increase factor (described in clause (ii)) for that subsequent fiscal year.

"(ii) PERCENTAGE INCREASE FACTOR.—For purposes of this subparagraph, the 'percentage increase factor' for a fiscal year is equal to zero or, if greater, the percentage by which (I) the State percentage growth factor (as defined in subparagraph (C)) for the fiscal year, exceeds (II) the percentage increase in the consumer price index for all urban consumers (U.S. city average) during the 12-month period beginning with July before the beginning of the fiscal year.

"(C) STATE PERCENTAGE GROWTH FACTOR.—In this paragraph, the term 'State percentage growth factor' means, for a State for a fiscal year, the percentage by which (i) the State outlay allotment for the State for the fiscal year (determined under this section without regard to this subsection or subsection (f) or (h)), exceeds (ii) such outlay allotment for such State for the preceding fiscal year (as so determined).

"(D) INDIVIDUALS COUNT ONLY ONCE.—An individual may at any time not be counted in more than one supplemental allotment population group.

"(4) APPLICABLE PER BENEFICIARY AMOUNT.—

"(A) IN GENERAL.—In this subsection, subject to subparagraph (D), the 'applicable per beneficiary amount', for a State for a fiscal year for a supplemental allotment population group, is equal to the base per beneficiary amount (determined under subparagraph (B)) for the State for the group, increased by the Secretary's estimate of the increase in the per beneficiary expenditures under this title (and title XIX) for States between fiscal year 1995 and fiscal year 1996, and further increased (for each subsequent fiscal year up to the fiscal year involved and in a compounded

manner) by the CPI increase factor (as defined in subparagraph (C)) for each such fiscal year.

"(B) BASE PER BENEFICIARY AMOUNT.—

"(i) IN GENERAL.—The Secretary shall determine for each State a base per beneficiary amount for each supplemental allotment population group equal to—

"(I) the sum of the total expenditure amounts described in clauses (ii) and (iii), divided by

"(II) the full-year equivalent number of such individuals in such group enrolled under the State plan under title XIX for fiscal year 1995.

"(ii) MEDICAL ASSISTANCE EXPENDITURES.—The total expenditure amount described in this clause, with respect to a supplemental allotment population group, is the total amount of expenditures for which Federal financial participation was provided to the State under paragraphs (1) and (5) of section 1903(a) for fiscal year 1995 with respect to medical assistance furnished with respect to individuals included in such group. Such amount shall not include expenditures attributable to payment adjustments under section 1923.

"(iii) ADMINISTRATIVE EXPENDITURES.—The total expenditure amount described in this clause, with respect to a supplemental allotment population group, is the product of—

"(I) the total amount of administrative expenditures for which Federal financial participation was provided to the State under section 1903(a) (other than paragraphs (1) and (5) of such section) for fiscal year 1995, and

"(II) the ratio described in clause (iv) for the population group.

"(iv) RATIO DESCRIBED.—The ratio described in this clause for a group is the ratio of—

"(I) the total amount of expenditures described in clause (ii) for the group, to

"(II) the total amount of expenditures described in such clause for all individuals under the State plan under title XIX in the base fiscal year.

"(C) CPI INCREASE FACTOR.—In subparagraph (A), the 'CPI increase factor' for a fiscal year is the percentage by which—

"(i) the Secretary's estimate of the average value of the consumer price index for all urban consumers (all items, U.S. city average) for months in the fiscal year, exceeds

"(ii) the average value of such index for months in the previous fiscal year.

"(D) SPECIAL RULES FOR CERTAIN MEDICARE BENEFICIARIES.—

"(i) QUALIFIED DISABLED AND WORKING INDIVIDUALS.—In the case of the supplemental allotment population group described in paragraph (2)(F), the 'applicable per beneficiary amount', for all States for a fiscal year is the sum of the medicare premiums applied under section 1818A for months in the fiscal year.

"(ii) OTHER MEDICARE BENEFICIARIES.—In the case of the supplemental allotment population group described in paragraph (2)(G), the 'applicable per beneficiary amount', for all States for a fiscal year is the sum of the medicare premiums applied under section 1839 for months in the fiscal year.

"(5) CONDITIONS FOR ACCESS TO UMBRELLA SUPPLEMENTAL ALLOTMENT.—

"(A) IN GENERAL.—A State may receive a supplemental umbrella allotment under this subsection for a fiscal year only if the following conditions are met:

"(i) The State provides assurances satisfactory to the Secretary that it will obligate during the fiscal year the full amount of the allotment otherwise provided under this section for the fiscal year.

"(ii) The State provides assurances satisfactory to the Secretary that any amount attributable to a carryover from a previous fiscal year under subsection (a)(2)(B) shall also be obligated under the plan by the end of the fiscal year.

"(iii) The State submits to the Secretary on a periodic basis such reports on numbers of individuals within each supplemental allotment population group as the Secretary may determine necessary to assure the accuracy of the supplemental umbrella allotments under this subsection. The Secretary may not require the submission of such reports more frequently than quarterly.

