the remuneration which, after remuneration (other than remuneration referred to in the succeeding paragraphs of this subsection) equal to the contribution and benefit base (as determined under section 230 of the Social Security Act) with respect to employment has been paid to an individual by an employer during the calendar year with respect to which such applicable contribution and benefit base is effective, is paid to such individual by such employer during such calendar year. If an employer (hereinafter referred to as successor employer) during any calendar year acquires substantially all the property used in a trade or business of another employer (hereinafter referred to as a predecessor), or used in a separate unit of a trade or business of a predecessor, and im-

[11] P.L. 108-203, §415, struck out "to taxes or contributions for similar purposes under" and substituted "exclusively to the laws applicable to".

mediately after the acquisition employs in his trade or business an individual who immediately prior to the acquisition was employed in the trade or business of such predecessor, then, for the purpose of determining whether the successor employer has paid remuneration (other than remuneration referred to in the succeeding paragraphs of this subsection) with respect to employment equal to the contribution and benefit base (as determined under subsection (x)) to such individual during such calendar year, any remuneration (other than remuneration referred to in the succeeding paragraphs of this subsection) with respect to employment paid (or considered under this paragraph as having been paid) to such individual by such predecessor during such calendar year and prior to such acquisition shall be considered as having been paid by such successor employer;

(2) the amount of any payment (including any amount paid by an employer for insurance or annuities, or into a fund, to provide for any such payment) made to, or on behalf of, an employee or any of his dependents under a plan or system established by an employer which makes provision for his employees generally (or for his employees generally and their dependents) or for a class or classes of his employees (or for a class or classes of his employees and their dependents), on account of—

(A) sickness or accident disability (but, in the case of payments made to an employee or any of his dependents, this subparagraph shall exclude from the term "wages" only payments which are received under a workmen's compensation law), or

(B) medical or hospitalization expenses in connection with sickness or accident disability, or

(C) death, except that this paragraph does not apply to a payment for group-term life insurance to the extent that such payment is includible in the gross income of the employee;

(3) [Stricken.[12]]

(4) any payment on account of sickness or accident disability, or medical or hospitalization expenses in connection with sickness or accident disability, made by an employer to, or on behalf of, an employee after the expiration of 6 calendar months following the last calendar month in which the employee worked for such employer;

(5) any payment made to, or on behalf of, an employee or his beneficiary—

(A) from or to a trust described in section 401(a) which is exempt from tax under section 501(a) at the time of such payment unless such payment is made to an employee of the trust as remuneration for services rendered as such employee and not as a beneficiary of the trust,

(B) under or to an annuity plan which, at the time of such payment, is a plan described in section 403(a),

(C) under a simplified employee pension (as defined in section 408(k)(1)), other than any contributions described in section 408(k)(6),

[12] P.L. 98-21, §324(a)(3)(B); 97 Stat. 123.

(D) under or to an annuity contract described in section 403(b), other than a payment for the purchase of such contract which is made by reason of a salary reduction agreement (whether evidenced by a written instrument or otherwise),

(E) under or to an exempt governmental deferred compensation plan (as defined in subsection (v)(3)),

(F) to supplement pension benefits under a plan or trust described in any of the foregoing provisions of this paragraph to take into account some portion or all of the increase in the cost of living (as determined by the Secretary of Labor) since retirement but only if such supplemental payments are under a plan which is treated as a welfare plan under section 3(2)(B)(ii) of the Employee Retirement Income Security Act of 1974,

(G) under a cafeteria plan (within the meaning of section 125) if such payment would not be treated as wages without regard to such plan and it is reasonable to believe that (if section 125 applied for purposes of this section) section 125 would not treat any wages as constructively received,

(H) under an arrangement to which section 408(p) applies, other than any elective contributions under paragraph (2)(A)(i) thereof, or

(I) under a plan described in section 457(e)(11)(A)(ii) and maintained by an eligible employer (as defined in section 457(e)(1));

(6) the payment by an employer (without deduction from the remuneration of the employee)—

(A) of the tax imposed upon an employee under section 3101, or

(B) of any payment required from an employee under a State unemployment compensation law,

with respect to remuneration paid to an employee for domestic service in a private home of the employer or for agricultural labor;

(7)(A) remuneration paid in any medium other than cash to an employee for service not in the course of the employer's trade or business or for domestic service in a private home of the employer;

(B) cash remuneration paid by an employer in any calendar year to an employee for domestic service in a private home of the employer (including domestic) on a farm operated for profit[13], if the cash remuneration paid in such year by the employer to the employee for such service is less than the applicable dollar threshold (as defined in subsection (x)) for such year;

(C) cash remuneration paid by an employer in any calendar year to an employee for service not in the course of the employer's trade or business, if the cash remuneration paid in such year by the employer to the employee for such service is less than $100. As used in this subparagraph, the term "service not in the course of the employer's trade or business" does not include domestic service in a private

[13] P.L. 108-203, §423(a), struck out "described in subsection (g)(5)" and substituted "on a farm operated for profit".

home of the employer and does not include service described in subsection (g)(5);

(8)(A) remuneration paid in any medium other than cash for agricultural labor;

(B) cash remuneration paid by an employer in any calendar year to an employee for agricultural labor unless—

(i) the cash remuneration paid in such year by the employer to the employee for such labor is $150 or more, or

(ii) the employer's expenditures for agricultural labor in such year equal or exceed $2,500,

except that clause (ii) shall not apply in determining whether remuneration paid to an employee constitutes "wages " under this section if such employee (I) is employed as a hand harvest laborer and is paid on a piece rate basis in an operation which has been, and is customarily and generally recognized as having been, paid on a piece rate basis in the region of employment, (II) commutes daily from his permanent residence to the farm on which he is so employed, and (III) has been employed in agriculture less than 13 weeks during the preceding calendar year;

(9) [Stricken. [14]]

(10) remuneration paid by an employer in any calendar year to an employee for service described in subsection (d)(3)(C) (relating to home workers), if the cash remuneration paid in such year by the employer to the employee for such service is less than $100;

(11) remuneration paid to or on behalf of an employee if (and to the extent that) at the time of the payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 217 (determined without regard to section 274(n));

(12)(A) tips paid in any medium other than cash;

(B) cash tips received by an employee in any calendar month in the course of his employment by an employer unless the amount of such cash tips is $20 or more;

(13) any payment or series of payments by an employer to an employee or any of his dependents which is paid—

(A) upon or after the termination of an employee's employment relationship because of (i) death, or (ii) retirement for disability, and

(B) under a plan established by the employer which makes provision for his employees generally or a class or classes of his employees (or for such employees or class or classes of employees and their dependents),

other than any such payment or series of payments which would have been paid if the employee's employment relationship had not been so terminated;

(14) any payment made by an employer to a survivor or the estate of a former employee after the calendar year in which such employee died;

(15) any payment made by an employer to an employee, if at the time such payment is made such employee is entitled to disability insurance benefits under section 223(a) of the Social

[14] P.L. 98-21, §324(a)(3)(B); 97 Stat.123.

Security Act and such entitlement commenced prior to the calendar year in which such payment is made, and if such employee did not perform any services for such employer during the period for which such payment is made;

(16) remuneration paid by an organization exempt from income tax under section 501(a) (other than an organization described in section 401(a)) or under section 521 in any calendar year to an employee for service rendered in the employ of such organization, if the remuneration paid in such year by the organization to the employee for such service is less than $100;

(17) any contribution, payment, or service provided by an employer which may be excluded from the gross income of an employee, his spouse, or his dependents, under the provisions of section 120 (relating to amounts received under qualified group legal services plans);

(18) any payment made, or benefit furnished, to or for the benefit of an employee if at the time of such payment or such furnishing it is reasonable to believe that the employee will be able to exclude such payment or benefit from income under section 127, 129, 134(b)(4), or 134(b)(5) [15] ;

(19) the value of any meals or lodging furnished by or on behalf of the employer if at the time of such furnishing it is reasonable to believe that the employee will be able to exclude such items from income under section 119;

(20) any benefit provided to or on behalf of an employee if at the time such benefit is provided it is reasonable to believe that the employee will be able to exclude such benefit from income under section 74(c), 108(f)(4) [16] 117, or 132; or [17]

(21) in the case of a member of an Indian tribe, any remuneration on which no tax is imposed by this chapter by reason of section 7873 (relating to income derived by Indians from exercise of fishing rights); or [18]

(22) remuneration on account of-- "(A) a transfer of a share of stock to any individual pursuant to an exercise of an incentive stock option (as defined in section 422(b)) or under an employee stock purchase plan (as defined in section 423(b)), or "(B) any disposition by the individual of such stock.".

Nothing in the regulations prescribed for purposes of chapter 24 (relating to income tax withholding) which provides an exclusion from "wages" as used in such chapter shall be construed to require a similar exclusion from "wages" in the regulations prescribed for purposes of this chapter. Except as otherwise provided in regulations prescribed by the Secretary, any third party which makes a payment included in wages solely by reason of the parenthetical matter contained in subparagraph (A) of paragraph (2) shall be treated for purposes of this chapter and chapter 22 as the employer with respect to such wages.

(b) EMPLOYMENT.—For purposes of this chapter, the term "employment" means any service, of whatever nature, performed (A) by an employee for the person employing him, irrespective of the citizenship or residence of either, (i) within the United States, or (ii)

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[15] P.L. 108-121, §106(b)(2), struck out "or 129" and substituted ", 129 or 134(b)(4)", applicable to taxable years beginning after December 31, 2002.

P.L. 108-375, §585(b)(2)(B), struck out "or 134(b)(4)", and substituted 134(b)(4), or 134(b)(5)".

[16] P.L. 108-357, §320(b)(1), inserted "108(f)(4)".

[17] P.L. 108-357, §251 (a)(1)(A),struck out "or".

[18] P.L. 108-357, §251(a)(1)(A), struck out the period and substituted "; or".

on or in connection with an American vessel or American aircraft under a contract of service which is entered into within the United States or during the performance of which and while the employee is employed on the vessel or aircraft it touches at a port in the United States, if the employee is employed on and in connection with such vessel or aircraft when outside the United States, or (B) outside the United States by a citizen or resident of the United States as an employee for an American employer (as defined in subsection (h)), or (C) if it is service, regardless of where or by whom performed, which is designated as employment or recognized as equivalent to employment under an agreement entered into under section 233 of the Social Security Act; except that such term shall not include—

(1) service performed by foreign agricultural workers lawfully admitted to the United States from the Bahamas, Jamaica, and the other British West Indies, or from any other foreign country or possession thereof, on a temporary basis to perform agricultural labor;

(2) domestic service performed in a local college club, or local chapter of a college fraternity or sorority, by a student who is enrolled and is regularly attending classes at a school, college, or university;

(3)(A) service performed by a child under the age of 18 in the employ of his father or mother;

(B) service not in the course of the employer's trade or business, or domestic service in a private home of the employer, performed by an individual under the age of 21 in the employ of his father or mother, or performed by an individual in the employ of his spouse or son or daughter; except that the provisions of this subparagraph shall not be applicable to such domestic service performed by an individual in the employ of his son or daughter if—

(i) the employer is a surviving spouse or a divorced individual and has not remarried, or has a spouse living in the home who has a mental or physical condition which results in such spouse's being incapable of caring for a son, daughter, stepson, or stepdaughter (referred to in clause (ii)) for at least 4 continuous weeks in the calendar quarter in which the service is rendered, and

(ii) a son, daughter, stepson, or stepdaughter of such employer is living in the home, and

(iii) the son, daughter, stepson, or stepdaughter (referred to in clause (ii)) has not attained age 18 or has a mental or physical condition which requires the personal care and supervision of an adult for at least 4 continuous weeks in the calendar quarter in which the service is rendered;

(4) service performed by an individual on or in connection with a vessel not an American vessel, or on or in connection with an aircraft not an American aircraft, if (A) the individual is employed on and in connection with such vessel or aircraft, when outside the United States and (B)(i) such individual is not a citizen of the United States or (ii) the employer is not an American employer;

(5) service performed in the employ of the United States or any instrumentality of the United States, if such service—

(A) would be excluded from the term "employment" for purposes of this title if the provisions of paragraphs (5) and (6) of this subsection as in effect in January 1983 had remained in effect, and

(B) is performed by an individual who—

(i) has been continuously performing service described in subparagraph (A) since December 31, 1983, and for purposes of this clause—

(I) if an individual performing service described in subparagraph (A) returns to the performance of such service after being separated therefrom for a period of less than 366 consecutive days, regardless of whether the period began before, on, or after December 31, 1983, then such service shall be considered continuous,

(II) if an individual performing service described in subparagraph (A) returns to the performance of such service after being detailed or transferred to an international organization as described under section 3343 of subchapter III of chapter 33 of title 5, United States Code, or under section 3581 of chapter 35 of such title, then the service performed for that organization shall be considered service described in subparagraph (A),

(III) if an individual performing service described in subparagraph (A) is reemployed or reinstated after being separated from such service for the purpose of accepting employment with the American Institute in Taiwan as provided under section 3310 of chapter 48 of title 22, United States Code, then the service performed for that Institute shall be considered service described in subparagraph (A),

(IV) if an individual performing service described in subparagraph (A) returns to the performance of such service after performing service as a member of a uniformed service (including, for purposes of this clause, service in the National Guard and temporary service in the Coast Guard Reserve) and after exercising restoration or reemployment rights as provided under chapter 43 of title 38, United States Code, then the service so performed as a member of a uniformed service shall be considered service described in subparagraph (A), and

(V) if an individual performing service described in subparagraph (A) returns to the performance of such service after employment (by a tribal organization) to which section 105(e)(2) of the Indian Self-Determination Act applies, then the service performed for that tribal organization shall be considered service described in subparagraph (A); or

(ii) is receiving an annuity from the Civil Service Retirement and Disability Fund, or benefits (for service as an employee) under another retirement system established by a law of the United States for employees of the Federal Government (other than for members of the uniformed service);

except that this paragraph shall not apply with respect to any such service performed on or after any date on which such individual performs—

(C) service performed as the President or Vice President of the United States,

(D) service performed—

(i) in a position placed in the Executive Schedule under sections 5312 through 5317 of title 5, United States Code,

(ii) as a noncareer appointee in the Senior Executive Service or a noncareer member of the Senior Foreign Service, or

(iii) in a position to which the individual is appointed by the President (or his designee) or the Vice President under section 105(a)(1), 106(a)(1), or 107(a)(1) or (b)(1) of title 3, United States Code, if the maximum rate of basic pay for such position is at or above the rate for level V of the Executive Schedule,

(E) service performed as the Chief Justice of the United States, an Associate Justice of the Supreme Court, a judge of a United States court of appeals, a judge of a United States district court (including the district court of a territory), a judge of the United States Claims Court [19], a judge of the United States Court of International Trade, a judge of the United States Tax Court, a United States magistrate, or a referee in bankruptcy or United States bankruptcy judge,

(F) service performed as a Member, Delegate, or Resident Commissioner of or to the Congress,

(G) any other service in the legislative branch of the Federal Government if such service—

(i) is performed by an individual who was not subject to subchapter III of chapter 83 of title 5, United States Code, or to another retirement system established by a law of the United States for employees of the Federal Government (other than for members of the uniformed services), on December 31, 1983, or

(ii) is performed by an individual who has, at any time after December 31, 1983, received a lump-sum payment under section 8342(a) of title 5, United States Code, or under the corresponding provision of the law establishing the other retirement system described in clause (i), or

(iii) is performed by an individual after such individual has otherwise ceased to be subject to subchapter III of chapter 83 of title 5, United States Code (without having an application pending for coverage under

[19] P.L. 102-572, §902(b)(1), deemed any reference to the "United States Claims Court" to be to the "United States Court of Federal Claims".

such subchapter), while performing service in the legislative branch (determined without regard to the provisions of subparagraph (B) relating to continuity of employment), for any period of time after December 31, 1983,

and for purposes of this subparagraph (G) an individual is subject to such subchapter III or to any such other retirement system at any time only if (a) such individual's pay is subject to deductions, contributions, or similar payments (concurrent with the service being performed at that time) under section 8334(a) of such title 5 or the corresponding provision of the law establishing such other system, or (in a case to which section 8332(k)(1) of such title applies) such individual is making payments of amounts equivalent to such deductions, contributions, or similar payments while on leave without pay, or (b) such individual is receiving an annuity from the Civil Service Retirement and Disability Fund, or is receiving benefits (for service as an employee) under another retirement system established by a law of the United States for employees of the Federal Government (other than for members of the uniformed services), or

(H) service performed by an individual—

(i) on or after the effective date of an election by such individual, under section 301 of the Federal Employees' Retirement System Act of 1986[20], section 307 of the Central Intelligence Agency Retirement Act (50 U.S.C. 2157), or the Federal Employees' Retirement System Open Enrollment Act of 1997 to become subject to the Federal Employees' Retirement System provided in chapter 84 of title 5, United States Code, or

(ii) on or after the effective date of an election by such individual, under regulations issued under section 860 of the Foreign Service Act of 1980, to become subject to the Foreign Service Pension System provided in subchapter II of chapter 8 of title I of such Act;

(6) service performed in the employ of the United States or any instrumentality of the United States if such service is performed—

(A) in a penal institution of the United States by an inmate thereof;

(B) by any individual as an employee included under section 5351(2) of title 5, United States Code (relating to certain interns, student nurses, and other student employees of hospitals of the Federal Government), other than as a medical or dental intern or a medical or dental resident in training; or

(C) by any individual as an employee serving on a temporary basis in case of fire, storm, earthquake, flood, or other similar emergency;

(7) service performed in the employ of a State, or any political subdivision thereof, or any instrumentality of any one or

[20] See Vol. II, P.L. 105–61, §642.

more of the foregoing which is wholly owned thereby, except that this paragraph shall not apply in the case of—

(A) service which, under subsection (j), constitutes covered transportation service,

(B) service in the employ of the Government of Guam or the Government of American Samoa or any political subdivision thereof, or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, performed by an officer or employee thereof (including a member of the legislature of any such Government or political subdivision), and, for purposes of this title with respect to the taxes imposed by this chapter—

(i) any person whose service as such an officer or employee is not covered by a retirement system established by a law of the United States shall not, with respect to such service, be regarded as an employee of the United States or any agency or instrumentality thereof, and

(ii) the remuneration for service described in clause (i) (including fees paid to a public official) shall be deemed to have been paid by the Government of Guam or the Government of American Samoa or by a political subdivision thereof or an instrumentality of any one or more of the foregoing which is wholly owned thereby, whichever is appropriate,

(C) service performed in the employ of the District of Columbia or any instrumentality which is wholly owned thereby, if such service is not covered by a retirement system established by a law of the United States (other than the Federal Employees Retirement System provided in chapter 84 of title 5, United States Code); except that the provisions of this subparagraph shall not be applicable to service performed—

(i) in a hospital or penal institution by a patient or inmate thereof;

(ii) by any individual as an employee included under section 5351(2) of title 5, United States Code (relating to certain interns, student nurses, and other student employees of hospitals of the District of Columbia Government), other than as a medical or dental intern or as a medical or dental resident in training;

(iii) by any individual as an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood or other similar emergency; or

(iv) by a member of a board, committee, or council of the District of Columbia, paid on a per diem, meeting, or other fee basis,

(D) service performed in the employ of the Government of Guam (or any instrumentality which is wholly owned by such Government) by an employee properly classified as a temporary or intermittent employee, if such service is not covered by a retirement system established by a law of Guam; except that (i) the provisions of this subparagraph shall not be applicable to services performed by an elected official or a member of the legislature or in a hospital or penal institution by a patient or inmate thereof, and (ii)

for purposes of this subparagraph, clauses (i) and (ii) of subparagraph (B) shall apply,

(E) service included under an agreement entered into pursuant to section 218 of the Social Security Act, or

(F) service in the employ of a State (other than the District of Columbia, Guam, or American Samoa), of any political subdivision thereof, or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, by an individual who is not a member of a retirement system of such State, political subdivision, or instrumentality, except that the provisions of this subparagraph shall not be applicable to service performed—

(i) by an individual who is employed to relieve such individual from unemployment;

(ii) in a hospital, home, or other institution by a patient or inmate thereof,

(iii) by any individual as an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or other similar emergency;

(iv) by an election official or election worker if the remuneration paid in a calendar year for such service is less than $1,000 with respect to service performed during any calendar year commending on or after January 1, 1995, ending on or before December 31, 1999, and the adjusted amount determined under section 218(c)(8)(B) of the Social Security Act for any calendar year commencing on or after January 1, 2000, with respect to service performed during such calendar year; or

(v) by an employee in a position compensated solely on a fee basis which is treated pursuant to section 1402(c)(2)(E) as a trade or business for purposes of inclusion of such fees in net earnings from self-employment;

for purposes of this subparagraph, except as provided in regulations prescribed by the Secretary, the term "retirement system" has the meaning given such term by section 218(b)(4) of the Social Security Act.

(8)(A) service performed by a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry or by a member of a religious order in the exercise of duties required by such order, except that this subparagraph shall not apply to service performed by a member of such an order in the exercise of such duties, if an election of coverage under subsection (r) is in effect with respect to such order, or with respect to the autonomous subdivision thereof to which such member belongs;

(B) service performed in the employ of a church or qualified church-controlled organization if such church or organization has in effect an election under subsection (w), other than service in an unrelated trade or business (within the meaning of section 513(a));

(9) service performed by an individual as an employee or employee representative as defined in section 3231;

(10) service performed in the employ of—

(A) a school, college, or university, or

(B) an organization described in section 509(a)(3) if the organization is organized, and at all times thereafter is operated, exclusively for the benefit of, to perform the functions of, or to carry out the purposes of a school, college, or university and is operated, supervised, or controlled by or in connection with such school, college, or university, unless it is a school, college, or university of a State or a political subdivision thereof and the services performed in its employ by a student referred to in section 218(c)(5) of the Social Security Act are covered under the agreement between the Commissioner of Social Security and such State entered into pursuant to section 218 of such Act;

if such service is performed by a student who is enrolled and regularly attending classes at such school, college, or university;

(11) service performed in the employ of a foreign government (including service as a consular or other officer or employee or a nondiplomatic representative);

(12) service performed in the employ of an instrumentality wholly owned by a foreign government—

(A) if the service is of a character similar to that performed in foreign countries by employees of the United States Government or of an instrumentality thereof; and

(B) if the Secretary of State shall certify to the Secretary of the Treasury that the foreign government, with respect to whose instrumentality and employees thereof exemption is claimed, grants an equivalent exemption with respect to similar service performed in the foreign country by employees of the United States Government and of instrumentalities thereof;

(13) service performed as a student nurse in the employ of a hospital or a nurses' training school by an individual who is enrolled and is regularly attending classes in a nurses' training school chartered or approved pursuant to State law;

(14)(A) service performed by an individual under the age of 18 in the delivery or distribution of newspapers or shopping news, not including delivery or distribution to any point for subsequent delivery or distribution;

(B) service performed by an individual in, and at the time of, the sale of newspapers or magazines to ultimate consumers, under an arrangement under which the newspapers or magazines are to be sold by him at a fixed price, his compensation being based on the retention of the excess of such price over the amount at which the newspapers or magazines are charged to him, whether or not he is guaranteed a minimum amount of compensation for such service, or is entitled to be credited with the unsold newspapers or magazines turned back;

(15) service performed in the employ of an international organization, except service which constitutes "employment" under subsection (y);

(16) service performed by an individual under an arrangement with the owner or tenant of land pursuant to which—

(A) such individual undertakes to produce agricultural or horticultural commodities (including livestock, bees,

poultry, and fur-bearing animals and wildlife) on such land,

(B) the agricultural or horticultural commodities produced by such individual, or the proceeds therefrom, are to be divided between such individual and such owner or tenant, and

(C) the amount of such individual's share depends on the amount of the agricultural or horticultural commodities produced;

(17) service in the employ of any organization which is performed (A) in any year during any part of which such organization is registered, or there is in effect a final order of the Subversive Activities Control Board requiring such organization to register, under the Internal Security Act of 1950, as amended, as a Communist-action organization, a Communist-front organization, or a Communist-infiltrated organization, and (B) after June 30, 1956;

(18) service performed in Guam by a resident of the Republic of the Philippines while in Guam on a temporary basis as a nonimmigrant alien admitted to Guam pursuant to section 101(a)(15)(H)(ii) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(15)(H)(ii));

(19) Service[21] which is performed by a nonresident alien individual for the period he is temporarily present in the United States as a nonimmigrant under subparagraph (F), (J), (M), or (Q) of section 101(a)(15) of the Immigration and Nationality Act, as amended, and which is performed to carry out the purpose specified in subparagraph (F), (J), (M), or (Q) as the case may be; or

(20) service (other than service described in paragraph (3)(A)) performed by an individual on a boat engaged in catching fish or other forms of aquatic animal life under an arrangement with the owner or operator of such boat pursuant to which—

(A) such individual does not receive any cash remuneration other than as provided in subparagraph (B) and other than cash remuneration—

(i) which does not exceed $100 per trip;

(ii) which is contingent on a minimum catch; and

(iii) which is paid solely for additional duties (such as mate, engineer, or cook) for which additional cash remuneration is traditional in the industry,

(B) such individual receives a share of the boat's (or the boats' in the case of a fishing operation involving more than one boat) catch of fish or other forms of aquatic animal life or a share of the proceeds from the sale of such catch, and

(C) the amount of such individual's share depends on the amount of the boat's (or the boats' in the case of a fishing operation involving more than one boat) catch of fish or other forms of aquatic animal life,

but only if the operating crew of such boat (or each boat from which the individual receives a share in the case of a fishing

[21] As in original. Possibly should be "service".

operation involving more than one boat) is normally made up of fewer than 10 individuals; or

(21) domestic service in a private home of an employer which—

(A) is performed in any year by an individual under the age of 18 during any portion of such year; and

(B) is not the principal occupation of such employee.

For purposes of paragraph (20), the operating crew of a boat shall be treated as normally made up of fewer than 10 individuals if the average size of the operating crew on trips made during the preceding 4 calendar quarters consisted of fewer than 10 individuals.

(c) INCLUDED AND EXCLUDED SERVICE.—For purposes of this chapter, if the services performed during one-half or more of any pay period by an employee for the person employing him constitute employment, all the services of such employee for such period shall be deemed to be employment; but if the services performed during more than one-half of any such pay period by an employee for the person employing him do not constitute employment, then none of the services of such employee for such period shall be deemed to be employment. As used in this subsection, the term "pay period" means a period (of not more than 31 consecutive days) for which a payment of remuneration is ordinarily made to the employee by the person employing him. This subsection shall not be applicable with respect to services performed in a pay period by an employee for the person employing him, where any of such service is excepted by subsection (b)(9).

(d) EMPLOYEE.—For purposes of this chapter, the term "employee" means—

(1) any officer of a corporation; or

(2) any individual who, under the usual common law rules applicable in determining the employer-employee relationship, has the status of an employee; or

(3) any individual (other than an individual who is an employee under paragraph (1) or (2)) who performs services for remuneration for any person—

(A) as an agent-driver or commission-driver engaged in distributing meat products, vegetable products, fruit products, bakery products, beverages (other than milk), or laundry or dry-cleaning services, for his principal;

(B) as a full-time life insurance salesman;

(C) as a home worker performing work, according to specifications furnished by the person for whom the services are performed, on materials or goods furnished by such person which are required to be returned to such person or a person designated by him; or

(D) as a traveling or city salesman, other than as an agent-driver or commission-driver, engaged upon a full-time basis in the solicitation on behalf of, and the transmission to, his principal (except for side-line sales activities on behalf of some other person) of orders from wholesalers, retailers, contractors, or operators of hotels, restaurants, or other similar establishments for merchandise for resale or supplies for use in their business operations;

if the contract of service contemplates that substantially all of such services are to be performed personally by such individ-

ual; except that an individual shall not be included in the term "employee" under the provisions of this paragraph if such individual has a substantial investment in facilities used in connection with the performance of such services (other than in facilities for transportation), or if the services are in the nature of a single transaction not part of a continuing relationship with the person for whom the services are performed; or

(4) any individual who performs services that are included under an agreement entered into pursuant to section 218 of the Social Security Act.

(e) STATE, UNITED STATES, AND CITIZEN.—For purposes of this chapter—

(1) STATE.—The term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

(2) UNITED STATES.—The term "United States" when used in a geographical sense includes the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

An individual who is a citizen of the Commonwealth of Puerto Rico (but not otherwise a citizen of the United States) shall be considered, for purposes of this section, as a citizen of the United States.

(f) AMERICAN VESSEL AND AIRCRAFT.—For purposes of this chapter, the term "American vessel" means any vessel documented or numbered under the laws of the United States; and includes any vessel which is neither documented or numbered under the laws of the United States nor documented under the laws of any foreign country, if its crew is employed solely by one or more citizens or residents of the United States or corporations organized under the laws of the United States or of any State; and the term "American aircraft" means an aircraft registered under the laws of the United States.

(g) AGRICULTURAL LABOR.—For purposes of this chapter, the term "agricultural labor" includes all service performed—

(1) on a farm, in the employ of any person, in connection with cultivating the soil, or in connection with raising or harvesting any agricultural or horticultural commodity, including the raising, shearing, feeding, caring for, training, and management of livestock, bees, poultry, and fur-bearing animals and wildlife;

(2) in the employ of the owner or tenant or other operator of a farm, in connection with the operation, management, conservation, improvement, or maintenance of such farm and its tools and equipment, or in salvaging timber or clearing land of brush and other debris left by a hurricane, if the major part of such service is performed on a farm;

(3) in connection with the production or harvesting of any commodity defined as an agricultural commodity in section 15(g) of the Agricultural Marketing Act, as amended (12 U.S.C. 1141j), or in connection with the ginning of cotton, or in connection with the operation or maintenance of ditches, canals, reservoirs, or waterways, not owned or operated for profit, used exclusively for supplying and storing water for farming purposes;

(4)(A) in the employ of the operator of a farm in handling, planting, drying, packing, packaging, processing, freezing, grading, storing, or delivering to storage or to market or to a

carrier for transportation to market, in its unmanufactured state, any agricultural or horticultural commodity; but only if such operator produced more than one-half of the commodity with respect to which such service is performed;

(B) in the employ of a group of operators of farms (other than a cooperative organization) in the performance of service described in subparagraph (A), but only if such operators produced all of the commodity with respect to which such service is performed. For purposes of this subparagraph, any unincorporated group of operators shall be deemed a cooperative organization if the number of operators comprising such group is more than 20 at any time during the calendar year in which such service is performed;

(C) the provisions of subparagraphs (A) and (B) shall not be deemed to be applicable with respect to service performed in connection with commercial canning or commercial freezing or in connection with any agricultural or horticultural commodity after its delivery to a terminal market for distribution for consumption; or

(5) on a farm operated for profit if such service is not in the course of the employer's trade or business[22].

(h) AMERICAN EMPLOYER.—For purposes of this chapter, the term "American employer" means an employer which is—

(1) the United States or any instrumentality thereof,

(2) an individual who is a resident of the United States,

(3) a partnership, if two-thirds or more of the partners are residents of the United States,

(4) a trust, if all of the trustees are residents of the United States, or

(5) a corporation organized under the laws of the United States or of any State.

(i) COMPUTATION OF WAGES IN CERTAIN CASES.—

(1) DOMESTIC SERVICE.—For purposes of this chapter, in the case of domestic service described in subsection (a)(7)(B), any payment of cash remuneration for such service which is more or less than a whole-dollar amount shall, under such conditions and to such extent as may be prescribed by regulations made under this chapter, be computed to the nearest dollar. For the purpose of the computation to the nearest dollar, the payment of a fractional part of a dollar shall be disregarded unless it amounts to one-half dollar or more, in which case it shall be increased to $1. The amount of any payment of cash remuneration so computed to the nearest dollar shall, in lieu of the amount actually paid, be deemed to constitute the amount of cash remuneration for purposes of subsection (a)(7)(B).

(2) SERVICE IN THE UNIFORMED SERVICES.—For purposes of this chapter, in the case of an individual performing service, as a member of a uniformed service, to which the provisions of subsection (m)(1) are applicable, the term "wages" shall, subject to the provisions of subsection (a)(1) of this section, include as such individual's remuneration for such service only (A) his basic pay as described in chapter 3 and section 1009 of title 37, United States Code, in the case of an individual performing

[22] P.L. 108-203, §423(c), struck out "or is domestic service in a private home of the employer".

service to which subparagraph (A) of such subsection (m)(1) applies, or (B) his compensation for such service as determined under section 206(a) of title 37, United States Code, in the case of an individual performing service to which subparagraph (B) of such subsection (m)(1) applies.

(3) PEACE CORPS VOLUNTEER SERVICE.—For purposes of this chapter, in the case of an individual performing service, as a volunteer or volunteer leader within the meaning of the Peace Corps Act, to which the provisions of section 3121(p) are applicable, the term "wages" shall, subject to the provisions of subsection (a)(1) of this section, include as such individual's remuneration for such service only amounts paid pursuant to section 5(c) or 6(1) of the Peace Corps Act.

(4) SERVICE PERFORMED BY CERTAIN MEMBERS OF RELIGIOUS ORDERS.—For purposes of this chapter, in any case where an individual is a member of a religious order (as defined in subsection (r)(2)) performing service in the exercise of duties required by such order, and an election of coverage under subsection (r) is in effect with respect to such order or with respect to the autonomous subdivision thereof to which such member belongs, the term "wages" shall, subject to the provisions of subsection (a)(1), include as such individual's remuneration for such service the fair market value of any board, lodging, clothing, and other perquisites furnished to such member by such order or subdivision thereof or by any other person or organization pursuant to an agreement with such order or subdivision, except that the amount included as such individual's remuneration under this paragraph shall not be less than $100 a month.

(5) SERVICE PERFORMED BY CERTAIN RETIRED JUSTICES AND JUDGES.—For purposes of this chapter, in the case of an individual performing service under the provisions of section 294 of title 28, United States Code (relating to assignment of retired justices and judges to active duty), the term "wages" shall not include any payment under section 371(b) of such title 28 which is received during the period of such service.

(j) COVERED TRANSPORTATION SERVICE.—For purposes of this chapter—

(1) EXISTING TRANSPORTATION SYSTEMS—GENERAL RULE.—Except as provided in paragraph (2), all service performed in the employ of a State or political subdivision in connection with its operation of a public transportation system shall constitute covered transportation service if any part of the transportation system was acquired from private ownership after 1936 and prior to 1951.

(2) EXISTING TRANSPORTATION SYSTEMS—CASES IN WHICH NO TRANSPORTATION EMPLOYEES, OR ONLY CERTAIN EMPLOYEES, ARE COVERED.—Service performed in the employ of a State or political subdivision in connection with the operation of its public transportation system shall not constitute covered transportation service if—

(A) any part of the transportation system was acquired from private ownership after 1936 and prior to 1951, and substantially all service in connection with the operation of the transportation system was, on December 31, 1950, covered under a general retirement system providing benefits

which, by reason of a provision of the State constitution dealing specifically with retirement systems of the State or political subdivisions thereof, cannot be diminished or impaired; or

(B) no part of the transportation system operated by the State or political subdivision on December 31, 1950, was acquired from private ownership after 1936 and prior to 1951;

except that if such State or political subdivision makes an acquisition after 1950 from private ownership of any part of its transportation system, then, in the case of any employee who—

(C) became an employee of such State or political subdivision in connection with and at the time of its acquisition after 1950 of such part, and

(D) prior to such acquisition rendered service in employment (including as employment service covered by an agreement under section 218 of the Social Security Act) in connection with the operation of such part of the transportation system acquired by the State or political subdivision,

the service of such employee in connection with the operation of the transportation system shall constitute covered transportation service, commencing with the first day of the third calendar quarter following the calendar quarter in which the acquisition of such part took place, unless on such first day such service of such employee is covered by a general retirement system which does not, with respect to such employee, contain special provisions applicable only to employees described in subparagraph (C).

(3) TRANSPORTATION SYSTEMS ACQUIRED AFTER 1950.—All service performed in the employ of a State or political subdivision thereof in connection with its operation of a public transportation system shall constitute covered transportation service if the transportation system was not operated by the State or political subdivision prior to 1951 and, at the time of its first acquisition (after 1950) from private ownership of any part of its transportation system, the State or political subdivision did not have a general retirement system covering substantially all service performed in connection with the operation of the transportation system.

(4) DEFINITIONS.—For purposes of this subsection—

(A) The term "general retirement system" means any pension, annuity, retirement, or similar fund or system established by a State or by a political subdivision thereof for employees of the State, political subdivision, or both; but such term shall not include such a fund or system which covers only service performed in positions connected with the operation of its public transportation system.

(B) A transportation system or a part thereof shall be considered to have been acquired by a State or political subdivision from private ownership if prior to the acquisition service performed by employees in connection with the operation of the system or part thereof acquired constituted employment under this chapter or subchapter A of chapter 9 of the Internal Revenue Code of 1939 or was covered by an agreement made pursuant to section 218 of the

Social Security Act and some of such employees became employees of the State or political subdivision in connection with and at the time of such acquisition.

(C) The term "political subdivision" includes an instrumentality of—

(i) a State,

(ii) one or more political subdivisions of a State, or

(iii) a State and one or more of its political subdivisions.

(k) [Repealed.[23]]

(l) AGREEMENTS ENTERED INTO BY AMERICAN EMPLOYERS WITH RESPECT TO FOREIGN AFFILIATES.—

(1) AGREEMENT WITH RESPECT TO CERTAIN EMPLOYEES OF FOREIGN AFFILIATE.—The Secretary shall, at the American employer's request, enter into an agreement (in such manner and form as may be prescribed by the Secretary) with any American employer (as defined in subsection (h)) who desires to have the insurance system established by title II of the Social Security Act extended to service performed outside the United States in the employ of any 1 or more of such employer's foreign affiliates (as defined in paragraph (6)) by all employees who are citizens or residents of the United States, except that the agreement shall not apply to any service performed by, or remuneration paid to, an employee if such service or remuneration would be excluded from the term "employment" or "wages", as defined in this section, had the service been performed in the United States. Such agreement may be amended at any time so as to be made applicable, in the same manner and under the same conditions, with respect to any other foreign affiliate of such American employer. Such agreement shall be applicable with respect to citizens or residents of the United States who, on or after the effective date of the agreement, are employees of and perform services outside the United States for any foreign affiliate specified in the agreement. Such agreement shall provide—

(A) that the American employer shall pay to the Secretary, at such time or times as the Secretary may by regulations prescribe, amounts equivalent to the sum of the taxes which would be imposed by sections 3101 and 3111 (including amounts equivalent to the interest, additions to the taxes, additional amounts, and penalties which would be applicable) with respect to the remuneration which would be wages if the services covered by the agreement constituted employment as defined in this section; and

(B) that the American employer will comply with such regulations relating to payments and reports as the Secretary may prescribe to carry out the purposes of this subsection.

(2) EFFECTIVE PERIOD OF AGREEMENT.—An agreement entered into pursuant to paragraph (1) shall be in effect for the period beginning with the first day of the calendar quarter in which such agreement is entered into or the first day of the succeeding calendar quarter, as may be specified in the agreement; except that in case such agreement is amended to in-

[23] P. L. 98-21, §102(b)(2); 97 Stat. 71.

clude the services performed for any other affiliate and such amendment is executed after the first month following the first calendar quarter for which the agreement is in effect, the agreement shall be in effect with respect to service performed for such other affiliate only after the calendar quarter in which such amendment is executed. Notwithstanding any other provision of this subsection, the period for which any such agreement is effective with respect to any foreign entity shall terminate at the end of any calendar quarter in which the foreign entity, at any time in such quarter, ceases to be a foreign affiliate as defined in paragraph (6).

(3) NO TERMINATION OF AGREEMENT.—No agreement under this subsection may be terminated, either in its entirety or with respect to any foreign affiliate, on or after June 15, 1989.

(4) DEPOSITS IN TRUST FUNDS.—For purposes of section 201 of the Social Security Act, relating to appropriations to the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, such remuneration—

(A) paid for services covered by an agreement entered into pursuant to paragraph (1) as would be wages if the services constituted employment, and

(B) as is reported to the Secretary pursuant to the provisions of such agreement or of the regulations issued under this subsection,

shall be considered wages subject to the taxes imposed by this chapter.

(5) OVERPAYMENTS AND UNDERPAYMENTS.—

(A) If more or less than the correct amount due under an agreement entered into pursuant to this subsection is paid with respect to any payment of remuneration, proper adjustments with respect to the amounts due under such agreement shall be made, without interest, in such manner and at such times as may be required by regulations prescribed by the Secretary.

(B) If an overpayment cannot be adjusted under subparagraph (A), the amount thereof shall be paid by the Secretary, through the Fiscal Service of the Treasury Department, but only if a claim for such overpayment is filed with the Secretary within two years from the time such overpayment was made.

(6) FOREIGN AFFILIATE DEFINED.—For purposes of this subsection and section 210(a) of the Social Security Act—

(A) IN GENERAL.—A foreign affiliate of an American employer is any foreign entity in which such American employer has not less than a 10-percent interest.

(B) DETERMINATION OF 10-PERCENT INTEREST.—For purposes of subparagraph (A), an American employer has a 10-percent interest in any entity if such employer has such an interest directly (or through one or more entities)—

(i) in the case of a corporation, in the voting stock thereof, and

(ii) in the case of any other entity, in the profits thereof.

(7) AMERICAN EMPLOYER AS SEPARATE ENTITY.—Each American employer which enters into an agreement pursuant to paragraph (1) of this subsection shall, for purposes of this sub-

section and section 6413(c)(2)(C), relating to special refunds in the case of employees of certain foreign entities, be considered an employer in its capacity as a party to such agreement separate and distinct from its identity as a person employing individuals on its own account.

(8) REGULATIONS.—Regulations of the Secretary to carry out the purposes of this subsection shall be designed to make the requirements imposed on American employers with respect to services covered by an agreement entered into pursuant to this subsection the same, so far as practicable, as those imposed upon employers pursuant to this title with respect to the taxes imposed by this chapter.

(m) SERVICE IN THE UNIFORMED SERVICES.—For purposes of this chapter—

(1) INCLUSION OF SERVICE.—The term "employment" shall, notwithstanding the provisions of subsection (b) of this section, include—

(A) service performed by an individual as a member of a uniformed service on active duty, but such term shall not include any such service which is performed while on leave without pay, and

(B) service performed by an individual as a member of a uniformed service on inactive duty training.

(2) ACTIVE DUTY.—The term "active duty" means "active duty" as described in section 102 of the Servicemen's and Veterans' Survivor Benefits Act, except that it shall also include "active duty for training" as described in such section.

(3) INACTIVE DUTY TRAINING.—The term "inactive duty training" means "inactive duty training" as described in such section 102.

(n) MEMBER OF A UNIFORMED SERVICE.—For purposes of this chapter, the term "member of a uniformed service" means any person appointed, enlisted, or inducted in a component of the Army, Navy, Air Force, Marine Corps, or Coast Guard (including a reserve component as defined in section 101(27) of title 38, United States Code), or in one of those services without specification of component, or as a commissioned officer of the Coast and Geodetic Survey, the National Oceanic and Atmospheric Administration Corps, or the Regular or Reserve Corps of the Public Health Service, and any person serving in the Army or Air Force under call or conscription. The term includes—

(1) a retired member of any of those services;

(2) a member of the Fleet Reserve or Fleet Marine Corps Reserve;

(3) a cadet at the United States Military Academy, a midshipman at the United States Naval Academy, and a cadet at the United States Coast Guard Academy or United States Air Force Academy;

(4) a member of the Reserve Officers' Training Corps, the Naval Reserve Officers' Training Corps, or the Air Force Reserve Officers' Training Corps, when ordered to annual training duty for fourteen days or more, and while performing authorized travel to and from that duty; and

(5) any person while en route to or from, or at, a place for final acceptance or for entry upon active duty in the military, naval, or air service—

(A) who has been provisionally accepted for such duty; or

(B) who, under the Military Selective Service Act, has been selected for active military, naval, or air service;

and has been ordered or directed to proceed to such place.