"(iv) The State provides assurances satisfactory to the Secretary that it has in effect such data collection procedures as may be necessary to provide for the reports described in clause (iii).

"(B) ESTIMATE.—The amount of any supplemental allotment under this subsection shall be estimated in advance of the fiscal year involved, based on data required to be reported under subparagraph (A)(iii). The Secretary is authorized to adjust such data on a preliminary basis if the Secretary determines that the estimates do not reasonably reflect the actual excess number of individuals in the supplemental allotment population groups for the fiscal year involved. Section 1512(b)(6) provides for adjustment of payments of the supplemental allotment under this subsection based on a final determination using data on

actual numbers of individual in each supplemental allotment population group.

"(6) ADJUSTMENT IN ALLOTMENT FOR SAVINGS FROM SLOWER POPULATION GROWTH.—

"(A) IN GENERAL.—The amount of the supplemental umbrella allotment to a State under this subsection for a fiscal year shall be reduced (but not below zero) by the sum, for each supplemental allotment population group described in paragraph (2), of the product of the following:

"(i) LESS-THAN-ANTICIPATED NUMBER OF INDIVIDUALS.—The less-than-anticipated number of individuals (if any, determined under subparagraph (B)) for State and the fiscal year who are in the population group.

"(ii) APPLICABLE PER BENEFICIARY AMOUNT.—The applicable per beneficiary amount (determined under paragraph (4)) for the State and fiscal year for the population group.

"(iii) FMAP.—The old Federal medical assistance percentage (as defined in section 1512(d)) for the State and fiscal year.

"(B) LESS-THAN-ANTICIPATED NUMBER OF INDIVIDUALS.—In this paragraph, the 'less-than-anticipated number of individuals', for a State for a fiscal year with respect to a supplemental allotment population group, is equal to the amount (if any) by which—

"(i) the anticipated number of such individuals (as determined under paragraph (3)(B)) for the State and fiscal year in such group, exceeds

"(ii) the number of full-year equivalent individuals in the population group for the State and fiscal year.

"(7) SPECIAL RULE FOR FISCAL YEAR 1997.—In applying this subsection to fiscal year 1997—

"(A) in determining the excess number of individuals under paragraph (3)—

"(i) the number of full-year equivalent individuals shall only be determined based on the portion of fiscal year 1997 in which the State plan is in effect under this title, and

"(ii) the anticipated number of such individuals (referred to in paragraph (3)(A)(ii)) shall be the anticipated number otherwise determined multiplied by the proportion of fiscal year 1997 in which such State plan will be in effect; and

"(B) if the State plan is effective before April 1, 1997, the amount of the supplemental allotment otherwise determined under this subsection shall be multiplied by the ratio of the portion of fiscal year 1997 that occurs on or after April 1, 1997, to the total portion of such fiscal year in which the State plan is in effect.

"(h) ALLOTMENT FOR MEDICAL ASSISTANCE FOR SERVICES PROVIDED IN INDIAN HEALTH SERVICE AND RELATED FACILITIES.—

"(1) IN GENERAL.—For purposes of this section for each of fiscal years 1998 through 2002 in the case of a subsection (h) supplemental allotment eligible State, the amount of the supplemental allotment under this subsection is the amount provided under paragraph (2) for the State for that year. Such amount may only be used for the purpose of providing medical assistance described in section 1512(f)(3) (relating to services provided by the Indian Health Service and related facilities).

"(2) SUPPLEMENTAL OUTLAY ALLOTMENT.—

"(A) IN GENERAL.—For purposes of paragraph (1), the amount under this paragraph for a subsection (h) supplemental allotment eligible State for a fiscal year is equal to the subsection (h) supplemental allotment ratio (as defined in subparagraph (C)) multiplied

by the subsection (h) supplemental pool amount (specified in subparagraph (D)) for the fiscal year.

"(B) SUBSECTION (h) SUPPLEMENTAL ALLOTMENT ELIGIBLE STATE.—In this subsection, the term 'subsection (h) supplemental allotment eligible State' means a State that has one or more facilities described in section 1512(f)(3)(A).

"(C) SUBSECTION (h) SUPPLEMENTAL ALLOTMENT RATIO.—In this paragraph, the 'subsection (h) supplemental allotment ratio' for a State is the ratio of—

"(i) the number of Indians residing in the State, to

"(ii) the sum of such numbers for all subsection (h) supplemental allotment eligible States.

"(D) SUBSECTION (h) SUPPLEMENTAL POOL AMOUNT.—In this paragraph, the 'subsection (h) supplemental pool amount', for—

"(i) fiscal year 1998 is $89,090,082,

"(ii) fiscal year 1999 is $94,238,788,

"(iii) fiscal year 2000 is $99,685,050,

"(iv) fiscal year 2001 is $105,446,063, and

"(v) fiscal year 2002 is $111,540,017.

"(E) DETERMINATION OF NUMBER.—The number of Indians residing in a State under this paragraph for a fiscal year shall be based on the most recent available estimate of the Secretary of the Interior.

"(3) INDIAN DEFINED.—The term 'Indian' has the meaning given such term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d)).

"SEC. 1512. PAYMENTS TO STATES.

"(a) AMOUNT OF PAYMENT.—From the allotment of a State under section 1511 for a fiscal year, subject to the succeeding provisions of this title, the Secretary shall pay to each State which has a State plan approved under part C, for each quarter in the fiscal year—

"(1) an amount equal to the applicable Federal medical assistance percentage (as defined in subsection (c)) of the total amount expended during such quarter as medical assistance under the plan; plus

"(2) an amount equal to the applicable Federal medical assistance percentage of the total amount expended during such quarter for medically-related services (as defined in section 1571(g)); plus

"(3) subject to section 1513(c)—

"(A) an amount equal to 90 percent of the amounts expended during such quarter for the design, development, and installation of information systems and for providing incentives to promote the enforcement of medical support orders, plus

"(B) an amount equal to 75 percent of the amounts expended during such quarter for medical personnel, administrative support of medical personnel, operation and maintenance of information systems, modification of information systems, quality assurance activities, utilization review, medical and peer review, anti-fraud activities, independent evaluations, coordination of benefits, and meeting reporting requirements under this title, plus

"(C) an amount equal to 50 percent of so much of the remainder of the amounts expended during such quarter as are expended by the State in the administration of the State plan.

"(b) PAYMENT PROCESS.—

"(1) QUARTERLY ESTIMATES.—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 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) PAYMENT.—

"(A) IN GENERAL.—The Secretary shall then pay to the State, in such installments as the Secretary may determine and in accordance with section 6503(a) of title 31, United States Code, the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section (or section 1903) to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection (or under section 1903(d)).

"(B) TREATMENT AS OVERPAYMENTS.—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 1555.

"(C) RECOVERY OF OVERPAYMENTS.—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) NO ADJUSTMENT FOR UNCOLLECTABLES.—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).

"(3) FEDERAL SHARE OF RECOVERIES.—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.

"(4) TIMING OF OBLIGATION OF FUNDS.—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) DISALLOWANCES.—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) or in the case described in paragraph (6)(C), and such State disputes such disallowance or an adjustment under such paragraph, 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 aver-

age of the bond equivalent of the weekly 90-day treasury bill auction rates during such period.

"(6) ADJUSTMENTS IN PAYMENTS REFLECTING OVER- AND UNDER-ESTIMATIONS OF SUPPLEMENTAL UMBRELLA ALLOTMENT.—

"(A) IN GENERAL.—Based on data reported under section 1511(g)(5)(A)(iii) and annual audits provided for under section 1551(a) on the actual excess number of individuals in each population group for a fiscal year, the Secretary shall determine the final amount of the supplemental umbrella allotment for each State for the fiscal year and whether, based on such final amount, the amount of payment made for the fiscal year was greater, or less, than the amount that should have been paid if payments had been made based on such final amount.

"(B) PAYMENT IN CASE OF UNDERESTIMATION.—If the Secretary determines under subparagraph (A) there was an underpayment to a State, the Secretary shall increase the amount of the next quarterly payment under this section to the State by the amount of such underpayment.

"(C) OFFSETTING OF PAYMENTS IN CASE OF OVERESTIMATION.—If the Secretary determines under subparagraph (A) there was an overpayment to a State, the Secretary shall, subject to the procedures provided under paragraph (5), decrease the amount of the payment for the next quarter (or, at the discretion of the Secretary, over a period of not more than 4 calendar quarters) by the amount of such overpayment. In the case in which a State seeks review of such a determination in accordance with the procedures under paragraph (5), the Secretary shall provide for completion of such review process within 1 year after the date the State requests such review.

"(c) APPLICABLE FEDERAL MEDICAL ASSISTANCE PERCENTAGE DEFINED.—In this section, except as provided in subsection (f), the term 'applicable Federal medical assistance percentage' means, with respect to one of the 50 States or the District of Columbia, at the State's or District's option—

"(1) the old Federal medical assistance percentage (as determined in subsection (d));

"(2) the lesser of—

"(A) new Federal medical assistance percentage (as determined under subsection (e)) or

"(B) the old Federal medical assistance percentage plus 10 percentage points; or

"(3) 60 percent.

"(d) OLD FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—

"(1) IN GENERAL.—Except as provided in paragraph (2) and subsection (f), the term 'old Federal medical assistance percentage' for any State is 100 percent less the State percentage; and the State percentage is that percentage which bears the same ratio to 45 percent 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.

"(2) LIMITATION ON RANGE.—In no case shall the old Federal medical assistance percentage be less than 50 percent or more than 83 percent.

"(3) PROMULGATION.—The old Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of section 1101(a)(8)(B).

"(e) NEW FEDERAL MEDICAL ASSISTANCE PERCENTAGE DEFINED.—

"(1) IN GENERAL.—

"(A) TERM DEFINED.—Except as provided in paragraph (3) and subsection (f), the term 'new Federal medical assistance percentage' means, for each of

the 50 States and the District of Columbia, 100 percent reduced by the product 0.39 and the ratio of—

"(i)(I) for each of the 50 States, the total taxable resources (TTR) ratio of the State specified in subparagraph (B), or

"(II) for the District of Columbia, the per capita income ratio specified in subparagraph (C),

to—

"(ii) the aggregate expenditure need ratio of the State or District, as described in subparagraph (D).