The term does not include a temporary member of the Coast Guard Reserve.

(o) CREW LEADER.—For purposes of this chapter, the term "crew leader" means an individual who furnishes individuals to perform agricultural labor for another person, if such individual pays (either on his own behalf or on behalf of such person) the individuals so furnished by him for the agricultural labor performed by them and if such individual has not entered into a written agreement with such person whereby such individual has been designated as an employee of such person; and such individuals furnished by the crew leader to perform agricultural labor for another person shall be deemed to be the employees of such crew leader. For purposes of this chapter and chapter 2, a crew leader shall, with respect to service performed in furnishing individuals to perform agricultural labor for another person and service performed as a member of the crew, be deemed not to be an employee of such other person.

(p) PEACE CORPS VOLUNTEER SERVICE.—For purposes of this chapter, the term "employment" shall, notwithstanding the provisions of subsection (b) of this section, include service performed by an individual as a volunteer or volunteer leader within the meaning of the Peace Corps Act.

(q) TIPS INCLUDED FOR BOTH EMPLOYEE AND EMPLOYER TAXES.—For purposes of this chapter, tips received by an employee in the course of his employment shall be considered remuneration for such employment (and deemed to have been paid by the employer for purposes of subsections (a) and (b) of section 3111). Such remuneration shall be deemed to be paid at the time a written statement including such tips is furnished to the employer pursuant to section 6053(a) or (if no statement including such tips is so furnished) at the time received; except that, in determining the employer's liability in connection with the taxes imposed by section 3111 with respect to such tips in any case where no statement including such tips was so furnished (or to the extent that the statement so furnished was inaccurate or incomplete), such remuneration shall be deemed for purposes of subtitle F to be paid on the date on which notice and demand for such taxes is made to the employer by the Secretary.

(r) ELECTION OF COVERAGE BY RELIGIOUS ORDERS.—

(1) CERTIFICATE OF ELECTION BY ORDER.—A religious order whose members are required to take a vow of poverty, or any autonomous subdivision of such order, may file a certificate (in such form and manner, and with such official, as may be prescribed by regulations under this chapter) electing to have the insurance system established by title II of the Social Security Act extended to services performed by its members in the exercise of duties required by such order or such subdivision thereof. Such certificate of election shall provide that—

(A) such election of coverage by such order or subdivision shall be irrevocable;

(B) such election shall apply to all current and future members of such order, or in the case of a subdivision

thereof to all current and future members of such order who belong to such subdivision;

(C) all services performed by a member of such an order or subdivision in the exercise of duties required by such order or subdivision shall be deemed to have been performed by such member as an employee of such order or subdivision; and

(D) the wages of each member, upon which such order or subdivision shall pay the taxes imposed by sections 3101 and 3111, will be determined as provided in subsection (i)(4).

(2) DEFINITION OF MEMBER.—For purposes of this subsection, a member of a religious order means any individual who is subject to a vow of poverty as a member of such order and who performs tasks usually required (and to the extent usually required) of an active member of such order and who is not considered retired because of old age or total disability.

(3) EFFECTIVE DATE FOR ELECTION.—(A) A certificate of election of coverage shall be in effect, for purposes of subsection (b)(8) and for purposes of section 210(a)(8) of the Social Security Act, for the period beginning with whichever of the following may be designated by the order or subdivision thereof:

(i) the first day of the calendar quarter in which the certificate is filed,

(ii) the first day of the calendar quarter succeeding such quarter, or

(iii) the first day of any calendar quarter preceding the calendar quarter in which the certificate is filed, except that such date may not be earlier than the first day of the twentieth calendar quarter preceding the quarter in which such certificate is filed.

Whenever a date is designated under clause (iii), the election shall apply to services performed before the quarter in which the certificate is filed only if the member performing such services was a member at the time such services were performed and is living on the first day of the quarter in which such certificate is filed.

(B) If a certificate of election filed pursuant to this subsection is effective for one or more calendar quarters prior to the quarter in which such certificate is filed, then—

(i) for purposes of computing interest and for purposes of section 6651 (relating to addition to tax for failure to file tax return), the due date for the return and payment of the tax for such prior calendar quarters resulting from the filing of such certificate shall be the last day of the calendar month following the calendar quarter in which the certificate is filed; and

(ii) the statutory period for the assessment of such tax shall not expire before the expiration of 3 years from such due date.

(s) CONCURRENT EMPLOYMENT BY TWO OR MORE EMPLOYERS.—For purposes of sections 3102, 3111, and 3121(a)(1), if two or more related corporations concurrently employ the same individual and compensate such individual through a common paymaster which is one of such corporations, each such corporation shall be considered to have paid as remuneration to such individual only the amounts

actually disbursed by it to such individual and shall not be considered to have paid as remuneration to such individual amounts actually disbursed to such individual by another of such corporations.

(t) [Repealed.[24]]

(u) APPLICATION OF HOSPITAL INSURANCE TAX TO FEDERAL, STATE, AND LOCAL EMPLOYMENT.—

(1) FEDERAL EMPLOYMENT.—For purposes of the taxes imposed by sections 3101(b) and 3111(b), subsection (b) shall be applied without regard to paragraph (5) thereof.

(2) STATE AND LOCAL EMPLOYMENT.—For purposes of the taxes imposed by sections 3101(b) and 3111(b)—

(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), subsection (b) shall be applied without regard to paragraph (7) thereof.

(B) EXCEPTION FOR CERTAIN SERVICES.—Service shall not be treated as employment by reason of subparagraph (A) if—

(i) the service is included under an agreement under section 218 of the Social Security Act, or

(ii) the service is performed—

(I) by an individual who is employed by a State or political subdivision thereof to relieve him from unemployment,

(II) in a hospital, home, or other institution by a patient or inmate thereof as an employee of a State or political subdivision thereof or of the District of Columbia,

(III) by an individual, as an employee of a State or political subdivision thereof or of the District of Columbia, serving on a temporary basis in case of fire, storm, snow, earthquake, flood or other similar emergency,

(IV) by any individual as an employee included under section 5351(2) of title 5, United States Code (relating to certain interns, student nurses, and other student employees of hospitals of the District of Columbia Government), other than as a medical or dental intern or a medical or dental resident in training,

(V) by an election official or election worker if the remuneration paid in a calendar year for such service is less than $1,000 with respect to service performed during any calendar year commencing on or after January 1, 1995, ending on or before December 31, 1999, and the adjusted amount determined under section 218(c)(8)(B) of the Social Security Act for any calendar year commencing on or after January 1, 2000, with respect to service performed during such calendar year, or

(VI) by an individual in a position described in section 1402(c)(2)(E).

As used in this subparagraph, the terms "State" and "political subdivision" have the meanings given those terms in section 218(b) of the Social Security Act.

[24] P.L. 100-203, §9006(b)(2); 101 Stat. 1330-289.

(C) EXCEPTION FOR CURRENT EMPLOYMENT WHICH CONTINUES.—Service performed for an employer shall not be treated as employment by reason of subparagraph (A) if—

(i) such service would be excluded from the term "employment" for purposes of this chapter if subparagraph (A) did not apply;

(ii) such service is performed by an individual—

(I) who was performing substantial and regular service for remuneration for that employer before April 1, 1986,

(II) who is a bona fide employee of that employer on March 31, 1986, and

(III) whose employment relationship with that employer was not entered into for purposes of meeting the requirements of this subparagraph; and

(iii) the employment relationship with that employer has not been terminated after March 31, 1986.

(D) TREATMENT OF AGENCIES AND INSTRUMENTALITIES.—For purposes of subparagraph (C), under regulations—

(i) All agencies and instrumentalities of a State (as defined in section 218(b) of the Social Security Act) or of the District of Columbia shall be treated as a single employer.

(ii) All agencies and instrumentalities of a political subdivision of a State (as so defined) shall be treated as a single employer and shall not be treated as described in clause (i).

(3) MEDICARE QUALIFIED GOVERNMENT EMPLOYMENT.—For purposes of this chapter, the term "medicare qualified government employment" means service which—

(A) is employment (as defined in subsection (b)) with the application of paragraphs (1) and (2), but

(B) would not be employment (as so defined) without the application of such paragraphs.

(v) TREATMENT OF CERTAIN DEFERRED COMPENSATION AND SALARY REDUCTION ARRANGEMENTS.—

(1) CERTAIN EMPLOYER CONTRIBUTIONS TREATED AS WAGES.—Nothing in any paragraph of subsection (a) (other than paragraph (1)) shall exclude from the term "wages"—

(A) any employer contribution under a qualified cash or deferred arrangement (as defined in section 401(k)) to the extent not included in gross income by reason of section 402(e)(3), or

(B) any amount treated as an employer contribution under section 414(h)(2) where the pickup referred to in such section is pursuant to a salary reduction agreement (whether evidenced by a written instrument or otherwise).

(2) TREATMENT OF CERTAIN NONQUALIFIED DEFERRED COMPENSATION PLANS.—

(A) IN GENERAL.—Any amount deferred under a nonqualified deferred compensation plan shall be taken into account for purposes of this chapter as of the later of—

(i) when the services are performed, or

(ii) when there is no substantial risk of forfeiture of the rights to such amount.

The preceding sentence shall not apply to any excess parachute payment (as defined in section 280G(b)) or to any specified stock compensation (as defined in section 4985) on which tax is imposed by section 4985.[25]

(B) TAXED ONLY ONCE.—Any amount taken into account as wages by reason of subparagraph (A) (and the income attributable thereto) shall not thereafter be treated as wages for purposes of this chapter.

(C) NONQUALIFIED DEFERRED COMPENSATION PLAN.—For purposes of this paragraph, the term "nonqualified deferred compensation plan" means any plan or other arrangement for deferral of compensation other than a plan described in subsection (a)(5).

(3) EXEMPT GOVERNMENTAL DEFERRED COMPENSATION PLAN.—For purposes of subsection (a)(5), the term "exempt governmental deferred compensation plan" means any plan providing for deferral of compensation established and maintained for its employees by the United States, by a State or political subdivision thereof, or by an agency or instrumentality of any of the foregoing. Such term shall not include—

(A) any plan to which section 83, 402(b), 403(c), 457(a), or 457(f)(1) applies,

(B) any annuity contract described in section 403(b), and

(C) the Thrift Savings Fund (within the meaning of subchapter III of chapter 84 of title 5, United States Code).

(w) EXEMPTION OF CHURCHES AND QUALIFIED CHURCH-CONTROLLED ORGANIZATIONS.—

(1) GENERAL RULE.—Any church or qualified church-con trolled organization (as defined in paragraph (3)) may make an election within the time period described in paragraph (2), in accordance with such procedures as the Secretary determines to be appropriate, that services performed in the employ of such church or organization shall be excluded from employment for purposes of title II of the Social Security Act and this chapter. An election may be made under this subsection only if the church or qualified church- controlled organization states that such church or organization is opposed for religious reasons to the payment of the tax imposed under section 3111.

(2) TIMING AND DURATION OF ELECTION.—

An election under this subsection must be made prior to the first date, more than 90 days after July 18, 1984, on which a quarterly employment tax return for the tax imposed under section 3111 is due, or would be due but for the election, from such church or organization. An election under this subsection shall apply to current and future employees, and shall apply to service performed after December 31, 1983. The election may be revoked by the church or organization under regulations prescribed by the Secretary. The election shall be revoked by the Secretary if such church or organization fails to furnish the information required under section 6051 to the Secretary for a period of 2 years or more with respect to remuneration paid for such services by such church or organization, and, upon request by the Secretary, fails to furnish all such previously unfurnished information for the period covered by the elec-

[25] P.L. 108-357, 802(c)(1), inserted "or to any specified stock compensation (as defined in section 4985) on which tax is imposed by section 4985) on which tax is imposed by by section 4985".

tion. Any revocation under the preceding sentence shall apply retroactively to the beginning of the 2-year period for which the information was not furnished.

(3) DEFINITIONS.—

(A) For purposes of this subsection, the term "church" means a church, a convention or association of churches, or an elementary or secondary school which is controlled, operated, or principally supported by a church or by a convention or association of churches.

(B) For purposes of this subsection, the term "qualified church-controlled organization" means any church-controlled tax-exempt organization described in section 501(c)(3), other than an organization which—

(i) offers goods, services, or facilities for sale, other than on an incidental basis, to the general public, other than goods, services, or facilities which are sold at a nominal charge which is substantially less than the cost of providing such goods, services, or facilities; and

(ii) normally receives more than 25 percent of its support from either (I) governmental sources, or (II) receipts from admissions, sales of merchandise, performance of services, or furnishing of facilities, in activities which are not unrelated trades or businesses, or both.

(x) APPLICABLE DOLLAR THRESHOLD.—For purposes of this subsection (a)(7)(B), the term "applicable dollar threshold" means $1,000. In the case of calendar years after 1995, the Commissioner of Social Security shall adjust such $1,000 amount at the same time and in the same manner as under section 215(a)(1)(B)(ii) of the Social Security Act with respect to the amounts referred to in section 215(a)(1)(B)(i) of such Act, except that, for purposes of this paragraph, 1993 shall be substituted for the calendar year referred to in section 215(a)(1)(B)(ii)(II) of such Act. If any amount as adjusted under the preceding sentence is not a multiple of $100, such amount shall be rounded to the next lowest multiply of $100.

(y) SERVICE IN THE EMPLOY OF INTERNATIONAL ORGANIZATIONS BY CERTAIN TRANSFERRED FEDERAL EMPLOYEES.—

(1) IN GENERAL.—For purposes of this chapter, service performed in the employ of an international organization by an individual pursuant to a transfer of such individual to such international organization pursuant to section 3582 of title 5, United States Code, shall constitute "employment" if—

(A) immediately before such transfer, such individual performed service with a Federal agency which constituted "employment" under subsection (b) for purposes of the taxes imposed by sections 3101(a) and 3111(a), and

(B) such individual would be entitled, upon separation from such international organization and proper application, to reemployment with such Federal agency under such section 3582.

(2) DEFINITIONS.—For purposes of this subsection—

(A) FEDERAL AGENCY.—The term "Federal agency" means an agency, as defined in section 3581(1) of title 5, United States Code.

(B) INTERNATIONAL ORGANIZATION.—The term "international organization" has the meaning provided such term by section 3581(3) of title 5, United States Code.

SEC. 3122. FEDERAL SERVICE.

In the case of the taxes imposed by this chapter with respect to service performed in the employ of the United States or in the employ of any instrumentality which is wholly owned by the United States, including such service which is medicare qualified government employment (as defined in section 3121(u)(3)), including service, performed as a member of a uniformed service, to which the provisions of section 3121(m)(1)are applicable, and including service, performed as a volunteer or volunteer leader within the meaning of the Peace Corps Act, to which the provisions of section 3121(p) are applicable, the determination of the amount of remuneration for such service, and the return and payment of the taxes imposed by this chapter, shall be made by the head of the Federal agency or instrumentality having the control of such service, or by such agents as such head may designate. In the case of the taxes imposed by this chapter with respect to service performed in the employ of an international organization pursuant to a transfer to which the provisions of section 3121(y) are applicable, the determination of the amount of remuneration for such service, and the return and payment of the taxes imposed by this chapter, shall be made by the head of the Federal agency from which the transfer was made. Nothing in this paragraph shall be construed to affect the Secretary's authority to determine under subsections (a) and (b) of section 3121 whether any such service constitutes employment, the periods of such employment, and whether remuneration paid for any such service constitutes wages. The person making such return may, for convenience of administration, make payments of the tax imposed under section 3111 with respect to such service without regard to the contribution and benefit base limitation in section 3121(a)(1), and he shall not be required to obtain a refund of the tax paid under section 3111 on that part of the remuneration not included in wages by reason of section 3121(a)(1). Payments of the tax imposed under section 3111 with respect to service, performed by an individual as a member of a uniformed service, to which the provisions of section 3121(m)(1) are applicable, shall be made from appropriations available for the pay of members of such uniformed service. The provisions of this section shall be applicable in the case of service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Army and Air Force Exchange Service, Army and Air Force Motion Picture Service, Navy Exchanges, Marine Corps Exchanges, or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of Defense, at installations of the Department of Defense for the comfort, pleasure, contentment, and mental and physical improvement of personnel of such Department; and for purposes of this section the Secretary of Defense shall be deemed to be the head of such instrumentality. The provisions of this section shall be applicable also in the case of service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Coast Guard Exchanges or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of Transportation, at in-

stallations of the Coast Guard for the comfort, pleasure, contentment, and mental and physical improvement of personnel of the Coast Guard; and for purposes of this section the Secretary of Transportation shall be deemed to be the head of such instrumentality.

SEC. 3123. DEDUCTIONS AS CONSTRUCTIVE PAYMENTS.

Whenever under this chapter or any act of Congress, or under the law of any State, an employer is required or permitted to deduct any amount from the remuneration of an employee and to pay the amount deducted to the United States, a State, or any political subdivision thereof, then for purposes of this chapter the amount so deducted shall be considered to have been paid to the employee at the time of such deduction.

SEC. 3124. ESTIMATE OF REVENUE REDUCTION.

The Secretary at intervals of not longer than 3 years shall estimate the reduction in the amount of taxes collected under this chapter by reason of the operation of section 3121(b)(9) and shall include such estimate in his annual report.

SEC. 3125. RETURNS IN THE CASE OF GOVERNMENTAL EMPLOYEES IN STATES, GUAM, AMERICAN SAMOA, AND THE DISTRICT OF COLUMBIA.

(a) STATES.—Except as otherwise provided in this section, in the case of the taxes imposed by sections 3101(b) and 3111(b) with respect to service performed in the employ of a State or any political subdivision thereof (or any instrumentality of any one or more of the foregoing which is wholly owned thereby), the return and payment of such taxes may be made by the head of the agency or instrumentality having the control of such service, or by such agents as such head may designate. The person making such return may, for convenience of administration, make payments of the tax imposed under section 3111 with respect to the service of such individuals without regard to the contribution and benefit base limitation in section 3121(a)(1).

(b) GUAM.—The return and payment of the taxes imposed by this chapter on the income of individuals who are officers or employees of the Government of Guam or any political subdivision thereof or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, and those imposed on such Government or political subdivision or instrumentality with respect to having such individuals in its employ, may be made by the Governor of Guam or by such agents as he may designate. The person making such return may, for convenience of administration, make payments of the tax imposed under section 3111 with respect to the service of such individuals without regard to the contribution and benefit base limitation in section 3121(a)(1).

(c) AMERICAN SAMOA.—The return and payment of the taxes imposed by this chapter on the income of individuals who are officers or employees of the Government of American Samoa or any political subdivision thereof or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, and those imposed on such Government or political subdivision or instrumentality with respect to having such individuals in its employ, may be made

by the Governor of American Samoa or by such agents as he may designate. The person making such return may, for convenience of administration, make payments of the tax imposed under section 3111 with respect to the service of such individuals without regard to the contribution and benefit base limitation in section 3121(a)(1).

(d) DISTRICT OF COLUMBIA.—In the case of the taxes imposed by this chapter with respect to service performed in the employ of the District of Columbia or in the employ of any instrumentality which is wholly owned thereby, the return and payment of the taxes may be made by the Mayor of the District of Columbia or such agents as he may designate. The person making such return may, for convenience of administration, make payments of the tax imposed by section 3111 with respect to such service without regard to the contribution and benefit base limitation in section 3121(a)(1).

SEC. 3126. RETURN AND PAYMENT BY GOVERNMENTAL EMPLOYER.

If the employer is a State or political subdivision thereof, or an agency or instrumentality of any one or more of the foregoing, the return of the amount deducted and withheld upon any wages under section 3101 and the amount of the tax imposed by section 3111 may be made by any officer or employee of such State or political subdivision or such agency or instrumentality, as the case may be, having control of the payment of such wages, or appropriately designated for that purpose.

SEC. 3127. EXEMPTION FOR EMPLOYERS AND THEIR EMPLOYEES WHERE BOTH ARE MEMBERS OF RELIGIOUS FAITHS OPPOSED TO PARTICIPATION IN SOCIAL SECURITY ACT PROGRAMS.

(a) IN GENERAL.—Notwithstanding any other provision of this chapter (and under regulations prescribed to carry out this section), in any case where—

(1) an employer (or, if the employer is a partnership, each partner therein) is a member of a recognized religious sect or division thereof described in section 1402(g)(1) and an adherent of established tenets or teachings of such sect or division as described in such section, and has filed and had approved under subsection (b) an application (in such form and manner, and with such official, as may be prescribed by such regulations) for an exemption from the taxes imposed by section 3111, and

(2) an employee of such employer who is also a member of such a religious sect or division and an adherent of its established tenets or teachings has filed and had approved under subsection (b) an identical application for exemption from the taxes imposed by section 3101,

such employer shall be exempt from the taxes imposed by section 3111 with respect to wages paid to each of the employees thereof who meets the requirements of paragraph (2) and each such employee shall be exempt from the taxes imposed by section 3101 with respect to such wages paid to him by such employer.

(b) APPROVAL OF APPLICATION.—An application for exemption filed by an employer (or a partner) under subsection (a)(1) or by an employee under subsection (a)(2) shall be approved only if—

(1) such application contains or is accompanied by the evidence described in section 1402(g)(1)(A) and a waiver described in section 1402(g)(1)(B),

(2) the Commissioner of Social Security makes the findings (with respect to such sect or division) described in section 1402(g)(1)(C), (D), and (E), and

(3) no benefit or other payment referred to in section 1402(g)(1)(B) became payable (or, but for section 203 or 222(b) of the Social Security Act, would have become payable) to the individual filing the application at or before the time of such filing.