"(B) TOTAL TAXABLE RESOURCES (TTR) RATIO.—For purposes of subparagraph (A)(i)(I), the total taxable resources (TTR) ratio for each of the 50 States is—

"(i) an amount equal to the most recent 3-year average of the total taxable resources (TTR) of the State, as determined by the Secretary of the Treasury, divided by

"(ii) an amount equal to the sum of the 3-year averages determined under clause (i) for each of the 50 States.

"(C) PER CAPITA INCOME RATIO.—For purposes of subparagraph (A)(i)(II), the per capita income ratio of the District of Columbia is—

"(i) an amount equal to the most recent 3-year average of the total personal income of the District of Columbia, as determined in accordance with the provisions of section 1101(a)(8)(B), divided by

"(ii) an amount equal to the total personal income of the continental United States (including Alaska) and Hawaii, as determined under section 1101(a)(8)(B).

"(D) AGGREGATE EXPENDITURE NEED RATIO.—For purposes of subparagraph (A), with respect to each

of the 50 States and the District of Columbia for a fiscal year, the aggregate expenditure need ratio is—

"(i) the State aggregate expenditure need (as defined in section 1511(d)) for the State for the fiscal year, divided by

"(ii) the sum of such State aggregate expenditure needs for the 50 States and the District of Columbia for the fiscal year.

"(2) LIMITATION ON RANGE.—Except as provided in subsection (f), the new Federal medical assistance percentage shall in no case be less than 40 percent or greater than 83 percent.

"(3) PROMULGATION.—The new Federal medical assistance percentage for any State shall be promulgated in a timely manner consistent with the promulgation of the old Federal medical assistance percentage under section 1101(a)(8)(B).

"(f) SPECIAL RULES.—For purposes of this title—

"(1) COMMONWEALTHS AND TERRITORIES.—In the case of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa, the old and new Federal medical assistance percentages are 50 percent.

"(2) ALASKA.—In the case of Alaska, the old Federal medical assistance percentage is that percentage which bears the same ratio to 45 percent as the square of the adjusted per capita income of such State bears to the square of the per capita income of the continental United States. For purposes of the preceding sentence, the adjusted per capita income for Alaska shall be determined by dividing the State's most recent 3-year average per capita by the health care cost index for such State (as determined under section 1511(d)(3)).

"(3) INDIAN HEALTH SERVICE AND RELATED FACILITIES.—The old and new Federal medical assistance percentages shall be 100 percent with respect to the amounts expended as medical assistance for services provided by—

"(A) an Indian Health Service facility;

"(B) an Indian health program operated by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act) pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service under the Indian Self-Determination Act; or

"(C) an urban Indian health program operated by an urban Indian organization pursuant to a grant or contract with the Indian Health Service under title V of the Indian Health Care Improvement Act.

"(4) NO STATE MATCHING REQUIRED FOR CERTAIN EXPENDITURES.—In applying subsection (a)(1) with respect to medical assistance provided to unlawful aliens pursuant to the exception specified in section 1513(f)(2), payment shall be made for the amount of such assistance without regard to any need for a State match.

"(5) SPECIAL TRANSITIONAL RULE.—

"(A) IN GENERAL.—Notwithstanding subsections (a) and (f), in order to receive the full State outlay allotment described in section 1511(c)(3)(C)(i), a State described in subparagraph (C) shall expend State funds in a fiscal year (before fiscal year 2000) under a State plan under this title in an amount not less than the adjusted base year State expenditures, plus the applicable percentage of the difference between such expenditures and the amount necessary to qualify for the full State outlay allotment so described in such fiscal year as determined under this section without regard to this paragraph.

"(B) REDUCTION IN ALLOTMENT IF EXPENDITURE NOT MET.—In the event a State described in subparagraph (C) fails to expend State funds in an amount required by subparagraph (A) for a fiscal year, the outlay allotment described in section 1511(c)(3)(C)(i) for such year for such State shall be

reduced by an amount which bears the same ratio to such outlay allotment as the State funds expended in such fiscal year bears to the amount required by subparagraph (A).

"(C) ADJUSTED BASE YEAR STATE EXPENDITURES.—For purposes of this paragraph, the term 'adjusted base year State expenditures' means, for Louisiana, $355,000,000.

"(D) APPLICABLE PERCENTAGE.—For purposes of this paragraph, the applicable percentage for a fiscal year is specified in the following table:

"Fiscal year:	Applicable Percentage:
1996	20
1997	40
1998	60
1999	80.

"(6) TREATMENT OF EXPENDITURES ATTRIBUTABLE TO UMBRELLA FUND.—The 'applicable Federal medical assistance percentage' with respect to amounts attributable to supplemental amounts described in section 1511(g), is the old Federal medical assistance percentage.