(c) EFFECTIVE PERIOD OF EXEMPTION.—An exemption granted under this section to any employer with respect to wages paid to any of the employees thereof, or granted to any such employee, shall apply with respect to wages paid by such employer during the period—

(1) commencing with the first day of the first calendar quarter, after the quarter in which such application is filed, throughout which such employer (or, if the employer is a partnership, each partner therein) or employee meets the applicable requirements specified in subsections (a) and (b), and

(2) ending with the last day of the calendar quarter preceding the first calendar quarter thereafter in which (A) such employer (or, if the employer is a partnership, any partner therein) or the employee involved does not meet the applicable requirements of subsection (a), or (B) the sect or division thereof of which such employer (or, if the employer is a partnership, any partner therein) or employee is a member is found by the Commissioner of Social Security to have ceased to meet the requirements of subsection (b)(2).

SEC. 3128. SHORT TITLE.

This chapter may be cited as the "Federal Insurance Contributions Act."

Subchapter A—Tax on Employees

SEC. 3201. RATE OF TAX.

(a) TIER 1 TAX.—In addition to other taxes, there is hereby imposed on the income of each employee a tax equal to the applicable percentage of the compensation received during any calendar year by such employee for services rendered by such employee. For purposes of the preceding sentence, the term "applicable percentage " means the percentage equal to the sum of the rates of tax in effect under subsections (a) and (b) of section 3101 for the calendar year. 3201.

(b) TIER 2 TAX.—

(1) IN GENERAL.—In addition to other taxes, there is hereby imposed on the income of each employee a tax equal to the applicable percentage of the compensation received during any calendar year by such employee for services rendered by such employee.

(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the term "applicable percentage" means—

(A) 4.90 percent in the case of compensation received during 2002 or 2003, and

(B) in the case of compensation received during any calendar year after 2003, the percentage determined under section 3241 for such calendar year.

(c) CROSS REFERENCE.—For application of different contribution bases with respect to the taxes imposed by subsections (a) and (b), see section 3231(e)(2).

* * * *

SEC. 3231. DEFINITIONS.

(a) EMPLOYER.—For purposes of this chapter, the term "employer" means any carrier (as defined in subsection (g)), and any company which is directly or indirectly owned or controlled by one or more such carriers or under common control therewith, and which operates any equipment or facility or performs any service (except trucking service, casual service, and the casual operation of equipment or facilities) in connection with the transportation of passengers or property by railroad, or the receipt, delivery, elevation, transfer in transit, refrigeration or icing, storage, or handling of property transported by railroad, and any receiver, trustee, or other individual or body, judicial or otherwise, when in the possession of the property or operating all or any part of the business of any such employer; except that the term " employer" shall not include any street, interurban, or suburban electric railway, unless such railway is operating as a part of a general steam-railroad system of transportation, but shall not exclude any part of the general steam-railroad system of transportation now or hereafter operated by any other motive power. The Surface Transportation Board is hereby authorized and directed upon request of the Secretary, or upon complaint of any party interested, to determine after hearing whether any line operated by electric power falls within the terms of this exception. The term "employer" shall also include railroad associations, traffic associations, tariff bureaus, demurrage bureaus, weighing and inspection bureaus, collection agencies and other associations, bureaus, agencies, or organizations controlled and maintained wholly or principally by two or more employers as hereinbefore defined and engaged in the performance of services in connection with or incidental to railroad transportation; and railway labor organizations, national in scope, which have been or may be organized in accordance with the provisions of the Railway Labor Act, as amended (45 U.S.C., chapter 8), and their State and National legislative committees and their general committees and their insurance departments and their local lodges and divisions, established pursuant to the constitutions and bylaws of such organizations. The term " employer " shall not include any company by reason of its being engaged in the mining of coal, the supplying of coal to an employer where delivery is not beyond the mine tipple, and the operation of equipment or facilities therefor, or in any of such activities.

(b) EMPLOYEE.—For purposes of this chapter, the term "employee" means any individual in the service of one or more employers for compensation; except that the term "employee" shall include an employee of a local lodge or division defined as an employer in subsection (a) only if he was in the service of or in the employment

relation to a carrier on or after August 29, 1935. An individual shall be deemed to have been in the employment relation to a carrier on August 29, 1935, if—

(1) he was on that date on leave of absence from his employment, expressly granted to him by the carrier by whom he was employed, or by a duly authorized representative of such carrier, and the grant of such leave of absence was established to the satisfaction of the Railroad Retirement Board before July 1947; or

(2) he was in the service of a carrier after August 29, 1935, and before January 1946 in each of 6 calendar months, whether or not consecutive; or

(3) before August 29, 1935, he did not retire and was not retired or discharged from the service of the last carrier by whom he was employed or its corporate or operating successor, but—

(A) solely by reason of his physical or mental disability he ceased before August 29, 1935, to be in the service of such carrier and thereafter remained continuously disabled until he attained age 65 or until August 1945, or

(B) solely for such last stated reason a carrier by whom he was employed before August 29, 1935, or a carrier who is its successor did not on or after August 29, 1935, and before August 1945 call him to return to service, or

(C) if he was so called he was solely for such reason unable to render service in 6 calendar months as provided in paragraph (2); or

(4) he was on August 29, 1935, absent from the service of a carrier by reason of a discharge which, within 1 year after the effective date thereof, was protested, to an appropriate labor representative or to the carrier, as wrongful, and which was followed within 10 years of the effective date thereof by his reinstatement in good faith to his former service with all his seniority rights;

except that an individual shall not be deemed to have been on August 29, 1935, in the employment relation to a carrier if before that date he was granted a pension or gratuity on the basis of which a pension was awarded to him pursuant to section 6 of the Railroad Retirement Act of 1937 (45 U.S.C. 228f), or if during the last payroll period before August 29, 1935, in which he rendered service to a carrier he was not in the service of an employer, in accordance with subsection (d), with respect to any service in such payroll period, or if he could have been in the employment relation to an employer only by reason of his having been, either before or after August 29, 1935, in the service of a local lodge or division defined as an employer in subsection (a). The term "employee" includes an officer of an employer. The term "employee " shall not include any individual while such individual is engaged in the physical operations consisting of the mining of coal, the preparation of coal, the handling (other than movement by rail with standard railroad locomotives) of coal not beyond the mine tipple, or the loading of coal at the tipple.

(c) EMPLOYEE REPRESENTATIVE.—For purposes of this chapter, the term "employee representative" means any officer or official representative of a railway labor organization other than a labor organization included in the term "employer" as defined in subsection (a), who before or after June 29, 1937, was in the service

of an employer as defined in subsection (a) and who is duly authorized and designated to represent employees in accordance with the Railway Labor Act (45 U.S.C., chapter 8), as amended, and any individual who is regularly assigned to or regularly employed by such officer or official representative in connection with the duties of his office.

(d) SERVICE.—For purposes of this chapter, an individual is in the service of an employer whether his service is rendered within or without the United States, if—

(1) he is subject to the continuing authority of the employer to supervise and direct the manner of rendition of his service, or he is rendering professional or technical services and is integrated into the staff of the employer, or he is rendering, on the property used in the employer's operations, other personal services the rendition of which is integrated into the employer's operations, and

(2) he renders such service for compensation;

except that an individual shall be deemed to be in the service of an employer, other than a local lodge or division or a general committee of a railway-labor-organization employer, not conducting the principal part of its business in the United States, only when he is rendering service to it in the United States; and an individual shall be deemed to be in the service of such a local lodge or division only if—

(3) all, or substantially all, the individuals constituting its membership are employees of an employer conducting the principal part of its business in the United States; or

(4) the headquarters of such local lodge or division is located in the United States;

and an individual shall be deemed to be in the service of such a general committee only if—

(5) he is representing a local lodge or division described in paragraph (3) or (4) immediately above; or

(6) all, or substantially all, the individuals represented by it are employees of an employer conducting the principal part of its business in the United States; or

(7) he acts in the capacity of a general chairman or an assistant general chairman of a general committee which represents individuals rendering service in the United States to an employer, but in such case if his office or headquarters is not located in the United States and the individuals represented by such general committee are employees of an employer not conducting the principal part of its business in the United States, only such proportion of the remuneration for such service shall be regarded as compensation as the proportion which the mileage in the United States under the jurisdiction of such general committee bears to the total mileage under its jurisdiction, unless such mileage formula is inapplicable, in which case such other formula as the Railroad Retirement Board may have prescribed pursuant to section 1(c) of the Railroad Retirement Act of 1937 (45 U.S.C. 228a) shall be applicable, and if the application of such mileage formula, or such other formula as the Board may prescribe, would result in the compensation of the individual being less than 10 percent of his remuneration for such service, no part of such remuneration shall be regarded as compensation;

Provided however, That an individual not a citizen or resident of the United States shall not be deemed to be in the service of an employer when rendering service outside the United States to an employer who is required under the laws applicable in the place where the service is rendered to employ therein, in whole or in part, citizens or residents thereof; and the laws applicable on August 29, 1935, in the place where the service is rendered shall be deemed to have been applicable there at all times prior to that date.

(e) COMPENSATION.—For purposes of this chapter—

(1) The term "compensation" means any form of money remuneration paid to an individual for services rendered as an employee to one or more employers. Such term does not include (i) the amount of any payment (including any amount paid by an employer for insurance or annuities, or into a fund, to provide for any such payment) made to, or on behalf of, an employee or any of his dependents under a plan or system established by an employer which makes provision for his employees generally (or for his employees generally and their dependents) or for a class or classes of his employees (or for a class or classes of his employees and their dependents), on account of sickness or accident disability or medical or hospitalization expenses in connection with sickness or accident disability or death, except that this clause does not apply to a payment for group-term life insurance to the extent that such payment is includible in the gross income of the employee, (ii) tips (except as is provided under paragraph (3)), (iii) an amount paid specifically— either as an advance, as reimbursement or allowance—for traveling or other bona fide and necessary expenses incurred or reasonably expected to be incurred in the business of the employer provided any such payment is identified by the employer either by a separate payment or by specifically indicating the separate amounts where both wages and expense reimbursement or allowance are combined in a single payment, or (iv) any remuneration which would not (if chapter 21 applied to such remuneration) be treated as wages (as defined in section 3121(a)) by reason of section 3121(a)(5). Such term does not include remuneration for service which is performed by a nonresident alien individual for the period he is temporarily present in the United States as a nonimmigrant under subparagraph (F), (J), (M), or (Q) of section 101(a)(15) of the Immigration and Nationality Act, as amended, and which is performed to carry out the purpose specified in subparagraph (F), (J), (M), or (Q) as the case may be. For the purpose of determining the amount of taxes under sections 3201 and 3221, compensation earned in the service of a local lodge or division of a railway-labor-organization employer shall be disregarded with respect to any calendar month if the amount thereof is less than $25. Compensation for service as a delegate to a national or international convention of a railway labor organization defined as an "employer " in subsection (a) of this section shall be disregarded for purposes of determining the amount of taxes due pursuant to this chapter if the individual rendering such service has not previously rendered service, other than as such a delegate, which may be included in his "years of service" for purposes of the Railroad Retirement Act.

Nothing in the regulations prescribed for purposes of chapter 24 (relating to wage withholding) which provides an exclusion from " wages" as used in such chapter shall be construed to require a similar exclusion from "compensation" in regulations prescribed for purposes of this chapter.

(2) APPLICATION OF CONTRIBUTION BASES.—

(A) COMPENSATION IN EXCESS OF APPLICABLE BASE EXCLUDED.—

(i) IN GENERAL.—The term "compensation" does not include that part of remuneration paid during any calendar year to an individual by an employer after remuneration equal to the applicable base has been paid during such calendar year to such individual by such employer for services rendered as an employee to such employer.

(ii) REMUNERATION NOT TREATED AS COMPENSATION EXCLUDED.—There shall not be taken into account under clause (i) remuneration which (without regard to clause (i)) is not treated as compensation under this subsection.

(iii) HOSPITAL INSURANCE TAXES.—Clause (i) shall not apply to—

(I) so much of the rate applicable under section 3201(a) or 3221(a) as does not exceed the rate of tax in effect under section 3101(b), and

(II) so much of the rate applicable under section 3211(a) as does not exceed the rate of tax in effect under section 1401(b).

(B) APPLICABLE BASE.—

(i) TIER 1 TAXES.—Except as provided in clause (ii), the term "applicable base" means for any calendar year the contribution and benefit base determined under section 230 of the Social Security Act for such calendar year.

(II) HOSPITAL INSURANCE TAXES.—For purposes of applying so much of the rate applicable under section 3201(a) or 3221(a) (as the case may be) as does not exceed the rate of tax in effect under section 3101(b), and for purposes of applying so much of the rate of tax applicable under section 3211(a)(1) as does not exceed the rate of tax in effect under section 1401(b), the term "applicable base" means for any calendar year the applicable contribution base determined under section 3121(x)(2) for such calendar year.

(ii) TIER 2 TAXES, ETC.—For purposes of—

(I) the taxes imposed by sections 3201(b), 3211(b), and 3221(b), and

(II) computing average monthly compensation under section 3(j) of the Railroad Retirement Act of 1974 (except with respect to annuity amounts determined under subsection (a) or (f)(3) of section 3 of such Act),

clause (2) of the first sentence, and the second sentence, of subsection (c) of section 230 of the Social Security Act shall be disregarded.

(C) SUCCESSOR EMPLOYERS.—For purposes of this paragraph, the second sentence of section 3121(a)(1) (relating to successor employers) shall apply, except that—

(i) the term "services" shall be substituted for "employment" each place it appears,

(ii) the term "compensation" shall be substituted for "remuneration (other than remuneration referred to in the succeeding paragraphs of this subsection)" each place it appears, and

(iii) the terms "employer", "services", and "compensation" shall have the meanings given such terms by this section.

(3) Solely for purposes of the taxes imposed by section 3201 and other provisions of this chapter insofar as they relate to such taxes, the term "compensation" also includes cash tips received by an employee in any calendar month in the course of his employment by an employer unless the amount of such cash tips is less than $20.

(4)(A) For purposes of applying sections 3201(a), 3211(a), and 3221(a), in the case of payments made to an employee or any of his dependents on account of sickness or accident disability, clause (i) of the second sentence of paragraph (1) shall exclude from the term "compensation" only—

(i) payments which are received under a workmen's compensation law, and

(ii) benefits received under the Railroad Retirement Act of 1974.

(B) Notwithstanding any other provision of law, for purposes of the sections specified in subparagraph (A), the term "compensation" shall include benefits paid under section 2(a) of the Railroad Unemployment Insurance Act for days of sickness, except to the extent that such sickness (as determined in accordance with standards prescribed by the Railroad Retirement Board) is the result of on-the-job injury.

(C) Under regulations prescribed by the Secretary, subparagraphs (A) and (B) shall not apply to payments made after the expiration of a 6-month period comparable to the 6-month period described in section 3121(a)(4).

(D) Except as otherwise provided in regulations prescribed by the Secretary, any third party which makes a payment included in compensation solely by reason of subparagraph (A) or (B) shall be treated for purposes of this chapter as the employer with respect to such compensation.

(5) The term "compensation" shall not include any benefit provided to or on behalf of an employee if at the time such benefit is provided it is reasonable to believe that the employee will be able to exclude such benefit from income under section 74(c), 108(f)(4)[26], 117, or 132.

(6) The term "compensation" shall not include any payment made, or benefit furnished, to or for the benefit of an employee if at the time of such payment or such furnishing it is reason-

[26] P.L. 108-357, §320(b)(2), inserted "108 (f)(4)".

able to believe that the employee will be able to exclude such payment or benefit from income under section 127.

(7) The term "compensation" shall not include any contribution, payment, or service provided by an employer which may be excluded from the gross income of an employee, his spouse, or his dependents, under the provisions of section 120 (relating to amounts received under qualified group legal services plans).

(8) TREATMENT OF CERTAIN DEFERRED COMPENSATION AND SALARY REDUCTION ARRANGEMENTS.—

(A) CERTAIN EMPLOYER CONTRIBUTIONS TREATED AS COMPENSATION.—Nothing in any paragraph of this subsection (other than paragraph (2)) shall exclude from the term "compensation" any amount described in subparagraph (A) or (B) of section 3121(v)(1).

(B) TREATMENT OF CERTAIN NONQUALIFIED DEFERRED COMPENSATION.—The rules of section 3121(v)(2) which apply for purposes of chapter 21 shall also apply for purposes of this chapter.

(9) MEALS AND LODGING.—The term "compensation" shall not include the value of meals or lodging furnished by or on behalf of the employer if at the time of such furnishing it is reasonable to believe that the employee will be able to exclude such items from income under section 119.

(10) ARCHER MSA CONTRIBUTIONS.—The term "compensation" shall not include any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b).

(11)[27] HEALTH SAVINGS ACCOUNT CONTRIBUTIONS.—The term "compensation" shall not include any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b).

(12)[28] QUALIFIED STOCK OPTIONS.—The term "compensation" shall not include any remuneration on account of—

(A) a transfer of a share of stock to any individual pursuant to an exercise of an incentive stock option (as defined in section 422(b)) or under an employee stock purchase plan (as defined in section 423(b)), or

(B) any disposition by the individual of such stock.

(f) COMPANY.—For purposes of this chapter, the term "company" includes corporations, associations, and joint-stock companies.

(g) CARRIER.—For purposes of this chapter, the term "carrier" means a rail carrier subject to part A of subtitle IV.

(h) TIPS CONSTITUTING COMPENSATION, TIME DEEMED PAID.—For purposes of this chapter, tips which constitute compensation for purposes of the taxes imposed by section 3201 shall be deemed to be paid at the time a written statement including such tips is furnished to the employer pursuant to section 6053(a) or (if no statement including such tips is so furnished) at the time received.

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[27] P.L. 108-173, §1201(d)(2)(A), added paragraph (11), applicable to taxable years beginning after December 21, 2003.

[28] P.L. 108-357, §251(a)(2), added paragraph (12), applicable to stock acquired pursuant to options exercised after October 22, 2004.

(i) CONCURRENT EMPLOYMENT BY 2 OR MORE EMPLOYERS.—For purposes of this chapter, if 2 or more related corporations which are employers concurrently employ the same individual and compensate such individual through a common paymaster which is 1 of such corporations, each such corporation shall be considered to have paid as remuneration to such individual only the amounts actually disbursed by it to such individual and shall not be considered to have paid as remuneration to such individual amounts actually disbursed to such individual by another of such corporations.

SEC. 3301. RATE OF TAX.

There is hereby imposed on every employer (as defined in section 3306(a)) for each calendar year an excise tax, with respect to having individuals in his employ, equal to—

(1) 6.2 percent in the case of calendar years 1988 through 2007; or

(2) 6.0 percent in the case of calendar year 2008 and each calendar year thereafter;

of the total wages (as defined in section 3306(b)) paid by him during the calendar year with respect to employment (as defined in section 3306(c)).

SEC. 3302. CREDITS AGAINST TAX.

(a) CONTRIBUTIONS TO STATE UNEMPLOYMENT FUNDS.—

(1) The taxpayer may, to the extent provided in this sub section and subsection (c), credit against the tax imposed by section 3301 the amount of contributions paid by him into an unemployment fund maintained during the taxable year under the unemployment compensation law of a State which is certified as provided in section 3304 for the 12-month period ending on October 31 of such year.

(2) The credit shall be permitted against the tax for the taxable year only for the amount of contributions paid with respect to such taxable year.

(3) The credit against the tax for any taxable year shall be permitted only for contributions paid on or before the last day upon which the taxpayer is required under section 6071 to file a return for such year; except that credit shall be permitted for contributions paid after such last day, but such credit shall not exceed 90 percent of the amount which would have been allowable as credit on account of such contributions had they been paid on or before such last day.

(4) Upon the payment of contributions into the unemployment fund of a State which are required under the unemployment compensation law of that State with respect to remuneration on the basis of which, prior to such payment into the proper fund, the taxpayer erroneously paid an amount as contributions under another unemployment compensation law, the payment into the proper fund shall, for purposes of credit against the tax, be deemed to have been made at the time of the erroneous payment. If, by reason of such other law, the taxpayer was entitled to cease paying contributions with respect to services subject to such other law, the payment into the proper fund shall, for purposes of credit against the tax, be deemed to

have been made on the date the return for the taxable year was filed under section 6071.

(5) In the case of wages paid by the trustee of an estate under title 11 of the United States Code, if the failure to pay contributions on time was without fault by the trustee, paragraph (3) shall be applied by substituting "100 percent" for "90 percent".

(b) ADDITIONAL CREDIT.—In addition to the credit allowed under subsection (a), a taxpayer may credit against the tax imposed by section 3301 for any taxable year an amount, with respect to the unemployment compensation law of each State certified as provided in section 3303 for the 12-month period ending on October 31 of such year, or with respect to any provisions thereof so certified, equal to the amount, if any, by which the contributions required to be paid by him with respect to the taxable year were less than the contributions such taxpayer would have been required to pay if throughout the taxable year he had been subject under such State law to the highest rate applied thereunder in such 12-month period to any person having individuals in his employ, or to a rate of 5.4%, whichever rate is lower.

(c) LIMIT ON TOTAL CREDITS.—

(1) The total credits allowed to a taxpayer under this section shall not exceed 90 percent of the tax against which such credits are allowable.

(2) If an advance or advances have been made to the unemployment account of a State under title XII of the Social Security Act, then the total credits (after applying subsections (a) and (b) and paragraph (1) of this subsection) otherwise allowable under this section for the taxable year in the case of a taxpayer subject to the unemployment compensation law of such State shall be reduced—

(A)(i) in the case of a taxable year beginning with the second consecutive January 1 as of the beginning of which there is a balance of such advances, by 5 percent of the tax imposed by section 3301 with respect to the wages paid by such taxpayer during such taxable year which are attributable to such State; and

(ii) in the case of any succeeding taxable year beginning with a consecutive January 1 as of the beginning of which there is a balance of such advances, by an additional 5 percent, for each such succeeding taxable year, of the tax imposed by section 3301 with respect to the wages paid by such taxpayer during such taxable year which are attributable to such State;

(B) in the case of a taxable year beginning with the third or fourth consecutive January 1 as of the beginning of which there is a balance of such advances, by the amount determined by multiplying the wages paid by such taxpayer during such taxable year which are attributable to such State by the percentage (if any), multiplied by a fraction, the numerator of which is the State's average annual wage in covered employment for the calendar year in which the determination is made and the denominator of which is the wage base under this chapter, by which—

(i) 2.7 percent multiplied by a fraction, the numerator of which is the wage base under this chapter and

the denominator of which is the estimated United States average annual wage in covered employment for the calendar year in which the determination is to be made, exceeds

(ii) the average employer contribution rate for such State for the calendar year preceding such taxable year; and

(C) in the case of a taxable year beginning with the fifth or any succeeding consecutive January 1 as of the beginning of which there is a balance of such advances, by the amount determined by multiplying the wages paid by such taxpayer during such taxable year which are attributable to such State by the percentage (if any) by which—

(i) the 5-year benefit cost rate applicable to such State for such taxable year or (if higher) 2.7 percent, exceeds

(ii) the average employer contribution rate for such State for the calendar year preceding such taxable year.

The provisions of the preceding sentence shall not be applicable with respect to the taxable year beginning January 1, 1975, or any succeeding taxable year which begins before January 1, 1980; and, for purposes of such sentence, January 1, 1980, shall be deemed to be the first January 1 occurring after January 1, 1974, and consecutive taxable years in the period commencing January 1, 1980, shall be determined as if the taxable year which begins on January 1, 1980, were the taxable year immediately succeeding the taxable year which began on January 1, 1974. Subparagraph (C) shall not apply with respect to any taxable year to which it would otherwise apply (but subparagraph (B) shall apply to such taxable year) if the Secretary of Labor determines (on or before November 10 of such taxable year) that the State meets the requirements of subsection (f)(2)(B) for such taxable year.

(3) If the Secretary of Labor determines that a State, or State agency, has not—

(A) entered into the agreement described in section 239 of the Trade Act of 1974, with the Secretary of Labor before July 15, 1975, or

(B) fulfilled its commitments under an agreement with the Secretary of Labor as described in section 239 of the Trade Act of 1974,

then, in the case of a taxpayer subject to the unemployment compensation law of such State, the total credits (after applying subsections (a) and (b) and paragraphs (1) and (2) of this section) otherwise allowable under this section for a year during which such State or agency does not enter into or fulfill such an agreement shall be reduced by 7 ½ percent of the tax imposed with respect to wages paid by such taxpayer during such year which are attributable to such State.

(d) DEFINITIONS AND SPECIAL RULES RELATING TO SUBSECTION (C).—

(1) RATE OF TAX DEEMED TO BE 6 PERCENT.—In applying sub section (c), the tax imposed by section 3301 shall be computed at the rate of 6 percent in lieu of the rate provided by such section.

(2) WAGES ATTRIBUTABLE TO A PARTICULAR STATE.—For purposes of subsection (c), wages shall be attributable to a particular State if they are subject to the unemployment compensation law of the State, or (if not subject to the unemployment compensation law of any State) if they are determined (under rules or regulations prescribed by the Secretary) to be attributable to such State.

(3) ADDITIONAL TAXES INAPPLICABLE WHERE ADVANCES ARE REPAID BEFORE NOVEMBER 10 OF TAXABLE YEAR.—Paragraph (2) of subsection (c) shall not apply with respect to any State for the taxable year if (as of the beginning of November 10 of such year) there is no balance of advances referred to in such paragraph.

(4) AVERAGE EMPLOYER CONTRIBUTION RATE.—For purposes of subparagraphs (B) and (C) of subsection (c)(2), the average employer contribution rate for any State for any calendar year is that percentage obtained by dividing—

(A) the total of the contributions paid into the State unemployment fund with respect to such calendar year, by

(B)(i) for purposes of subparagraph (B) of subsection (c)(2), the total of the wages (as determined without any limitation on amount) attributable to such State subject to contributions under this chapter with respect to such calendar year, and

(ii) for purposes of subparagraph (C) of subsection (c)(2), the total of the remuneration subject to contributions under the State unemployment compensation law with respect to such calendar year.

For purposes of subparagraph (C) of subsection (c)(2), if the average employer contribution rate for any State for any calendar year (determined without regard to this sentence) equals or exceeds 2.7 percent, such rate shall be determined by increasing the amount taken into account under subparagraph (A) of the preceding sentence by the aggregate amount of employee payments (if any) into the unemployment fund of such State with respect to such calendar year which are to be used solely in the payment of unemployment compensation.

(5) 5-YEAR BENEFIT COST RATE.—For purposes of subparagraph (C) of subsection (c)(2), the 5-year benefit cost rate applicable to any State for any taxable year is that percentage obtained by dividing—

(A) one-fifth of the total of the compensation paid under the State unemployment compensation law during the 5-year period ending at the close of the second calendar year preceding such taxable year, by

(B) the total of the remuneration subject to contributions under the State unemployment compensation law with respect to the first calendar year preceding such taxable year.

(6) ROUNDING.—If any percentage referred to in either subparagraph (B) or (C) of subsection (c)(2) is not a multiple of .1 percent, it shall be rounded to the nearest multiple of .1 percent.

(7) DETERMINATION AND CERTIFICATION OF PERCENTAGES.—The percentage referred to in subsection (c)(2)(B) or (C) for any taxable year for any State having a balance referred to therein

shall be determined by the Secretary of Labor, and shall be certified by him to the Secretary of the Treasury before June 1 of such year, on the basis of a report furnished by such State to the Secretary of Labor before May 1 of such year. Any such State report shall be made as of the close of March 31 of the taxable year, and shall be made on such forms, and shall contain such information, as the Secretary of Labor deems necessary to the performance of his duties under this section.

(e) SUCCESSOR EMPLOYER.—Subject to the limits provided by subsection (c), if—

(1) an employer acquires during any calendar year substan tially all the property used in the trade or business of another person, or used in a separate unit of a trade or business of such other person, and immediately after the acquisition employs in his trade or business one or more individuals who immediately prior to the acquisition were employed in the trade or business of such other person, and

(2) such other person is not an employer for the calendar year in which the acquisition takes place,

then, for the calendar year in which the acquisition takes place, in addition to the credits allowed under subsections (a) and (b), such employer may credit against the tax imposed by section 3301 for such year an amount equal to the credits which (without regard to subsection (c)) would have been allowable to such other person under subsections (a) and (b) and this subsection for such year, if such other person had been an employer, with respect to remuneration subject to contributions under the unemployment compensation law of a State paid by such other person to the individual or individuals described in paragraph (1).

(f) LIMITATION ON CREDIT REDUCTION.—

(1) LIMITATION.—

In the case of any State which meets the requirements of paragraph (2) with respect to any taxable year the reduction under subsection (c)(2) in credits otherwise applicable to taxpayers subject to the unemployment compensation law of such State shall not exceed the greater of—

(A) the reduction which was in effect with respect to such State under subsection (c)(2) for the preceding taxable year, or

(B) 0.6 percent of the wages paid by the taxpayer during such taxable year which are attributable to such State.

(2) REQUIREMENTS.—The requirements of this paragraph are met by any State with respect to any taxable year if the Secretary of Labor determines (on or before November 10 of such taxable year) that—

(A) no State action was taken during the 12-month period ending on September 30 of such taxable year (excluding any action required under State law as in effect prior to the date of the enactment of this subsection) which has resulted or will result in a reduction in such State's unemployment tax effort (as defined by the Secretary of Labor in regulations),

(B) no State action was taken during the 12-month period ending on September 30 of such taxable year (excluding any action required under State law as in effect prior to the date of the enactment of this subsection) which has

resulted or will result in a net decrease in the solvency of the State unemployment compensation system (as defined by the Secretary of Labor in regulations),

(C) the State unemployment tax rate for the taxable year equals or exceeds the average benefit cost ratio for calendar years in the 5-calendar year period ending with the last calendar year before the taxable year, and

(D) the outstanding balance for such State of advances under title XII of the Social Security Act on September 30 of such taxable year was not greater than the outstanding balance for such State of such advances on September 30 of the third preceding taxable year (or, for purposes of applying this subparagraph to taxable year 1983, September 30, 1981).

The requirements of subparagraphs (C) and (D) shall not apply to taxable years 1981 and 1982.

(3) CREDIT REDUCTIONS FOR SUBSEQUENT YEARS.—If the credit reduction under subsection (c)(2) is limited by reason of paragraph (1) of this subsection for any taxable year, for purposes of applying subsection (c)(2) to subsequent taxable years (including years after 1987), the taxable year for which the credit reduction was so limited (and January 1 thereof) shall not be taken into account.

(4) STATE UNEMPLOYMENT TAX RATE.—For purposes of this subsection—

(A) IN GENERAL.—The State unemployment tax rate for any taxable year is the percentage obtained by dividing —

(i) the total amount of contributions paid into the State unemployment fund with respect to such taxable year, by

(ii) the total amount of the remuneration subject to contributions under the State unemployment compensation law with respect to such taxable year (determined without regard to any limitation on the amount of wages subject to contribution under the State law).

(B) TREATMENT OF ADDITIONAL TAX UNDER THIS CHAPTER.—

(i) TAXABLE YEAR 1983.—In the case of taxable year 1983, any additional tax imposed under this chapter with respect to any State by reason of subsection (c)(2) shall be treated as contributions paid into the State unemployment fund with respect to such taxable year.

(ii) TAXABLE YEAR 1984.—In the case of taxable year 1984, any additional tax imposed under this chapter with respect to any State by reason of subsection (c)(2) shall (to the extent such additional tax is attributable to a credit reduction in excess of 0.6 of wages attributable to such State) be treated as contributions paid into the State unemployment fund with respect to such taxable year.

(5) BENEFIT COST RATIO.—For purposes of this subsection—

(A) IN GENERAL.—The benefit cost ratio for any calendar year is the percentage determined by dividing—

(i) the sum of the total of the compensation paid under the State unemployment compensation law during such calendar year and any interest paid during

such calendar year on advances made to the State under title XII of the Social Security Act, by

(ii) the total amount of the remuneration subject to contributions under the State unemployment compensation law with respect to such calendar year (determined without regard to any limitation on the amount of remuneration subject to contribution under the State law).

(B) REIMBURSABLE BENEFITS NOT TAKEN INTO ACCOUNT.—For purposes of subparagraph (A), compensation shall not be taken into account to the extent—

(i) the State is entitled to reimbursement for such compensation under the provisions of any Federal law, or

(ii) such compensation is attributable to services performed for a reimbursing employer.

(C) REIMBURSING EMPLOYER.—The term "reimbursing employer" means any governmental entity or other organization (or group of governmental entities or any other organizations) which makes reimbursements in lieu of contributions to the State unemployment fund.

(D) SPECIAL RULES FOR YEARS BEFORE 1985.—

(i) TAXABLE YEAR 1983.—For purposes of determining whether a State meets the requirements of paragraph (2)(C) for taxable year 1983, only regular compensation (as defined in section 205 of the Federal-State Extended Unemployment Compensation Act of 1970) shall be taken into account for purposes of determining the benefit ratio for any preceding calendar year before 1982.

(ii) TAXABLE YEAR 1984.—For purposes of determining whether a State meets the requirements of paragraph (2)(C) for taxable year 1984, only regular compensation (as so defined) shall be taken into account for purposes of determining the benefit ratio for any preceding calendar year before 1981.

(E) ROUNDING.—If any percentage determined under subparagraph (A) is not a multiple of .1 percent, such percentage shall be reduced to the nearest multiple of .1 percent.

(6) REPORTS.—The Secretary of Labor may, by regulations, require a State to furnish such information at such time and in such manner as may be necessary for purposes of this subsection.

(7) DEFINITIONS AND SPECIAL RULES.—The definitions and special rules set forth in subsection (d) shall apply to this subsection in the same manner as they apply to subsection (c).

(8) PARTIAL LIMITATION.—

(A) In the case of a State which would meet the requirements of this subsection for a taxable year prior to 1986 but for its failure to meet one of the requirements contained in subparagraph (C) or (D) of paragraph (2), the reduction under subsection (c)(2) in credits otherwise applicable to taxpayers in such State for such taxable year and each subsequent year (in a period of consecutive years for

each of which a credit reduction is in effect for taxpayers in such State) shall be reduced by 0.1 percentage point.

(B) In the case of a State which does not meet the requirements of paragraph (2) but meets the requirements of subparagraphs (A) and (B) of paragraph (2) and which also meets the requirements of section 1202(b)(8)(B) of the Social Security Act with respect to such taxable year, the reduction under subsection (c)(2) in credits otherwise applicable to taxpayers in such State for such taxable year and each subsequent year (in a period of consecutive years for each of which a credit reduction is in effect for taxpayers in such State) shall be further reduced by an additional 0.1 percentage point.

(C) In no case shall the application of subparagraphs (A) and (B) reduce the credit reduction otherwise applicable under subsection (c)(2) below the limitation under paragraph (1).

(g) CREDIT REDUCTION NOT TO APPLY WHEN STATE MAKES CERTAIN REPAYMENTS.—

(1) IN GENERAL.—In the case of any State which meets re quirements of paragraph (2) with respect to any taxable year, subsection (c)(2) shall not apply to such taxable year; except that such taxable year (and January 1 of such taxable year) shall (except as provided in subsection (f)(3)) be taken into account for purposes of applying subsection (c)(2) to succeeding taxable years.

(2) REQUIREMENTS.—The requirements of this paragraph are met by any State with respect to any taxable year if the Secretary of Labor determines that—

(A) the repayments during the 1-year period ending on November 9 of such taxable year made by such State of advances under title XII of the Social Security Act are not less than the sum of—

(i) the potential additional taxes for such taxable year, and

(ii) any advances made to such State during such 1-year period under such title XII,

(B) there will be sufficient amounts in the State unemployment fund to pay all compensation during the 3-month period beginning on November 1 of such taxable year without receiving any advance under title XII of the Social Security Act, and

(C) there is a net increase in the solvency of the State unemployment compensation system for the taxable year attributable to changes made in the State law after the date on which the first advance taken into account in determining the amount of the potential additional taxes was made (or, if later, after the date of the enactment of this subsection) and such net increase equals or exceeds the potential additional taxes for such taxable year.

(3) DEFINITIONS.—For purposes of paragraph (2)—

(A) POTENTIAL ADDITIONAL TAXES.—The term "potential additional taxes" means, with respect to any State for any taxable year, the aggregate amount of the additional tax which would be payable under this chapter for such taxable year by all taxpayers subject to the unemployment

compensation law of such State for such taxable year if paragraph (2) of subsection (c) had applied to such taxable year and any preceding taxable year without regard to this subsection but with regard to subsection (f).

(B) TREATMENT OF CERTAIN REDUCTIONS.—Any reduction in the State's balance under section 901(d)(1) of the Social Security Act shall not be treated as a repayment made by such State.

(4) REPORTS.—The Secretary of Labor may require a State to furnish such information at such time and in such manner as may be necessary for purposes of paragraph (2).

SEC. 3303. CONDITIONS OF ADDITIONAL CREDIT ALLOWANCE.

(a) STATE STANDARDS.—A taxpayer shall be allowed an additional credit under section 3302(b) with respect to any reduced rate of contributions permitted by a State law, only if the Secretary of Labor finds that under such law—

(1) no reduced rate of contributions to a pooled fund or to a partially pooled account is permitted to a person (or group of persons) having individuals in his (or their) employ except on the basis of his (or their) experience with respect to unemployment or other factors bearing a direct relation to unemployment risk during not less than the 3 consecutive years immediately preceding the computation date;

(2) no reduced rate of contributions to a guaranteed employment account is permitted to a person (or a group of persons) having individuals in his (or their) employ unless—

(A) the guaranty of remuneration was fulfilled in the year preceding the computation date; and

(B) the balance of such account amounts to not less than 2 ½ percent of that part of the payroll or payrolls for the 3 years preceding the computation date by which contributions to such account were measured; and

(C) such contributions were payable to such account with respect to 3 years preceding the computation date;

(3) no reduced rate of contributions to a reserve account is permitted to a person (or group of persons) having individuals in his (or their) employ unless—

(A) compensation has been payable from such account throughout the year preceding the computation date, and

(B) the balance of such account amounts to not less than five times the largest amount of compensation paid from such account within any 1 of the 3 years preceding such date, and

(C) the balance of such account amounts to not less than 2 ½ 2 percent of that part of the payroll or payrolls for the 3 years preceding such date by which contributions to such account were measured, and

(D) such contributions were payable to such account with respect to the 3 years preceding the computation date.

For any person (or group of persons) who has (or have) not been subject to the State law for a period of time sufficient to compute the reduced rates permitted by paragraphs (1), (2), and (3) of this subsection on a 3-year basis (i) the period of time required may be reduced to the amount of time the person (or group of persons) has

(or have) had experience under or has (or have) been subject to the State law, whichever is appropriate, but in no case less than 1 year immediately preceding the computation date, or (ii) a reduced rate (not less than 1 percent) may be permitted by the State law on a reasonable basis other than as permitted by paragraph (1), (2), or (3).

(b) CERTIFICATION BY THE SECRETARY OF LABOR WITH RESPECT TO ADDITIONAL CREDIT ALLOWANCE.—

(1) On October 31 of each calendar year, the Secretary of Labor shall certify to the Secretary of the Treasury the law of each State (certified by the Secretary of Labor as provided in section 3304 for the 12-month period ending on such October 31), with respect to which he finds that reduced rates of contributions were allowable with respect to such 12-month period only in accordance with the provisions of subsection (a).

(2) If the Secretary of Labor finds that under the law of a single State (certified by the Secretary of Labor as provided in section 3304) more than one type of fund or account is maintained, and reduced rates of contributions to more than one type of fund or account were allowable with respect to any 12-month period ending on October 31, and one or more of such reduced rates were allowable under conditions not fulfilling the requirements of subsection (a), the Secretary of Labor shall, on such October 31, certify to the Secretary of the Treasury only those provisions of the State law pursuant to which reduced rates of contributions were allowable with respect to such 12-month period under conditions fulfilling the requirements of subsection (a), and shall, in connection therewith, designate the kind of fund or account, as defined in subsection (c), established by the provisions so certified. If the Secretary of Labor finds that a part of any reduced rate of contributions payable under such law or under such provisions is required to be paid into one fund or account and a part into another fund or account, the Secretary of Labor shall make such certification pursuant to this paragraph as he finds will assure the allowance of additional credits only with respect to that part of the reduced rate of contributions which is allowed under provisions which do fulfill the requirements of subsection (a).

(3) The Secretary of Labor shall, within 30 days after any State law is submitted to him for such purpose, certify to the State agency his findings with respect to reduced rates of contributions to a type of fund or account, as defined in subsection (c), which are allowable under such State law only in accordance with the provisions of subsection (a). After making such findings, the Secretary of Labor shall not withhold his certification to the Secretary of the Treasury of such State law, or of the provisions thereof with respect to which such findings were made, for any 12-month period ending on October 31 pursuant to paragraph (1) or (2) unless, after reasonable notice and opportunity for hearing to the State agency, the Secretary of Labor finds the State law no longer contains the provisions specified in subsection (a) or the State has, with respect to such 12-month period, failed to comply substantially with any such provision.

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

(1) RESERVE ACCOUNT.—The term "reserve account" means a separate account in an unemployment fund, maintained with respect to a person (or group of persons) having individuals in his (or their) employ, from which account, unless such account is exhausted, is paid all and only compensation payable on the basis of services performed for such person (or for one or more of the persons comprising the group).

(2) POOLED FUND.—The term "pooled fund " means an unemployment fund or any part thereof (other than a reserve account or a guaranteed employment account) into which the total contributions of persons contributing thereto are payable, in which all contributions are mingled and undivided, and from which compensation is payable to all individuals eligible for compensation from such fund.

(3) PARTIALLY POOLED ACCOUNT.—The term "partially pooled account" means a part of an unemployment fund in which part of the fund all contributions thereto are mingled and undivided, and from which part of the fund compensation is payable only to individuals to whom compensation would be payable from a reserve account or from a guaranteed employment account but for the exhaustion or termination of such reserve account or of such guaranteed employment account. Payments from a reserve account or guaranteed employment account into a partially pooled account shall not be construed to be inconsistent with the provisions of paragraph (1) or (4).

(4) GUARANTEED EMPLOYMENT ACCOUNT.—The term "guaranteed employment account" means a separate account, in an unemployment fund, maintained with respect to a person (or group of persons) having individuals in his (or their) employ who, in accordance with the provisions of the State law or of a plan thereunder approved by the State agency,

(A) guarantees in advance at least 30 hours of work, for which remuneration will be paid at not less than stated rates, for each of 40 weeks (or if more, 1 weekly hour may be deducted for each added week guaranteed) in a year, to all the individuals who are in his (or their) employ in, and who continue to be available for suitable work in, one or more distinct establishments, except that any such individual's guaranty may commence after a probationary period (included within the 11 or less consecutive weeks immediately following the first week in which the individual renders services), and

(B) gives security or assurance, satisfactory to the State agency, for the fulfillment of such guaranties, from which account, unless such account is exhausted or terminated, is paid all and only compensation, payable on the basis of services performed for such person (or for one or more of the persons comprising the group), to any such individual whose guaranteed remuneration has not been paid (either pursuant to the guaranty or from the security or assurance provided for the fulfillment of the guaranty), or whose guaranty is not renewed and who is otherwise eligible for compensation under the State law.

(5) YEAR.—The term "year" means any 12 consecutive calendar months.

(6) BALANCE.—The term "balance", with respect to a reserve account or a guaranteed employment account, means the amount standing to the credit of the account as of the computation date; except that, if subsequent to January 1, 1940, any moneys have been paid into or credited to such account other than payments thereto by persons having individuals in their employ, such term shall mean the amount in such account as of the computation date less the total of such other moneys paid into or credited to such account subsequent to January 1, 1940.

(7) COMPUTATION DATE.—The term "computation date" means the date, occurring at least once in each calendar year and within 27 weeks prior to the effective date of new rates of contributions, as of which such rates are computed.