"(g) USE OF LOCAL FUNDS.—

"(1) IN GENERAL.—Subject to paragraph (2), a State may use local funds to meet the non-Federal share of the expenditures under the State plan with respect to which payments may be made under this section.

"(2) LIMITATION.—For any fiscal year local funds may not exceed 40 percent of the total of the non-Federal share of such expenditures for the fiscal year.

"(h) PERMITTING INTER-GOVERNMENTAL FUNDS TRANSFERS.—

"(1) IN GENERAL.—Public funds, as defined in paragraph (2), may be considered as the State's share in determining State financial participation under this title.

"(2) PUBLIC FUNDS DEFINED.—For purposes of this subsection, the term 'public funds' means funds—

"(A) that are—

"(i) appropriated directly to the State or to the local agency administering the State plan under this title, or transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or

"(ii) certified by the contributing public agency as representing expenditures eligible for Federal financial participation under this title; and

"(B) that—

"(i) are not Federal funds, or

"(ii) are Federal funds authorized by Federal law to be used to match other Federal funds.

"SEC. 1513. LIMITATION ON USE OF FUNDS; DISALLOWANCE.

"(a) IN GENERAL.—Funds provided to a State under this title shall only be used to carry out the purposes of this title.

"(b) DISALLOWANCES FOR EXCLUDED PROVIDERS.—

"(1) IN GENERAL.—Payment shall not be made to a State under this part for expenditures for items and services furnished—

"(A) by a provider who was 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) under the medical direction or on the prescription of a physician who was so excluded, if the provider of the services knew or had reason to know of the exclusion.

"(2) EXCEPTION FOR EMERGENCY SERVICES.—Subparagraph (A) shall not apply to emergency items or services, not including hospital emergency room services.

"(c) LIMITATIONS ON PAYMENTS FOR MEDICALLY-RELATED SERVICES AND ADMINISTRATIVE EXPENSES.—

"(1) IN GENERAL.—No Federal financial assistance is available for expenditures under the State plan for—

"(A) medically-related services for a quarter to the extent such expenditures exceed 5 percent of the total expenditures under the plan for the quarter, or

"(B) total administrative expenses (other than expenses described in paragraph (2) during the first 8 quarters in which the plan is in effect under this title) for quarters in a fiscal year to the extent such expenditures exceed the sum of $20,000,000 plus 10 percent of the total expenditures under the plan for the year.

"(2) ADMINISTRATIVE EXPENSES NOT SUBJECT TO LIMITATION.—The administrative expenses referred to in this paragraph are expenditures under the State plan for the following activities:

"(A) Quality assurance.

"(B) The development and operation of the certification program for nursing facilities and intermediate care facilities for the mentally retarded under section 1557.

"(C) Utilization review activities, including medical activities and activities of peer review organizations.

"(D) Inspection and oversight of providers and capitated health care organizations.

"(E) Anti-fraud activities.

"(F) Independent evaluations.

"(G) Activities required to meet reporting requirements under this title.

"(d) TREATMENT OF THIRD PARTY LIABILITY.—No payment shall be made to a State under this part for expenditures for medical assistance provided for an individual under its State 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 be-

cause the individual is eligible for or is provided medical assistance under the plan.

"(e) SECONDARY PAYER PROVISIONS.—Except as otherwise provided by law, no payment shall be made to a State under this part for expenditures for medical assistance provided for an individual under its State 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 subsection, rules similar to the rules for overpayments under section 1512(b) shall apply.

"(f) LIMITATION ON PAYMENTS FOR SERVICES TO NONLAWFUL ALIENS.—

"(1) IN GENERAL.—Notwithstanding the preceding provisions of this section, except as provided in paragraph (2), no payment may be made to a State under this part 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) EXCEPTION.—Payment may 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 (or, at the option of the State, for prenatal care),

"(B) such alien otherwise meets the eligibility requirements for medical assistance under the State plan (other than a 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) EMERGENCY MEDICAL CONDITION DEFINED.—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.

"(g) LIMITATION ON PAYMENT FOR CERTAIN OUTPATIENT PRESCRIPTION DRUGS.—

"(1) IN GENERAL.—No payment may be made to a State under this part for medical assistance for covered outpatient drugs (as defined in section 1575(i)(2)) of a manufacturer provided under the State plan unless the manufacturer (as defined in section 1575(i)(4)) of the drug—

"(A) has entered into a master rebate agreement with the Secretary under section 1575,

"(B) is otherwise complying with the provisions of such section,

"(C) is complying with the provisions of section 8126 of title 38, United States Code, including the requirement of entering into a master agreement with the Secretary of Veterans Affairs under such section, and

"(D) subject to paragraph (4), is complying with the provisions of section 340B of the Public Health Service Act, including the requirement of entering into an agreement with the Secretary under such section.

"(2) CONSTRUCTION.—Nothing in this subsection shall be construed as requiring a State to participate in the master rebate agreement under section 1575.