(8) REDUCED RATE.—The term "reduced rate" means a rate of contributions lower than the standard rate applicable under the State law, and the term "standard rate" means the rate on the basis of which variations therefrom are computed.

(d) VOLUNTARY CONTRIBUTIONS.—A State law may, without being deemed to violate the standards set forth in subsection (a), permit voluntary contributions to be used in the computation of reduced rates if such contributions are paid prior to the expiration of 120 days after the beginning of the year for which such rates are effective.

(e) PAYMENTS BY CERTAIN NONPROFIT ORGANIZATIONS.—A State may, without being deemed to violate the standards set forth in subsection (a), permit an organization (or a group of organizations) described in section 501(c)(3) which is exempt from income tax under section 501(a) to elect (in lieu of paying contributions) to pay into the State unemployment fund amounts equal to the amounts of compensation attributable under the State law to service performed in the employ of such organization (or group).

(f) TRANSITION.—To facilitate the orderly transition to coverage of service to which section 3309(a)(1)(A) applies, a State law may provide that an organization (or group of organizations) which elects before April 1, 1972, to make payments (in lieu of contributions) into the State unemployment fund as provided in section 3309(a)(2), and which had paid contributions into such fund under the State law with respect to such service performed in its employ before January 1, 1969, is not required to make any such payment (in lieu of contributions) on account of compensation paid after its election as heretofore described which is attributable under the State law to service performed in its employ, until the total of such compensation equals the amount—

(1) by which the contributions paid by such organization (or group) with respect to a period before the election provided by section 3309(a)(2), exceed

(2) the unemployment compensation for the same period which was charged to the experience-rating account of such organization (or group) or paid under the State law on the basis of wages paid by it or service performed in its employ, whichever is appropriate.

(g) TRANSITIONAL RULE FOR UNEMPLOYMENT COMPENSATION AMENDMENTS OF 1976.—To facilitate the orderly transition to coverage of service to which section 3309(a)(1)(A) applies by reason of the enactment of the Unemployment Compensation Amendments of

1976, a State law may provide that an organization (or group of organizations) which elects, when such election first becomes available under the State law with respect to such service, to make payments (in lieu of contributions) into the State unemployment fund as provided in section 3309(a)(2), and which had paid contributions into such fund under the State law with respect to such service performed in its employ before the date of the enactment of this subsection, is not required to make any such payment (in lieu of contributions) on account of compensation paid after its election as heretofore described which is attributable under the State law to such service performed in its employ, until the total of such compensation equals the amount—

(1) by which the contributions paid by such organization (or group) on the basis of wages for such service with respect to a period before the election provided by section 3309(a)(2), exceed

(2) the unemployment compensation for the same period which was charged to the experience-rating account of such organization (or group) or paid under the State law on the basis of such service performed in its employ or wages paid for such service, whichever is appropriate.

SEC. 3304. APPROVAL OF STATE LAWS.

(a) REQUIREMENTS.—The Secretary of Labor shall approve any State law submitted to him, within 30 days of such submission, which he finds provides that—

(1) all compensation is to be paid through public employment offices or such other agencies as the Secretary of Labor may approve;

(2) no compensation shall be payable with respect to any day of unemployment occurring within 2 years after the first day of the first period with respect to which contributions are required;

(3) all money received in the unemployment fund shall (except for refunds of sums erroneously paid into such fund and except for refunds paid in accordance with the provisions of section 3305(b)) immediately upon such receipt be paid over to the Secretary of the Treasury to the credit of the Unemployment Trust Fund established by section 904 of the Social Security Act (42 U.S.C. 1104);

(4) all money withdrawn from the unemployment fund of the State shall be used solely in the payment of unemployment compensation, exclusive of expenses of administration, and for refunds of sums erroneously paid into such fund and refunds paid in accordance with the provisions of section 3305(b); except that—

(A) an amount equal to the amount of employee payments into the unemployment fund of a State may be used in the payment of cash benefits to individuals with respect to their disability, exclusive of expenses of administration;

(B) the amounts specified by section 903(c)(2) or 903(d)(4) of the Social Security Act may, subject to the conditions prescribed in such section, be used for expenses incurred by the State for administration of its unemployment compensation law and public employment offices;

(C) nothing in this paragraph shall be construed to prohibit deducting an amount from unemployment compensation otherwise payable to an individual and using the amount so deducted to pay for health insurance, or the withholding of Federal, State, or local individual income tax, if the individual elected to have such deduction made and such deduction was made under a program approved by the Secretary of Labor;

(D) amounts may be deducted from unemployment benefits and used to repay overpayments as provided in section 303(g) of the Social Security Act; and

(E) amounts may be withdrawn for the payment of short-time compensation under a plan approved by the Secretary of Labor; and

(F) amounts may be withdrawn for the payment of allowances under a self–employment assistance program (as defined in section 3306(t));

(5) compensation shall not be denied in such State to any otherwise eligible individual for refusing to accept new work under any of the following conditions:

(A) if the position offered is vacant due directly to a strike, lockout, or other labor dispute;

(B) if the wages, hours, or other conditions of the work offered are substantially less favorable to the individual than those prevailing for similar work in the locality;

(C) if as a condition of being employed the individual would be required to join a company union or to resign from or refrain from joining any bona fide labor organization;

(6)(A) compensation is payable on the basis of service to which section 3309(a)(1) applies, in the same amount, on the same terms, and subject to the same conditions as compensation payable on the basis of other service subject to such law; except that—

(i) with respect to services in an instructional, research, or principal administrative capacity for an educational institution to which section 3309(a)(1) applies, compensation shall not be payable based on such services for any week commencing during the period between two successive academic years or terms (or, when an agreement provides instead for a similar period between two regular but not successive terms, during such period) to any individual if such individual performs such services in the first of such academic years (or terms) and if there is a contract or reasonable assurance that such individual will perform services in any such capacity for any educational institution in the second of such academic years or terms,

(ii) with respect to services in any other capacity for an educational institution to which section 3309(a)(1) applies—

(I) compensation payable on the basis of such services may be denied to any individual for any week which commences during a period between 2 successive academic years or terms if such individual performs such services in the first of such academic years or terms and there is a reasonable assurance that

such individual will perform such services in the second of such academic years or terms, except that

(II) if compensation is denied to any individual for any week under subclause (I) and such individual was not offered an opportunity to perform such services for the educational institution for the second of such academic years or terms, such individual shall be entitled to a retroactive payment of the compensation for each week for which the individual filed a timely claim for compensation and for which compensation was denied solely by reason of subclause (I),

(iii) with respect to any services described in clause (i) or (ii), compensation payable on the basis of such services shall be denied to any individual for any week which commences during an established and customary vacation period or holiday recess if such individual performs such services in the period immediately before such vacation period or holiday recess, and there is a reasonable assurance that such individual will perform such services in the period immediately following such vacation period or holiday recess,

(iv) with respect to any services described in clause (i) or (ii), compensation payable on the basis of services in any such capacity shall be denied as specified in clauses (i), (ii), and (iii) to any individual who performed such services in an educational institution while in the employ of an educational service agency, and for this purpose the term "educational service agency" means a governmental agency or governmental entity which is established and operated exclusively for the purpose of providing such services to one or more educational institutions,

(v) with respect to services to which section 3309(a)(1) applies, if such services are provided to or on behalf of an educational institution, compensation may be denied under the same circumstances as described in clauses (i) through (iv), and

(vi) with respect to services described in clause (ii), clauses (iii) and (iv) shall be applied by substituting "may be denied" for "shall be denied", and

(B) payments (in lieu of contributions) with respect to service to which section 3309(a)(1) applies may be made into the State unemployment fund on the basis set forth in section 3309(a)(2);

(7) an individual who has received compensation during his benefit year is required to have had work since the beginning of such year in order to qualify for compensation in his next benefit year;

(8) compensation shall not be denied to an individual for any week because he is in training with the approval of the State agency (or because of the application, to any such week in training, of State law provisions relating to availability for work, active search for work, or refusal to accept work);

(9)(A) compensation shall not be denied or reduced to an individual solely because he files a claim in another State (or a contiguous country with which the United States has an agreement with respect to unemployment compensation) or because

he resides in another State (or such a contiguous country) at the time he files a claim for unemployment compensation;

(B) the State shall participate in any arrangements for the payment of compensation on the basis of combining an individual's wages and employment covered under the State law with his wages and employment covered under the unemployment compensation law of other States which are approved by the Secretary of Labor in consultation with the State unemployment compensation agencies as reasonably calculated to assure the prompt and full payment of compensation in such situations. Any such arrangement shall include provisions for (i) applying the base period of a single State law to a claim involving the combining of an individual's wages and employment covered under two or more State laws, and (ii) avoiding duplicate use of wages and employment by reason of such combining;

(10) compensation shall not be denied to any individual by reason of cancellation of wage credits or total reduction of his benefit rights for any cause other than discharge for misconduct connected with his work, fraud in connection with a claim for compensation, or receipt of disqualifying income;

(11) extended compensation shall be payable as provided by the Federal-State Extended Unemployment Compensation Act of 1970;

(12) no person shall be denied compensation under such State law solely on the basis of pregnancy or termination of pregnancy;

(13) compensation shall not be payable to any individual on the basis of any services, substantially all of which consist of participating in sports or athletic events or training or preparing to so participate, for any week which commences during the period between two successive sport seasons (or similar periods) if such individual performed such services in the first of such seasons (or similar periods) and there is a reasonable assurance that such individual will perform such services in the later of such seasons (or similar periods);

(14)(A) compensation shall not be payable on the basis of services performed by an alien unless such alien is an individual who was lawfully admitted for permanent residence at the time such services were performed, was lawfully present for purposes of performing such services, or was permanently residing in the United States under color of law at the time such services were performed (including an alien who was lawfully present in the United States as a result of the application of the provisions of section 212(d)(5) of the Immigration and Nationality Act),

(B) any data or information required of individuals applying for compensation to determine whether compensation is not payable to them because of their alien status shall be uniformly required from all applicants for compensation, and

(C) in the case of an individual whose application for compensation would otherwise be approved, no determination by the State agency that compensation to such individual is not payable because of his alien status shall be made except upon a preponderance of the evidence;

(15) the amount of compensation payable to an individual for any week which begins after March 31, 1980, and which begins in a period with respect to which such individual is receiving a governmental or other pension, retirement or retired pay, annuity, or any other similar periodic payment which is based on the previous work of such individual shall be reduced (but not below zero) by an amount equal to the amount of such pension, retirement or retired pay, annuity, or other payment, which is reasonably attributable to such week except that—

(A) the requirements of this paragraph shall apply to any pension, retirement or retired pay, annuity, or other similar periodic payment only if—

(i) such pension, retirement or retired pay, annuity, or similar payment is under a plan maintained (or contributed to) by a base period employer or chargeable employer (as determined under applicable law), and

(ii) in the case of such a payment not made under the Social Security Act or the Railroad Retirement Act of 1974 (or the corresponding provisions of prior law), services performed for such employer by the individual after the beginning of the base period (or remuneration for such services) affect eligibility for, or increase the amount of, such pension, retirement or retired pay, annuity, or similar payment, and

(B) the State law may provide for limitations on the amount of any such a reduction to take into account contributions made by the individual for the pension, retirement or retired pay, annuity, or other similar periodic payment;

(16)(A) wage information contained in the records of the agency administering the State law which is necessary (as determined by the Secretary of Health and Human Services in regulations) for purposes of determining an individual's eligibility for assistance, or the amount of such assistance, under a State program funded under part A of title IV of the Social Security Act, shall be made available to a State or political subdivision thereof when such information is specifically requested by such State or political subdivision for such purposes,

(B) wage and unemployment compensation information contained in the records of such agency shall be furnished to the Secretary of Health and Human Services (in accordance with regulations promulgated by such Secretary) as necessary for the purposes of the National Directory of New Hires established under section 453(i) of the Social Security Act, and

(C) such safeguards are established as are necessary (as determined by the Secretary of Health and Human Services in regulations) to insure that information furnished under subparagraph (A) or (B) is used only for the purposes authorized under such subparagraph;

(17) any interest required to be paid on advances under title XII of the Social Security Act shall be paid in a timely manner and shall not be paid, directly or indirectly (by an equivalent reduction in State unemployment taxes or otherwise) by such State from amounts in such State's unemployment fund; and

(18) Federal individual income tax from unemployment compensation is to be deducted and withheld if an individual receiving such compensation voluntarily requests such deduction and withholding; and

(19) all the rights, privileges, or immunities conferred by such law or by acts done pursuant thereto shall exist subject to the power of the legislature to amend or repeal such law at any time.

(b) NOTIFICATION.—The Secretary of Labor shall, upon approving such law, notify the governor of the State of his approval.

(c) CERTIFICATION.—On October 31 of each taxable year the Secretary of Labor shall certify to the Secretary of the Treasury each State whose law he has previously approved, except that he shall not certify any State which, after reasonable notice and opportunity for hearing to the State agency, the Secretary of Labor finds has amended its law so that it no longer contains the provisions specified in subsection (a) or has with respect to the 12-month period ending on such October 31 failed to comply substantially with any such provision in such subsection. No finding of a failure to comply substantially with any provision in paragraph (5) of subsection (a) shall be based on an application or interpretation of State law (1) until all administrative review provided for under the laws of the State has been exhausted, or (2) with respect to which the time for judicial review provided by the laws of the State has not expired, or (3) with respect to which any judicial review is pending. On October 31 of any taxable year, the Secretary of Labor shall not certify any State which, after reasonable notice and opportunity for hearing to the State agency, the Secretary of Labor finds has failed to amend its law so that it contains each of the provisions required by law to be included therein (including provisions relating to the Federal-State Extended Unemployment Compensation Act of 1970 (or any amendments thereto) as required under subsection (a)(11)), or has, with respect to the twelve-month period ending on such October 31, failed to comply substantially with any such provision.

(d) NOTICE OF NONCERTIFICATION.—If at any time the Secretary of Labor has reason to believe that a State whose law he has previously approved may not be certified under subsection (c), he shall promptly so notify the governor of such State.

(e) CHANGE OF LAW DURING 12-MONTH PERIOD.—Whenever—

(1) any provision of this section, section 3302, or section 3303 refers to a 12-month period ending on October 31 of a year, and

(2) the law applicable to one portion of such period differs from the law applicable to another portion of such period,

then such provision shall be applied by taking into account for each such portion the law applicable to such portion.

(f) DEFINITION OF INSTITUTION OF HIGHER EDUCATION.—For purposes of subsection (a)(6), the term "institution of higher education" means an educational institution in any State which—

(1) admits as regular students only individuals having a certificate of graduation from a high school, or the recognized equivalent of such a certificate;

(2) is legally authorized within such State to provide a program of education beyond high school;

(3) provides an educational program for it which awards a bachelor's or higher degree, or provides a program which is ac-

ceptable for full credit toward such a degree, or offers a program of training to prepare students for gainful employment in a recognized occupation; and

(4) is a public or other nonprofit institution.

SEC. 3305. APPLICABILITY OF STATE LAW.

(a) INTERSTATE AND FOREIGN COMMERCE.—No person required under a State law to make payments to an unemployment fund shall be relieved from compliance therewith on the ground that he is engaged in interstate or foreign commerce, or that the State law does not distinguish between employees engaged in interstate or foreign commerce and those engaged in intrastate commerce.

(b) FEDERAL INSTRUMENTALITIES IN GENERAL.—The legislature of any State may require any instrumentality of the United States (other than an instrumentality to which section 3306(c)(6) applies), and the individuals in its employ, to make contributions to an unemployment fund under a State unemployment compensation law approved by the Secretary of Labor under section 3304 and (except as provided in section 5240 of the Revised Statutes, as amended (12 U.S.C., sec. 484), and as modified by subsection (c)), to comply otherwise with such law. The permission granted in this subsection shall apply (A) only to the extent that no discrimination is made against such instrumentality, so that if the rate of contribution is uniform upon all other persons subject to such law on account of having individuals in their employ, and upon all employees of such persons, respectively, the contributions required of such instrumentality or the individuals in its employ shall not be at a greater rate than is required of such other persons and such employees, and if the rates are determined separately for different persons or classes of persons having individuals in their employ or for different classes of employees, the determination shall be based solely upon unemployment experience and other factors bearing a direct relation to unemployment risk; (B) only if such State law makes provision for the refund of any contributions required under such law from an instrumentality of the United States or its employees for any year in the event such State is not certified by the Secretary of Labor under section 3304 with respect to such year; and (C) only if such State law makes provision for the payment of unemployment compensation to any employee of any such instrumentality of the United States in the same amount, on the same terms, and subject to the same conditions as unemployment compensation is payable to employees of other employers under the State unemployment compensation law.

(c) NATIONAL BANKS.—Nothing contained in section 5240 of the Revised Statutes, as amended (12 U.S.C. 484), shall prevent any State from requiring any national banking association to render returns and reports relative to the association's employees, their remuneration and services, to the same extent that other persons are required to render like returns and reports under a State law requiring contributions to an unemployment fund. The Comptroller of the Currency shall, upon receipt of a copy of any such return or report of a national banking association from, and upon request of, any duly authorized official, body, or commission of a State, cause an examination of the correctness of such return or report to be made at the time of the next succeeding examination of such association, and shall thereupon transmit to such official, body, or com-

mission a complete statement of his findings respecting the accuracy of such returns or reports.

(d) FEDERAL PROPERTY.—No person shall be relieved from compliance with a State unemployment compensation law on the ground that services were performed on land or premises owned, held, or possessed by the United States, and any State shall have full jurisdiction and power to enforce the provisions of such law to the same extent and with the same effect as though such place were not owned, held, or possessed by the United States.

(e) [Repealed.[29]]

(f) AMERICAN VESSELS.—The legislature of any State in which a person maintains the operating office, from which the operations of an American vessel operating on navigable waters within or within and without the United States are ordinarily and regularly supervised, managed, directed and controlled, may require such person and the officers and members of the crew of such vessel to make contributions to its unemployment fund under its State unemployment compensation law approved by the Secretary of Labor under section 3304 and otherwise to comply with its unemployment compensation law with respect to the service performed by an officer or member of the crew on or in connection with such vessel to the same extent and with the same effect as though such service was performed entirely within such State. Such person and the officers and members of the crew of such vessel shall not be required to make contributions, with respect to such service, to the unemployment fund of any other State. The permission granted by this subsection is subject to the condition that such service shall be treated, for purposes of wage credits given employees, like other service subject to such State unemployment compensation law performed for such person in such State, and also subject to the same limitation, with respect to contributions required from such person and from the officers and members of the crew of such vessel, as is imposed by the second sentence (other than clause (B) thereof) of subsection (b) with respect to contributions required from instrumentalities of the United States and from individuals in their employ.

(g) VESSELS OPERATED BY GENERAL AGENTS OF UNITED STATES.—The permission granted by subsection (f) shall apply in the same manner and under the same conditions (including the obligation to comply with all requirements of State unemployment compensation laws) to general agents of the Secretary of Commerce with respect to service performed by officers and members of the crew on or in connection with American vessels—

(1) owned by or bareboat chartered to the United States, and

(2) whose business is conducted by such general agents.

As to any such vessel, the State permitted to require contributions on account of such service shall be the State to which the general agent would make contributions if the vessel were operated for his own account. Such general agents are designated, for this purpose, instrumentalities of the United States neither wholly nor partially owned by it and shall not be exempt from the tax imposed by section 3301. The permission granted by this subsection is subject to the same conditions and limitations as are imposed in subsection (f), except that clause (B) of the second sentence of subsection (b) shall apply.

[29] P. L. 83-767, §4(c); 68 Stat. 1135.

(h) REQUIREMENT BY STATE OF CONTRIBUTIONS.—Any State may, as to service performed on account of which contributions are made pursuant to subsection (g)—

(1) require contributions from persons performing such service under its unemployment compensation law or temporary disability insurance law administered in connection therewith, and

(2) require general agents of the Secretary of Commerce to make contributions under such temporary disability insurance law and to make such deductions from wages or remuneration as are required by such unemployment compensation or temporary disability insurance law.

(i) GENERAL AGENT AS LEGAL ENTITY.—Each general agent of the Secretary of Commerce making contributions pursuant to subsection (g) or (h) shall, for purposes of such subsections, be considered a legal entity in his capacity as an instrumentality of the United States, separate and distinct from his identity as a person employing individuals on his own account.

(j) DENIAL OF CREDITS IN CERTAIN CASES.—Any person required, pursuant to the permission granted by this section, to make contributions to an unemployment fund under a State unemployment compensation law approved by the Secretary of Labor under section 3304 shall not be entitled to the credits permitted, with respect to the unemployment compensation law of a State, by subsections (a) and (b) of section 3302 against the tax imposed by section 3301 for any taxable year if, on October 31 of such taxable year, the Secretary of Labor certifies to the Secretary of the Treasury his finding, after reasonable notice and opportunity for hearing to the State agency, that the unemployment compensation law of such State is inconsistent with any one or more of the conditions on the basis of which such permission is granted or that, in the application of the State law with respect to the 12-month period ending on such October 31, there has been a substantial failure to comply with any one or more of such conditions. For purposes of section 3310, a finding of the Secretary of Labor under this subsection shall be treated as a finding under section 3304(c).

SEC. 3306. DEFINITIONS.

(a) EMPLOYER.—For purposes of this chapter—

(1) IN GENERAL.—The term "employer" means, with respect to any calendar year, any person who—

(A) during any calendar quarter in the calendar year or the preceding calendar year paid wages of $1,500 or more, or

(B) on each of some 20 days during the calendar year or during the preceding calendar year, each day being in a different calendar week, employed at least one individual in employment for some portion of the day.

For purposes of this paragraph, there shall not be taken into account any wages paid to, or employment of, an employee performing domestic services referred to in paragraph (3).

(2) AGRICULTURAL LABOR.—In the case of agricultural labor, the term "employer" means, with respect to any calendar year, any person who—

(A) during any calendar quarter in the calendar year or the preceding calendar year paid wages of $20,000 or more for agricultural labor, or

(B) on each of some 20 days during the calendar year or during the preceding calendar year, each day being in a different calendar week, employed at least 10 individuals in employment in agricultural labor for some portion of the day.

(3) DOMESTIC SERVICE.—In the case of domestic service in a private home, local college club, or local chapter of a college fraternity or sorority, the term " employer" means, with respect to any calendar year, any person who during any calendar quarter in the calendar year or the preceding calendar year paid wages in cash of $1,000 or more for such service.

(4) SPECIAL RULE.—A person treated as an employer under paragraph (3) shall not be treated as an employer with respect to wages paid for any service other than domestic service referred to in paragraph (3) unless such person is treated as an employer under paragraph (1) or (2) with respect to such other service.

(b) WAGES.—For purposes of this chapter, the term "wages" means all remuneration for employment, including the cash value of all remuneration (including benefits) paid in any medium other than cash; except that such term shall not include—

(1) that part of the remuneration which, after remuneration (other than remuneration referred to in the succeeding paragraphs of this subsection) equal to $7,000 with respect to employment has been paid to an individual by an employer during any calendar year, is paid to such individual by such employer during such calendar year. If an employer (hereinafter referred to as successor employer) during any calendar year acquires substantially all the property used in a trade or business of another employer (hereinafter referred to as a predecessor), or used in a separate unit of a trade or business of a predecessor, and immediately after the acquisition employs in his trade or business an individual who immediately prior to the acquisition was employed in the trade or business of such predecessor, then, for the purpose of determining whether the successor employer has paid remuneration (other than remuneration referred to in the succeeding paragraphs of this subsection) with respect to employment equal to $7,000 to such individual during such calendar year, any remuneration (other than remuneration referred to in the succeeding paragraphs of this subsection) with respect to employment paid (or considered under this paragraph as having been paid) to such individual by such predecessor during such calendar year and prior to such acquisition shall be considered as having been paid by such successor employer;

(2) the amount of any payment (including any amount paid by an employer for insurance or annuities, or into a fund, to provide for any such payment) made to, or on behalf of, an employee or any of his dependents under a plan or system established by an employer which makes provision for his employees generally (or for his employees generally and their dependents) or for a class or classes of his employees (or for a class or classes of his employees and their dependents), on account of—

(A) sickness or accident disability (but, in the case of payments made to an employee or any of his dependents, this subparagraph shall exclude from the term "wages" only payments which are received under a workmen's compensation law), or

(B) medical or hospitalization expenses in connection with sickness or accident disability, or

(C) death;

(3) [Stricken.[30]]

(4) any payment on account of sickness or accident disability, or medical or hospitalization expenses in connection with sickness or accident disability, made by an employer to, or on behalf of, an employee after the expiration of 6 calendar months following the last calendar month in which the employee worked for such employer;

(5) any payment made to, or on behalf of, an employee or his beneficiary—

(A) from or to a trust described in section 401(a) which is exempt from tax under section 501(a) at the time of such payment unless such payment is made to an employee of the trust as remuneration for services rendered as such employee and not as a beneficiary of the trust, or

(B) under or to an annuity plan which, at the time of such payment, is a plan described in section 403(a),

(C) under a simplified employee pension (as defined in section 408(k)(1)), other than any contributions described in section 408(k)(6),

(D) under or to an annuity contract described in section 403(b), other than a payment for the purchase of such contract which is made by reason of a salary reduction agreement (whether evidenced by a written instrument or otherwise),

(E) under or to an exempt governmental deferred compensation plan (as defined in section 3121(v)(3)),

(F) to supplement pension benefits under a plan or trust described in any of the foregoing provisions of this paragraph to take into account some portion or all of the increase in the cost of living (as determined by the Secretary of Labor) since retirement but only if such supplemental payments are under a plan which is treated as a welfare plan under section 3(2)(B)(ii) of the Employee Retirement Income Security Act of 1974;

(G) under a cafeteria plan (within the meaning of section 125) if such payment would not be treated as wages without regard to such plan and it is reasonable to believe that (if section 125 applied for purposes of this section) section 125 would not treat any wages as constructively received, or

(H) under an arrangement to which section 408(p) applies, other than any elective contributions under paragraph (2)(A)(i) thereof,

(6) the payment by an employer (without deduction from the remuneration of the employee)—

[30] P. L. 98-21, §324(b)(3)(B); 97 Stat. 124.

(A) of the tax imposed upon an employee under section 3101, or

(B) of any payment required from an employee under a State unemployment compensation law,

with respect to remuneration paid to an employee for domestic service in a private home of the employer or for agricultural labor;

(7) remuneration paid in any medium other than cash to an employee for service not in the course of the employer's trade or business;

(8) [Stricken.[31]]

(9) remuneration paid to or on behalf of an employee if (and to the extent that) at the time of the payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 217 (determined without regard to section 274(n));

(10) any payment or series of payments by an employer to an employee or any of his dependents which is paid—

(A) upon or after the termination of an employee's employment relationship because of (i) death, or (ii) retirement for disability, and

(B) under a plan established by the employer which makes provision for his employees generally or a class or classes of his employees (or for such employees or class or classes of employees and their dependents),

other than any such payment or series of payments which would have been paid if the employee's employment relationship had not been so terminated;

(11) remuneration for agricultural labor paid in any medium other than cash;

(12) any contribution, payment, or service, provided by an employer which may be excluded from the gross income of an employee, his spouse, or his dependents, under the provisions of section 120 (relating to amounts received under qualified group legal services plans);

(13) any payment made, or benefit furnished, to or for the benefit of an employee if at the time of such payment or such furnishing it is reasonable to believe that the employee will be able to exclude such payment or benefit from income under section 127, 129, 134(b)(4), or 134(b)(5)[32];

(14) the value of any meals or lodging furnished by or on behalf of the employer if at the time of such furnishing it is reasonable to believe that the employee will be able to exclude such items from income under section 119;

(15) any payment made by an employer to a survivor or the estate of a former employee after the calendar year in which such employee died;

(16) any benefit provided to or on behalf of an employee if at the time such benefit is provided it is reasonable to believe

[31] P. L. 98-21, §324(b)(3)(B); 97 Stat. 124.

[32] P.L. 108-121, §106(b)(3), struck out "or 129" and substituted ", 129, or 134(b)(4)", applicable to taxable years beginning after December 31, 2002.

P.L 108-375, §585(b)(2)(C), struck out "or 134(b)(4)" and substituted "134(b)(4), or 134(b)(5)", applicable to travel benefits provided after October 28, 2004.

that the employee will be able to exclude such benefit from income under section 74(c), 108(f)(4)[33], 117, or 132;[34]

(17) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(d); or[35]

(18) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(d);[36]

(19)[37] remuneration on account of—

(A) a transfer of a share of stock to any individual pursuant to an exercise of an incentive stock option (as defined in section 422(b)) or under an employee stock purchase plan (as defined in section 423(b)), or

(B) any disposition by the individual of such stock.

Except as otherwise provided in regulations prescribed by the Secretary, any third party which makes a payment included in wages solely by reason of the parenthetical matter contained in subparagraph (A) of paragraph (2) shall be treated for purposes of this chapter and chapter 22 as the employer with respect to such wages. Nothing in the regulations prescribed for purposes of chapter 24 (relating to income tax withholding) which provides an exclusion from "wages" as used in such chapter shall be construed to require a similar exclusion from "wages" in the regulations prescribed for purposes of this chapter.

(c) EMPLOYMENT.—For purposes of this chapter, the term "employment" means any service performed prior to 1955, which was employment for purposes of subchapter C of chapter 9 of the Internal Revenue Code of 1939 under the law applicable to the period in which such service was performed, and (A) any service, of whatever nature, performed after 1954 by an employee for the person employing him, irrespective of the citizenship or residence of either, (i) within the United States, or (ii) on or in connection with an American vessel or American aircraft under a contract of service which is entered into within the United States or during the performance of which and while the employee is employed on the vessel or aircraft it touches at a port in the United States, if the employee is employed on and in connection with such vessel or aircraft when outside the United States, and (B) any service, of whatever nature, performed after 1971 outside the United States (except in a contiguous country with which the United States has an agreement relating to unemployment compensation) by a citizen of the United States as an employee of an American employer (as defined in subsection (j)(3)), except—

(1) agricultural labor (as defined in subsection (k)) unless—

(A) such labor is performed for a person who—

(i) during any calendar quarter in the calendar year or the preceding calendar year paid remuneration in

[33] P.L 108-357, §320(b)(3), inserted "108(f)(4)".

[34] P.L. 108-173, §1201(d)(2)(B), struck out "or".

[35] P.L. 108-173, §1201(d)(2)(B), struck out the period and substituted "; or".

[36] P.L. 108-173, §1201(d)(2)(B), added paragraph (18), applicable to taxable years after December 31, 2003.

P.L. 108-357, §251(a)(3) struck out the period at the end of paragraph (18).

[37] P.L. 108-357, §251(a)(3), added paragraph (19), applicable to stock acquired pursuant to options exercised after October 22, 2004.

P.L. 108-173, §251(a)(3), struck out "or".

cash of $20,000 or more to individuals employed in agricultural labor (including labor performed by an alien referred to in subparagraph (B)), or

(ii) on each of some 20 days during the calendar year or the preceding calendar year, each day being in a different calendar week, employed in agricultural labor (including labor performed by an alien referred to in subparagraph (B)) for some portion of the day (whether or not at the same moment of time) 10 or more individuals; and

(B) such labor is not agricultural labor performed by an individual who is an alien admitted to the United States to perform agricultural labor pursuant to sections 214(c) and 101(a)(15)(H) of the Immigration and Nationality Act;

(2) domestic service in a private home, local college club, or local chapter of a college fraternity or sorority unless performed for a person who paid cash remuneration of $1,000 or more to individuals employed in such domestic service in any calendar quarter in the calendar year or the preceding calendar year;

(3) service not in the course of the employer's trade or business performed in any calendar quarter by an employee, unless the cash remuneration paid for such service is $50 or more and such service is performed by an individual who is regularly employed by such employer to perform such service. For purposes of this paragraph, an individual shall be deemed to be regularly employed by an employer during a calendar quarter only if—

(A) on each of some 24 days during such quarter such individual performs for such employer for some portion of the day service not in the course of the employer's trade or business, or

(B) such individual was regularly employed (as determined under subparagraph (A)) by such employer in the performance of such service during the preceding calendar quarter;

(4) service performed on or in connection with a vessel or aircraft not an American vessel or American aircraft, if the employee is employed on and in connection with such vessel or aircraft when outside the United States;

(5) service performed by an individual in the employ of his son, daughter, or spouse, and service performed by a child under the age of 21 in the employ of his father or mother;

(6) service performed in the employ of the United States Government or of an instrumentality of the United States which is—

(A) wholly or partially owned by the United States, or

(B) exempt from the tax imposed by section 3301 by virtue of any provision of law which specifically refers to such section (or the corresponding section of prior law) in granting such exemption;

(7) service performed in the employ of a State, or any political subdivision thereof, or in the employ of an Indian tribe, or any instrumentality of any one or more of the foregoing which is wholly owned by one or more States or political subdivisions or Indian tribes; and any service performed in the employ of

any instrumentality of one or more States or political subdivisions to the extent that the instrumentality is, with respect to such service, immune under the Constitution of the United States from the tax imposed by section 3301;

(8) service performed in the employ of a religious, charitable, educational, or other organization described in section 501(c)(3) which is exempt from income tax under section 501(a);

(9) service performed by an individual as an employee or employee representative as defined in section 1 of the Railroad Unemployment Insurance Act (45 U.S.C. 351);

(10)(A) service performed in any calendar quarter in the employ of any organization exempt from income tax under section 501(a) (other than an organization described in section 401(a)) or under section 521, if the remuneration for such service is less than $50, or

(B) service performed in the employ of a school, college, or university, if such service is performed (i) by a student who is enrolled and is regularly attending classes at such school, college, or university, or (ii) by the spouse of such a student, if such spouse is advised, at the time such spouse commences to perform such service, that (I) the employment of such spouse to perform such service is provided under a program to provide financial assistance to such student by such school, college, or university, and (II) such employment will not be covered by any program of unemployment insurance, or

(C) service performed by an individual who is enrolled at a nonprofit or public educational institution which normally maintains a regular faculty and curriculum and normally has a regularly organized body of students in attendance at the place where its educational activities are carried on as a student in a full-time program, taken for credit at such institution, which combines academic instruction with work experience, if such service is an integral part of such program, and such institution has so certified to the employer, except that this subparagraph shall not apply to service performed in a program established for or on behalf of an employer or group of employers, or

(D) service performed in the employ of a hospital, if such service is performed by a patient of such hospital;

(11) service performed in the employ of a foreign government (including service as a consular or other officer or employee or a nondiplomatic representative);

(12) service performed in the employ of an instrumentality wholly owned by a foreign government—

(A) if the service is of a character similar to that performed in foreign countries by employees of the United States Government or of an instrumentality thereof; and

(B) if the Secretary of State shall certify to the Secretary of the Treasury that the foreign government, with respect to whose instrumentality exemption is claimed, grants an equivalent exemption with respect to similar service performed in the foreign country by employees of the United States Government and of instrumentalities thereof;

(13) service performed as a student nurse in the employ of a hospital or a nurses' training school by an individual who is

enrolled and is regularly attending classes in a nurses' training school chartered or approved pursuant to State law; and service performed as an intern in the employ of a hospital by an individual who has completed a 4 years' course in a medical school chartered or approved pursuant to State law;

(14) service performed by an individual for a person as an insurance agent or as an insurance solicitor, if all such service performed by such individual for such person is performed for remuneration solely by way of commission;

(15)(A) service performed by an individual under the age of 18 in the delivery or distribution of newspapers or shopping news, not including delivery or distribution to any point for subsequent delivery or distribution;

(B) service performed by an individual in, and at the time of, the sale of newspapers or magazines to ultimate consumers, under an arrangement under which the newspapers or magazines are to be sold by him at a fixed price, his compensation being based on the retention of the excess of such price over the amount at which the newspapers or magazines are charged to him, whether or not he is guaranteed a minimum amount of compensation for such service, or is entitled to be credited with the unsold newspapers or magazines turned back;

(16) service performed in the employ of an international organization;

(17) service performed by an individual in (or as an officer or member of the crew of a vessel while it is engaged in) the catching, taking, harvesting, cultivating, or farming of any kind of fish, shellfish, crustacea, sponges, seaweeds, or other aquatic forms of animal and vegetable life (including service performed by any such individual as an ordinary incident to any such activity), except—

(A) service performed in connection with the catching or taking of salmon or halibut, for commercial purposes, and

(B) service performed on or in connection with a vessel of more than 10 net tons (determined in the manner provided for determining the register tonnage of merchant vessels under the laws of the United States);

(18) service described in section 3121(b)(20);

(19) Service[38] which is performed by a nonresident alien individual for the period he is temporarily present in the United States as a nonimmigrant under subparagraph (F), (J), (M), or (Q) of section 101(a)(15) of the Immigration and Nationality Act, as amended, and which is performed to carry out the purpose specified in subparagraph (F), (J), (M), or (Q) as the case may be;

(20) service performed by a full time student (as defined in subsection (q)) in the employ of an organized camp—

(A) if such camp—

(i) did not operate for more than 7 months in the calendar year and did not operate for more than 7 months in the preceding calendar year, or

(ii) had average gross receipts for any 6 months in the preceding calendar year which were not more than

[38] As in original. Probably should be "service".

33 ⅓ percent of its average gross receipts for the other 6 months in the preceding calendar year; and

(B) if such full time student performed services in the employ of such camp for less than 13 calendar weeks in such calendar year; or

(21) service performed by a person committed to a penal institution.

(d) INCLUDED AND EXCLUDED SERVICE.—For purposes of this chapter, if the services performed during one-half or more of any pay period by an employee for the person employing him constitute employment, all the services of such employee for such period shall be deemed to be employment; but if the services performed during more than one-half of any such pay period by an employee for the person employing him do not constitute employment, then none of the services of such employee for such period shall be deemed to be employment. As used in this subsection, the term "pay period" means a period (of not more than 31 consecutive days) for which a payment of remuneration is ordinarily made to the employee by the person employing him. This subsection shall not be applicable with respect to services performed in a pay period by an employee for the person employing him, where any of such service is excepted by subsection (c)(9).

(e) STATE AGENCY.—For purposes of this chapter, the term "State agency" means any State officer, board, or other authority, designated under a State law to administer the unemployment fund in such State.

(f) UNEMPLOYMENT FUND.—For purposes of this chapter, the term "unemployment fund" means a special fund, established under a State law and administered by a State agency, for the payment of compensation. Any sums standing to the account of the State agency in the Unemployment Trust Fund established by section 904 of the Social Security Act, as amended (42 U.S.C. 1104), shall be deemed to be a part of the unemployment fund of the State, and no sums paid out of the Unemployment Trust Fund to such State agency shall cease to be a part of the unemployment fund of the State until expended by such State agency. An unemployment fund shall be deemed to be maintained during a taxable year only if throughout such year, or such portion of the year as the unemployment fund was in existence, no part of the moneys of such fund was expended for any purpose other than the payment of compensation (exclusive of expenses of administration) and for refunds of sums erroneously paid into such fund and refunds paid in accordance with the provisions of section 3305(b); except that—

(1) an amount equal to the amount of employee payments into the unemployment fund of a State may be used in the payment of cash benefits to individuals with respect to their disability, exclusive of expenses of administration;

(2) the amounts specified by section 903(c)(2) or 903(d)(4) of the Social Security Act may, subject to the conditions prescribed in such section, be used for expenses incurred by the State for administration of its unemployment compensation law and public employment offices,

(3) nothing in this subsection shall be construed to prohibit deducting any amount from unemployment compensation otherwise payable to an individual and using the amount so deducted to pay for health insurance, or the withholding of Fed-

eral, State, or local individual income tax, if the individual elected to have such deduction made and such deduction was made under a program approved by the Secretary of Labor;

(4) amounts may be deducted from unemployment benefits and used to repay overpayments as provided in section 303(g) of the Social Security Act;

(5) amounts may be withdrawn for the payment of short-time compensation under a plan approved by the Secretary of Labor; and

(5)[39] amounts may be withdrawn for the payment of allowances under a self–employment assistance program (as defined in subsection (t)).

(g) CONTRIBUTIONS.—For purposes of this chapter, the term "contributions" means payments required by a State law to be made into an unemployment fund by any person on account of having individuals in his employ, to the extent that such payments are made by him without being deducted or deductible from the remuneration of individuals in his employ.

(h) COMPENSATION.—For purposes of this chapter, the term "compensation" means cash benefits payable to individuals with respect to their unemployment.

(i) EMPLOYEE.—For purposes of this chapter, the term "employee" has the meaning assigned to such term by section 3121(d), except that paragraph (4) and subparagraphs (B) and (C) of paragraph (3) shall not apply.

(j) STATE, UNITED STATES, AND AMERICAN EMPLOYER.—For purposes of this chapter—

(1) STATE.—The term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, and the Virgin Islands.

(2) UNITED STATES.—The term "United States" when used in a geographical sense includes the States, the District of Columbia, the Commonwealth of Puerto Rico, and the Virgin Islands.

(3) AMERICAN EMPLOYER.—The term "American employer" means a person who is—

(A) an individual who is a resident of the United States,

(B) a partnership, if two-thirds or more of the partners are residents of the United States,

(C) a trust, if all of the trustees are residents of the United States, or

(D) a corporation organized under the laws of the United States or of any State.

An individual who is a citizen of the Commonwealth of Puerto Rico or the Virgin Islands (but not otherwise a citizen of the United States) shall be considered, for purposes of this section, as a citizen of the United States.

(k) AGRICULTURAL LABOR.—For purposes of this chapter, the term "agricultural labor" has the meaning assigned to such term by subsection (g) of section 3121, except that for purposes of this chapter subparagraph (B) of paragraph (4) of such subsection (g) shall be treated as reading:

"(B) in the employ of a group of operators of farms (or a cooperative organization of which such operators are members) in the performance of service described in subparagraph (A), but only if such operators produced more

[39] As in original.

than one-half of the commodity with respect to which such service is performed; ".

(l) [Repealed.[40]]

(m) AMERICAN VESSEL AND AIRCRAFT.—For purposes of this chapter, the term "American vessel" means any vessel documented or numbered under the laws of the United States; and includes any vessel which is neither documented or numbered under the laws of the United States nor documented under the laws of any foreign country, if its crew is employed solely by one or more citizens or residents of the United States or corporations organized under the laws of the United States or of any State; and the term "American aircraft" means an aircraft registered under the laws of the United States.

(n) VESSELS OPERATED BY GENERAL AGENTS OF UNITED STATES.—Notwithstanding the provisions of subsection (c)(6), service performed by officers and members of the crew of a vessel which would otherwise be included as employment under subsection (c) shall not be excluded by reason of the fact that it is performed on or in connection with an American vessel—

(1) owned by or bareboat chartered to the United States and

(2) whose business is conducted by a general agent of the Secretary of Commerce.

For purposes of this chapter, each such general agent shall be considered a legal entity in his capacity as such general agent, separate and distinct from his identity as a person employing individuals on his own account, and the officers and members of the crew of such an American vessel whose business is conducted by a general agent of the Secretary of Commerce shall be deemed to be performing services for such general agent rather than the United States. Each such general agent who in his capacity as such is an employer within the meaning of subsection (a) shall be subject to all the requirements imposed upon an employer under this chapter with respect to service which constitutes employment by reason of this subsection.

(o) SPECIAL RULE IN CASE OF CERTAIN AGRICULTURAL WORKERS.—

(1) CREW LEADERS WHO ARE REGISTERED OR PROVIDE SPECIALIZED AGRICULTURAL LABOR.—For purposes of this chapter, any individual who is a member of a crew furnished by a crew leader to perform agricultural labor for any other person shall be treated as an employee of such crew leader—

(A) if—

(i) such crew leader holds a valid certificate of registration under the Migrant and Seasonal Agricultural Worker Protection Act; or

(ii) substantially all the members of such crew operate or maintain tractors, mechanized harvesting or crop-dusting equipment, or any other mechanized equipment, which is provided by such crew leader; and

(B) if such individual is not an employee of such other person within the meaning of subsection (i).