"(3) EFFECT OF SUBSEQUENT AMENDMENTS.—For purposes of subparagraphs (C) and (D), in determining whether a manufacturer is in compliance with the requirements of section 8126 of title 38, United States Code, or section 340B of the Public Health Service Act—

"(A) the Secretary shall not take into account any amendments to such sections that are enacted after the enactment of title VI of the Veterans Health Care Act of 1992, and

"(B) a manufacturer is deemed to meet such requirements if the manufacturer establishes to the satisfaction of the Secretary that the manufacturer would comply (and has offered to comply) with the provisions of such sections (as in effect immediately after the enactment of the Veterans Health Care Act of 1992) 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 the Veterans Health Care Act of 1992.

"(4) EFFECT OF ESTABLISHMENT OF ALTERNATIVE MECHANISM UNDER PUBLIC HEALTH SERVICE ACT.—If the Secretary does not establish a mechanism to ensure against duplicate discounts or rebates under section 340B(a)(5)(A) of the Public Health Service Act within 12 months of the date of the enactment of such section, the following requirements shall apply:

"(A) Each covered entity under such section shall inform the State when it is seeking reimbursement from the State plan for medical assistance with respect to a unit of any covered outpatient drug which is subject to an agreement under section 340B(a) of such Act.

"(B) Each such State shall provide a means by which such an 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 with respect to such a drug.

"(h) LIMITATION ON PAYMENT FOR ABORTIONS.—

"(1) IN GENERAL.—Payment shall not be made to a State under this part 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.

"(2) EXCEPTION.—Paragraph (1) shall not apply to an abortion—

"(A) if the pregnancy is the result of an act of rape or incest, or

"(B) in the case where a woman suffers from a physical disorder, illness, or injury that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

"(i) LIMITATION ON PAYMENT FOR ASSISTING DEATHS.—Payment shall not be made to a State under this part for amounts expended under the State plan to pay for, or to assist in the purchase, in whole or in part, of health benefit coverage that includes payment for any drug, biological product, or service which was furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.

"PART C—ESTABLISHMENT AND AMENDMENT OF STATE PLANS

"SEC. 1521. DESCRIPTION OF STRATEGIC OBJECTIVES AND PERFORMANCE GOALS.

"(a) DESCRIPTION.—A State plan shall include a description of the strategic objectives and performance goals the State has established for providing health care services to low-income populations under this title, including a general description of

the manner in which the plan is designed to meet these objectives and goals.

"(b) CERTAIN OBJECTIVES AND GOALS REQUIRED.—A State plan shall include strategic objectives and performance goals relating to rates of childhood immunizations, reductions in infant mortality and morbidity, and access to services for children with special health care needs (as defined by the State).

"(c) CONSIDERATIONS.—In specifying these objectives and goals the State may consider factors such as the following:

"(1) The State's priorities with respect to providing assistance to low-income populations.

"(2) The State's priorities with respect to the general public health and the health status of individuals eligible for assistance under the State plan.

"(3) The State's financial resources, the particular economic conditions in the State, and relative adequacy of the health care infrastructure in different regions of the State.

"(d) PERFORMANCE MEASURES.—To the extent practicable—

"(1) one or more performance goals shall be established by the State for each strategic objective identified in the State plan; and

"(2) the State plan shall describe, how program performance 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.

"(e) PERIOD COVERED.—

"(1) STRATEGIC OBJECTIVES.—The strategic objectives shall cover a period of not less than 5 years and shall be updated and revised at least every 3 years.

"(2) PERFORMANCE GOALS.—The performance goals shall be established for dates that are not more than 3 years apart.

"SEC. 1522. ANNUAL REPORTS.

"(a) IN GENERAL.—In the case of a State with a State plan that is in effect for part or all of a fiscal year, no later than March 31 following such fiscal year the State shall prepare and submit to the Secretary and the Congress a report on program activities and performance under this title for such fiscal year.

"(b) CONTENTS.—Each annual report under this section for a fiscal year shall include the following:

"(1) EXPENDITURE AND BENEFICIARY SUMMARY.—

"(A) INITIAL SUMMARY.—For the report for fiscal year 1997, a summary of all expenditures under the State plan during the fiscal year as follows:

"(i) Aggregate medical assistance expenditures, disaggregated to the extent required to determine compliance with the set-aside requirement of section 1502(c) and to determine the program need of the State under section 1511(d)(2).

"(ii) For each general category of eligible individuals (specified in subsection (c)(1)), aggregate medical assistance expenditures and the total and average number of eligible individuals under the State plan.

"(iii) By each general category of eligible individuals, total expenditures for each of the categories of health care items and services (specified in subsection (c)(2)) which are covered under the State plan and provided on a fee-for-service basis.

"(iv) By each general category of eligible individuals, total expenditures for payments to capitated health care organizations (as defined in section 1504(c)(1)).

"(v) Total administrative expenditures.

"(B) SUBSEQUENT SUMMARIES.—For reports for each succeeding fiscal year, a summary of—

"(i) all expenditures under the State plan, and

"(ii) the total and average number of eligible individuals under the State plan for each general category of eligible individuals.