(2) OTHER CREW LEADERS.—For purposes of this chapter, in the case of any individual who is furnished by a crew leader to perform agricultural labor for any other person and who is

[40] P. L. 83-767, §4(c); 68 Stat. 1135.

not treated as an employee of such crew leader under paragraph (1)—

(A) such other person and not the crew leader shall be treated as the employer of such individual; and

(B) such other person shall be treated as having paid cash remuneration to such individual in an amount equal to the amount of cash remuneration paid to such individual by the crew leader (either on his behalf or on behalf of such other person) for the agricultural labor performed for such other person.

(3) CREW LEADER.—For purposes of this subsection, the term "crew leader" means an individual who—

(A) furnishes individuals to perform agricultural labor for any other person,

(B) pays (either on his behalf or on behalf of such other person) the individuals so furnished by him for the agricultural labor performed by them, and

(C) has not entered into a written agreement with such other person under which such individual is designated as an employee of such other person.

(p) CONCURRENT EMPLOYMENT BY TWO OR MORE EMPLOYERS.—For purposes of sections 3301, 3302, and 3306(b)(1), if two or more related corporations concurrently employ the same individual and compensate such individual through a common paymaster which is one of such corporations, each such corporation shall be considered to have paid as remuneration to such individual only the amounts actually disbursed by it to such individual and shall not be considered to have paid as remuneration to such individual amounts actually disbursed to such individual by another of such corporations.

(q) FULL TIME STUDENT.—For purposes of subsection (c)(20), an individual shall be treated as a full time student for any period—

(1) during which the individual is enrolled as a full time student at an educational institution, or

(2) which is between academic years or terms if—

(A) the individual was enrolled as a full time student at an educational institution for the immediately preceding academic year or term, and

(B) there is a reasonable assurance that the individual will be so enrolled for the immediately succeeding academic year or term after the period described in subparagraph (A).

(r) TREATMENT OF CERTAIN DEFERRED COMPENSATION AND SALARY REDUCTION ARRANGEMENTS.—

(1) CERTAIN EMPLOYER CONTRIBUTIONS TREATED AS WAGES.—Nothing in any paragraph of subsection (b) (other than paragraph (1)) shall exclude from the term "wages"—

(A) any employer contribution under a qualified cash or deferred arrangement (as defined in section 401(k)) to the extent not included in gross income by reason of section 402(e)(3), or

(B) any amount treated as an employer contribution under section 414(h)(2) where the pickup referred to in such section is pursuant to a salary reduction agreement (whether evidenced by a written instrument or otherwise).

(2) TREATMENT OF CERTAIN NONQUALIFIED DEFERRED COMPENSATION PLANS.—

(A) IN GENERAL.—Any amount deferred under a nonqualified deferred compensation plan shall be taken into account for purposes of this chapter as of the later of—

(i) when the services are performed, or

(ii) when there is no substantial risk of forfeiture of the rights to such amount.

(B) TAXED ONLY ONCE.—Any amount taken into account as wages by reason of subparagraph (A) (and the income attributable thereto) shall not thereafter be treated as wages for purposes of this chapter.

(C) NONQUALIFIED DEFERRED COMPENSATION PLAN.—For purposes of this paragraph, the term "nonqualified deferred compensation plan" means any plan or other arrangement for deferral of compensation other than a plan described in subsection (b)(5).

(s) TIPS TREATED AS WAGES.—For purposes of this chapter, the term "wages" includes tips which are—

(1) received while performing services which constitute employment, and

(2) included in a written statement furnished to the employer pursuant to section 6053(a).

(t) SELF–EMPLOYMENT ASSISTANCE PROGRAM.—For the purposes of this chapter, the term "self–employment assistance program" means a program under which—

(1) individuals who meet the requirements described in paragraph (3) are eligible to receive an allowance in lieu of regular unemployment compensation under the State law for the purpose of assisting such individuals in establishing a business and becoming self–employed;

(2) the allowance payable to individuals pursuant to paragraph (1) is payable in the same amount, at the same interval, on the same terms, and subject to the same conditions, as regular unemployment compensation under the State law, except that—

(A) State requirements relating to availability for work, active search for work, and refusal to accept work are not applicable to such individuals;

(B) State requirements relating to disqualifying income are not applicable to income earned from self–employment by such individuals; and

(C) such individuals are considered to be unemployed for the purposes of Federal and State laws applicable to unemployment compensation,

as long as such individuals meet the requirements applicable under this subsection;

(3) individuals may receive the allowance described in paragraph (1) if such individuals—

(A) are eligible to receive regular unemployment compensation under the State law, or would be eligible to receive such compensation except for the requirements described in subparagraph (A) or (B) of paragraph (2);

(B) are identified pursuant to a State worker profiling system as individuals likely to exhaust regular unemployment compensation; and

(C) are participating in self–employment assistance activities which—

(i) include entrepreneurial training, business counseling, and technical assistance; and

(ii) are approved by the State agency; and

(D) are actively engaged on a full–time basis in activities (which may include training) relating to the establishment of a business and becoming self–employed;

(4) the aggregate number of individuals receiving the allowance under the program does not at any time exceed 5 percent of the number of individuals receiving regular unemployment compensation under the State law at such time;

(5) the program does not result in any cost to the Unemployment Trust Fund (established by section 904(a) of the Social Security Act) in excess of the cost that would be incurred by such State and charged to such fund if the State had not participated in such program; and

(6) the program meets such other requirements as the Secretary of Labor determines to be appropriate.

(u) INDIAN TRIBE.—For purposes of this chapter, the term "Indian tribe" has the meaning given to such term by section 4(e) of the Indian Self–Determination and Education Assistance Act (25 U.S.C. 450b(e)), and includes any subdivision, subsidiary, or business enterprise wholly owned by such an Indian tribe.

SEC. 3307. DEDUCTIONS AS CONSTRUCTIVE PAYMENTS.

Whenever under this chapter or any act of Congress, or under the law of any State, an employer is required or permitted to deduct any amount from the remuneration of an employee and to pay the amount deducted to the United States, a State, or any political subdivision thereof, then for purposes of this chapter the amount so deducted shall be considered to have been paid to the employee at the time of such deduction.

SEC. 3308. INSTRUMENTALITIES OF THE UNITED STATES.

Notwithstanding any other provision of law (whether enacted before or after the enactment of this section) which grants to any instrumentality of the United States an exemption from taxation, such instrumentality shall not be exempt from the tax imposed by section 3301 unless such other provision of law grants a specific exemption, by reference to section 3301 (or the corresponding section of prior law), from the tax imposed by such section.

SEC. 3309. STATE LAW COVERAGE OF SERVICES PERFORMED FOR NONPROFIT ORGANIZATIONS OR GOVERNMENTAL ENTITIES.

(a) STATE LAW REQUIREMENTS.—For purposes of section 3304(a)(6)—

(1) except as otherwise provided in subsections (b) and (c), the services to which this paragraph applies are—

(A) service excluded from the term "employment" solely by reason of paragraph (8) of section 3306(c), and

(B) service excluded from the term "employment" solely by reason of paragraph (7) of section 3306(c); and

(2) the State law shall provide that a governmental entity, including an Indian tribe, or any other organization (or group of governmental entities or other organizations) which, but for

the requirements of this paragraph, would be liable for contributions with respect to service to which paragraph (1) applies may elect, for such minimum period and at such time as may be provided by State law, to pay (in lieu of such contributions) into the State unemployment fund amounts equal to the amounts of compensation attributable under the State law to such service. The State law may provide safeguards to ensure that governmental entities or other organizations so electing will make the payments required under such elections.

(b) SECTION NOT TO APPLY TO CERTAIN SERVICE.—This section shall not apply to service performed—

(1) in the employ of (A) a church or convention or association of churches, (B) an organization which is operated primarily for religious purposes and which is operated, supervised, controlled, or principally supported by a church or convention or association of churches, or (C) an elementary or secondary school which is operated primarily for religious purposes, which is described in section 501(c)(3), and which is exempt from tax under section 501(a);

(2) by a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry or by a member of a religious order in the exercise of duties required by such order;

(3) in the employ of a governmental entity referred to in paragraph (7) of section 3306(c), if such service is performed by an individual in the exercise of his duties—

(A) as an elected official;

(B) as a member of a legislative body, or a member of the judiciary, of a State or political subdivision thereof, or of an Indian tribe;

(C) as a member of the State National Guard or Air National Guard;

(D) as an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or similar emergency;

(E) in a position which, under or pursuant to the State or tribal law, is designated as (i) a major nontenured policymaking or advisory position, or (ii) a policymaking or advisory position the performance of the duties of which ordinarily does not require more than 8 hours per week; or

(F) as an election official or election worker if the amount of remuneration received by the individual during the calendar year for services as an election official or election worker is less than $1,000;

(4) in a facility conducted for the purpose of carrying out a program of—

(A) rehabilitation for individuals whose earning capacity is impaired by age or physical or mental deficiency or injury, or

(B) providing remunerative work for individuals who because of their impaired physical or mental capacity cannot be readily absorbed in the competitive labor market,

by an individual receiving such rehabilitation or remunerative work;

(5) as part of an unemployment work-relief or work-training program assisted or financed in whole or in part by any Fed-

eral agency or an agency of a State or political subdivision thereof or of an Indian tribe, by an individual receiving such work relief or work training; and

(6) by an inmate of a custodial or penal institution.

(c) NONPROFIT ORGANIZATIONS MUST EMPLOY 4 OR MORE.—This section shall not apply to service performed during any calendar year in the employ of any organization unless on each of some 20 days during such calendar year or the preceding calendar year, each day being in a different calendar week, the total number of individuals who were employed by such organization in employment (determined without regard to section 3306(c)(8) and by excluding service to which this section does not apply by reason of subsection (b)) for some portion of the day (whether or not at the same moment of time) was 4 or more.

(d) ELECTION BY INDIAN TRIBE.—The State law shall provide that an Indian tribe may make contributions for employment as if the employment is within the meaning of section 3306 or make payments in lieu of contributions under this section, and shall provide that an Indian tribe may make separate elections for itself and each subdivision, subsidiary, or business enterprise wholly owned by such Indian tribe. State law may require a tribe to post a payment bond or take other reasonable measures to assure the making of payments in lieu of contributions under this section. Notwithstanding the requirements of section 3306(a)(6), if, within 90 days of having received a notice of delinquency, a tribe fails to make contributions, payments in lieu of contributions, or payment of penalties or interest (at amounts or rates comparable to those applied to all other employers covered under the State law) assessed with respect to such failure, or if the tribe fails to post a required payment bond, then service for the tribe shall not be excepted from employment under section 3306(c)(7) until any such failure is corrected. This subsection shall apply to an Indian tribe within the meaning of section 4(e) of the Indian Self–Determination and Education Assistance Act (25 U.S.C. 450b(e)).

SEC. 3310. JUDICIAL REVIEW.

(a) IN GENERAL.—Whenever under section 3303(b) or section 3304(c) the Secretary of Labor makes a finding pursuant to which he is required to withhold a certification with respect to a State under such section, such State may, within 60 days after the Governor of the State has been notified of such action, file with the United States court of appeals for the circuit in which such State is located or with the United States Court of Appeals for the District of Columbia, a petition for review of such action. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary of Labor. The Secretary of Labor thereupon shall file in the court the record of the proceedings on which he based his action as provided in section 2112 of title 28 of the United States Code.[41]

(b) FINDINGS OF FACT.—The findings of fact by the Secretary of Labor, if supported by substantial evidence, shall be conclusive; but the court, for good cause shown, may remand the case to the Secretary of Labor to take further evidence, and the Secretary of Labor may thereupon make new or modified findings of fact and

[41] See Vol. II, title 28.

may modify his previous action, and shall certify to the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence.

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

(d) STAY OF SECRETARY OF LABOR'S ACTION.—

(1) The Secretary of Labor shall not withhold any certification under section 3303(b) or section 3304(c) until the expiration of 60 days after the Governor of the State has been notified of the action referred to in subsection (a) or until the State has filed a petition for review of such action, whichever is earlier.

(2) The commencement of judicial proceedings under this section shall stay the Secretary of Labor's action for a period of 30 days, and the court may thereafter grant interim relief if warranted, including a further stay of the Secretary of Labor's action and including such other relief as may be necessary to preserve status or rights.

SEC. 3311. SHORT TITLE.

This chapter may be cited as the "Federal Unemployment Tax Act."

* * * *

SEC. 3402. INCOME TAX COLLECTED AT SOURCE.

* * * *

(i) CHANGES IN WITHHOLDING.—

(1) IN GENERAL.—The Secretary may by regulations provide for increases in the amount of withholding otherwise required under this section in cases where the employee requests such changes.

(2) TREATMENT AS TAX.—Any increased withholding under paragraph (1) shall for all purposes be considered tax required to be deducted and withheld under this chapter.

* * * *

SEC. 3507. ADVANCE PAYMENT OF EARNED INCOME CREDIT.

(a) GENERAL RULE.—Except as otherwise provided in this section, every employer making payment of wages to an employee with respect to whom an earned income eligibility certificate is in effect shall, at the time of paying such wages, make an additional payment to such employee equal to such employee's earned income advance amount.

(b) EARNED INCOME ELIGIBILITY CERTIFICATE.—For purposes of this title, an earned income eligibility certificate is a statement furnished by an employee to the employer which—

(1) certifies that the employee will be eligible to receive the credit provided by section 32 for the taxable year,

(2) certifies that the employee has 1 or more qualifying children (within the meaning of section 32(c)(3)) for such taxable year,

(3) certifies that the employee does not have an earned income eligibility certificate in effect for the calendar year with respect to the payment of wages by another employer, and

(4) states whether or not the employee's spouse has an earned income eligibility certificate in effect.

For purposes of this section, a certificate shall be treated as being in effect with respect to a spouse if such a certificate will be in effect on the first status determination date following the date on which the employee furnishes the statement in question.

(c) EARNED INCOME ADVANCE AMOUNT.—

(1) IN GENERAL.—For purposes of this title, the term "earned income advance amount" means, with respect to any payroll period, the amount determined—

(A) on the basis of the employee's wages from the employer for such period, and

(B) in accordance with tables prescribed by the Secretary.

In the case of an employee who is a member of the Armed Forces of the United States, the earned income advance amount shall be determined by taking into account such employee's earned income as determined for purposes of section 32.

(2) ADVANCE AMOUNT TABLES.—The tables referred to in paragraph (1)(B)—

(A) shall be similar in form to the tables prescribed under section 3402 and, to the maximum extent feasible, shall be coordinated with such tables, and

(B) if the employee is not married, or if no earned income eligibility certificate is in effect with respect to the spouse of the employee, shall treat the credit provided by section 32 as if it were a credit—

(i) of not more than 60 percent of the credit percentage in effect under section 32(b)(1) for an eligible individual with 1 qualifying child and with earned income not in excess of the earned income amount in effect under section 32(b)(2) for such an eligible individual, which

(ii) phases out at 60 percent of the phaseout percentage in effect under section 32(b)(1) for such an eligible individual between the phaseout amount in effect under section 32(b)(2) for such an eligible individual and the amount of earned income at which the credit under section 32(a) phases out for such an eligible, or

(C) if an earned income eligibility certificate is in effect with respect to the spouse of the employee, shall treat the credit as if it were a credit determined under subparagraph (B) by substituting ½ of the amounts of earned income described in such subparagraph for such amounts.

(d) PAYMENTS TO BE TREATED AS PAYMENTS OF WITHHOLDING AND FICA TAXES.

(1) IN GENERAL.—For purposes of this title, payments made by an employer under subsection (a) to his employees for any payroll period—

(A) shall not be treated as the payment of compensation, and

(B) shall be treated as made out of—

(i) amounts required to be deducted and withheld for the payroll period under section 3401 (relating to wage withholding), and

(ii) amounts required to be deducted for the payroll period under section 3102 (relating to FICA employee taxes), and

(iii) amounts of the taxes imposed for the payroll period under section 3111 (relating to FICA employer taxes),

as if the employer had paid to the Secretary, on the day on which the wages are paid to the employees, an amount equal to such payments.

(2) ADVANCE PAYMENTS EXCEED TAXES DUE.—In the case of any employer, if for any payroll period the aggregate amount of earned income advance payments exceeds the sum of the amounts referred to in paragraph (1)(B), each such advance payment shall be reduced by an amount which bears the same ratio to such excess as such advance payment bears to the aggregate amount of all such advance payments.

(3) EMPLOYER MAY MAKE FULL ADVANCE PAYMENTS.—The Secretary shall prescribe regulations under which an employer may elect (in lieu of any application of paragraph (2))—

(A) to pay in full all earned income advance amounts, and

(B) to have additional amounts paid by reason of this paragraph treated as the advance payment of taxes imposed by this title.

(4) FAILURE TO MAKE ADVANCE PAYMENTS.—For purposes of this title (including penalties), failure to make any advance payment under this section at the time provided therefor shall be treated as the failure at such time to deduct and withhold under chapter 24 an amount equal to the amount of such advance payment.

(e) FURNISHING AND TAKING EFFECT OF CERTIFICATES.—For purposes of this section—

(1) WHEN CERTIFICATE TAKES EFFECT.—

(A) FIRST CERTIFICATE FURNISHED.—An earned income eligibility certificate furnished the employer in cases in which no previous such certificate had been in effect for the calendar year shall take effect as of the beginning of the first payroll period ending, or the first payment of wages made without regard to a payroll period, on or after the date on which such certificate is so furnished (or if later, the first day of the calendar year for which furnished).

(B) LATER CERTIFICATE.—An earned income eligibility certificate furnished the employer in cases in which a previous such certificate had been in effect for the calendar year shall take effect with respect to the first payment of wages made on or after the first status determination date

which occurs at least 30 days after the date on which such certificate is so furnished, except that at the election of the employer such certificate may be made effective with respect to any payment of wages made on or after the date on which such certificate is so furnished. For purposes of this section, the term "status determination date" means January 1, May 1, July 1, and October 1 of each year.

(2) PERIOD DURING WHICH CERTIFICATE REMAINS IN EFFECT.—An earned income eligibility certificate which takes effect under this section for any calendar year shall continue in effect with respect to the employee during such calendar year until revoked by the employee or until another such certificate takes effect under this section.

(3) CHANGE OF STATUS.—

(A) REQUIREMENT TO REVOKE OR FURNISH NEW CERTIFICATE.—If, after an employee has furnished an earned income eligibility certificate under this section, there has been a change of circumstances which has the effect of—

(i) making the employee ineligible for the credit provided by section 32 for the taxable year, or

(ii) causing an earned income eligibility certificate to be in effect with respect to the spouse of the employee,

the employee shall, within 10 days after such change in circumstances, furnish the employer with a revocation of such certificate or with a new certificate (as the case may be). Such a revocation (or such a new certificate) shall take effect under the rules provided by paragraph (1)(B) for a later certificate and shall be made in such form as the Secretary shall by regulations prescribe.

(B) CERTIFICATE NO LONGER IN EFFECT.—If, after an employee has furnished an earned income eligibility certificate under this section which certifies that such a certificate is in effect with respect to the spouse of the employee, such a certificate is no longer in effect with respect to such spouse, then the employee may furnish the employer with a new earned income eligibility certificate.

(4) FORM AND CONTENTS OF CERTIFICATE.—Earned income eligibility certificates shall be in such form and contain such other information as the Secretary may by regulations prescribe.

(5) TAXABLE YEAR DEFINED.—The term " taxable year" means the last taxable year of the employee under subtitle A beginning in the calendar year in which the wages are paid.

(f) INTERNAL REVENUE SERVICE NOTIFICATION.—The Internal Revenue Service shall take such steps as may be appropriate to ensure that taxpayers who have 1 or more qualifying children and who receive a refund of the credit under section 32 are aware of the availability of earned income advance amounts under this section.

SEC. 3508. TREATMENT OF REAL ESTATE AGENTS AND DIRECT SELLERS.

(a) GENERAL RULE.—For purposes of this title, in the case of services performed as a qualified real estate agent or as a direct seller—

(1) the individual performing such services shall not be treated as an employee, and

(2) the person for whom such services are performed shall not be treated as an employer.

(b) DEFINITIONS.—For purposes of this section—

(1) QUALIFIED REAL ESTATE AGENT.—The term "qualified real estate agent" means any individual who is a sales person if—

(A) such individual is a licensed real estate agent,

(B) substantially all of the remuneration (whether or not paid in cash) for the services performed by such individual as a real estate agent is directly related to sales or other output (including the performance of services) rather than to the number of hours worked, and

(C) the services performed by the individual are performed pursuant to a written contract between such individual and the person for whom the services are performed and such contract provides that the individual will not be treated as an employee with respect to such services for Federal tax purposes.

(2) DIRECT SELLER.—The term "direct seller" means any person if—

(A) such person—

(i) is engaged in the trade or business of selling (or soliciting the sale of) consumer products to any buyer on a buy-sell basis, a deposit-commission basis, or any similar basis which the Secretary prescribes by regulations, for resale (by the buyer or any other person) in the home or otherwise than in a permanent retail establishment,

(ii) is engaged in the trade or business of selling (or soliciting the sale of) consumer products in the home or otherwise than in a permanent retail establishment, or

(iii) is engaged in the trade or business of the delivering or distribution of newspapers or shopping news (including any services directly related to such trade or business),

(B) substantially all the remuneration (whether or not paid in cash) for the performance of the services described in subparagraph (A) is directly related to sales or other output (including the performance of services) rather than to the number of hours worked, and

(C) the services performed by the person are performed pursuant to a written contract between such person and the person for whom the services are performed and such contract provides that the person will not be treated as an employee with respect to such services for Federal tax purposes.

(3) COORDINATION WITH RETIREMENT PLANS FOR SELF-EMPLOYED.—This section shall not apply for purposes of subtitle A to the extent that the individual is treated as an employee under section 401(c)(1) (relating to self-employed individuals).

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