"(2) UTILIZATION SUMMARY.—

"(A) INITIAL SUMMARY.—For the report for fiscal year 1997, summary statistics on the utilization of health care services under the State plan during the year as follows:

"(i) For each general category of eligible individuals and for each of the categories of health care items and services which are covered under the State plan and provided on a fee-for-service basis, the number and percentage of persons who received such a type of service or item during the period covered by the report.

"(ii) Summary of health care utilization data reported to the State by capitated health care organizations.

"(B) SUBSEQUENT SUMMARIES.—For reports for each succeeding fiscal year, summary statistics on the utilization of health care services under the State plan.

"(3) ACHIEVEMENT OF PERFORMANCE GOALS.—With respect to each performance goal established under section 1521 and applicable to the year involved—

"(A) a brief description of the goal;

"(B) a description of the methods to be used to measure the attainment of such goal;

"(C) data on the actual performance with respect to the goal;

"(D) a review of the extent to which the goal was achieved, based on such data; and

"(E) if a performance goal has not been met—

"(i) why the goal was not met, and

"(ii) actions to be taken in response to such performance, including adjustments in performance goals or program activities for subsequent years.

"(4) PROGRAM EVALUATIONS.—A summary of the findings of evaluations under section 1523 completed during the fiscal year covered by the report.

"(5) FRAUD AND ABUSE AND QUALITY CONTROL ACTIVITIES.—A general description of the State's activities under part D to detect and deter fraud and abuse and to assure quality of services provided under the program.

"(6) PLAN ADMINISTRATION.—

"(A) A description of the administrative roles and responsibilities of entities in the State responsible for administration of this title.

"(B) Organizational charts for each entity in the State primarily responsible for activities under this title.

"(C) A brief description of each interstate compact (if any) the State has entered into with other States with respect to activities under this title.

"(D) General citations to the State statutes and administrative rules governing the State's activities under this title.

"(c) DESCRIPTION OF CATEGORIES.—In this section:

"(1) GENERAL CATEGORIES OF ELIGIBLE INDIVIDUALS.—Each of the following is a general category of eligible individuals:

"(A) Pregnant women.

"(B) Children.

"(C) Blind or disabled adults who are not elderly individuals.

"(D) Elderly individuals.

"(E) Other adults.

"(2) CATEGORIES OF HEALTH CARE ITEMS AND SERVICES.—The health care items and services described in each

paragraph of section 1571(a) shall be considered a separate category of health care items and services.

"SEC. 1523. PERIODIC, INDEPENDENT EVALUATIONS.

"(a) IN GENERAL.—During fiscal year 1999 and every third fiscal year thereafter, each State shall provide for an evaluation of the operation of its State plan under this title.

"(b) INDEPENDENT.—Each such evaluation with respect to an activity under the State plan shall be conducted by an entity that is neither responsible under State law for the submission of the State plan (or part thereof) nor responsible for administering (or supervising the administration of) the activity. If consistent with the previous sentence, such an entity may be a college or university, a State agency, a legislative branch agency in a State, or an independent contractor.

"(c) RESEARCH DESIGN.—Each such evaluation shall be conducted in accordance with a research design that is based on generally accepted models of survey design and sampling and statistical analysis.

"SEC. 1524. DESCRIPTION OF PROCESS FOR STATE PLAN DEVELOPMENT.

"Each State plan shall include a description of the process under which the plan shall be developed and implemented in the State (consistent with section 1525).

"SEC. 1525. CONSULTATION IN STATE PLAN DEVELOPMENT.

"(a) PUBLIC NOTICE PROCESS.—Before submitting a State plan or a plan amendment described in subsection (c) to the Secretary under part C, a State shall provide—

"(1) public notice respecting the submittal of the proposed plan or amendment, including a general description of the plan or amendment,

"(2) a means for the public to inspect or obtain a copy (at reasonable charge) of the proposed plan or amendment,

"(3) an opportunity for submittal and consideration of public comments on the proposed plan or amendment, and

"(4) for consultation with one or more advisory committees established and maintained by the State.

The previous sentence shall not apply to a revision of a State plan (or revision of an amendment to a plan) made by a State under section 1529(c)(1) or to a plan amendment withdrawal described in section 1529(c)(4).

"(b) CONTENTS OF NOTICE.—A notice under subsection (a)(1) for a proposed plan or amendment shall include a description of—

"(1) the general purpose of the proposed plan or amendment (including applicable effective dates),

"(2) where the public may inspect the proposed plan or amendment,

"(3) how the public may obtain a copy of the proposed plan or amendment and the applicable charge (if any) for the copy, and

"(4) how the public may submit comments on the proposed plan or amendment, including any deadlines applicable to consideration of such comments.

"(c) AMENDMENTS DESCRIBED.—An amendment to a State plan described in this subsection is an amendment which makes a material and substantial change in eligibility under the State plan or the benefits provided under the plan.

"(d) PUBLICATION.—Notices under this section may be published (as selected by the State) in one or more daily newspapers of general circulation in the State or in any publication used by the State to publish State statutes or rules.

"(e) COMPARABLE PROCESS.—A separate notice, or notices, shall not be required under this section for a State if notice of the State plan or an amendment to the plan will be provided under a process specified in State law that is substantially equivalent to the notice process specified in this section.

"SEC. 1526. SUBMITTAL AND APPROVAL OF STATE PLANS.

"(a) SUBMITTAL.—As a condition of receiving funding under part B, each State shall submit to the Secretary a State plan that meets the applicable requirements of this title.

"(b) APPROVAL.—Except as the Secretary may provide under section 1529 (including subsection (b) relating to noncompliance with required guarantees), a State plan submitted under subsection (a)—

"(1) shall be approved for purposes of this title, and

"(2) shall be effective beginning on a date that is specified in the plan, but in no case earlier than 60 days after the date the plan is submitted.

"(c) CONSTRUCTION.—Nothing in this section shall be construed as prohibiting a State from submitting a State plan that includes the coverage and benefits (including those provided under a waiver granted under section 1115) of its State plan under title XIX (as in effect as of the date of the enactment of the Medicaid Restructuring Act of 1996), so long as such plan complies with the applicable requirements of this title, including the guarantees under section 1501, and remains subject to the funding provisions of section 1511.

"SEC. 1527. SUBMITTAL AND APPROVAL OF PLAN AMENDMENTS.

"(a) SUBMITTAL OF AMENDMENTS.—A State may amend, in whole or in part, its State plan at any time through transmittal of a plan amendment under this section.

"(b) APPROVAL.—Except as the Secretary may provide under section 1529 (including subsection (b) relating to noncompliance with required guarantees), an amendment to a State plan submitted under subsection (a)—

"(1) shall be approved for purposes of this title, and

"(2) shall be effective as provided in subsection (c).

"(c) EFFECTIVE DATES FOR AMENDMENTS.—

"(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, an amendment to a State plan

shall take effect on one or more effective dates specified in the amendment.

"(2) AMENDMENTS RELATING TO ELIGIBILITY OR BENEFITS.—Except as provided in paragraph (4)—

"(A) 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 or contemporaneous public notice of the change, in a form and manner provided under applicable State law.

"(B) 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.

"(3) OTHER AMENDMENTS.—Subject to paragraph (4), any plan amendment that is not described in paragraph (2) 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.

"(4) EXCEPTION.—The requirements of paragraphs (2) and (3) shall not apply to a plan amendment that is submitted on a timely basis pursuant to a court order or an order of the Secretary.

"SEC. 1528. PROCESS FOR STATE WITHDRAWAL FROM PROGRAM.

"(a) IN GENERAL.—A State may rescind its State plan and discontinue participation in the program under this title at any time after providing—

"(1) the public with 90 days prior notice in a publication in one or more daily newspapers of general circulation in the State or in any publication used by the State to publish State statutes or rules, and

"(2) the Secretary with 90 days prior written notice.

"(b) EFFECTIVE DATE.—Such discontinuation shall not apply to payments under part B for expenditures made for items and services furnished under the State plan before the effective date of the discontinuation.

"(c) PRORATION OF ALLOTMENTS.—In the case of any withdrawal under this section other than at the end of a Federal fiscal year, notwithstanding any provision of section 1511 to the contrary, the Secretary shall provide for such appropriate proration of the application of allotments under section 1511 as is appropriate.

"SEC. 1529. SANCTIONS FOR NONCOMPLIANCE.

"(a) PROMPT REVIEW OF PLAN SUBMITTALS.—The Secretary shall promptly review State plans and plan amendments submitted under this part to determine if they substantially comply with the requirements of this title.

"(b) DETERMINATIONS OF NONCOMPLIANCE WITH CERTAIN GUARANTEES.—

"(1) AT TIME OF PLAN OR AMENDMENT SUBMITTAL.—If the Secretary determines that a State plan or plan amendment submitted under this part violates the guarantees of coverage and benefits under subsections (a) and (b) of section 1501, the Secretary shall notify the State in writing of such determination and shall issue an order specifying that the plan or amendment, insofar as it is in violation with such requirement, shall not be effective, except as provided in subsection (d), as of the date specified in the order.

"(2) VIOLATIONS IN ADMINISTRATION OF PLAN.—If the Secretary determines, after reasonable notice and opportunity for a hearing for the State, that in the administration of a State plan there is a violation of guarantee of coverage and benefits under subsection (a) or (b) of section 1501, the Secretary shall provide the State with written notice of the determination and with an order to remedy such violation. Such an order shall become effective prospectively, as specified in the order, after the date of receipt of

such written notice. Such an order may include the withholding of funds, consistent with subsection (g), for parts of the State plan affected by such violation, until the Secretary is satisfied that the violation has been corrected.

"(3) CONSULTATION WITH STATE.—Before making a determination adverse to a State under this section, the Secretary shall—

"(A) reasonably consult with the State involved,

"(B) offer the State a reasonable opportunity to clarify the submission and submit further information to substantiate compliance with the requirements of subsections (a) and (b) of section 1501, and

"(C) reasonably consider any such clarifications and information submitted.

"(4) JUSTIFICATION OF ANY INCONSISTENCIES IN DETERMINATIONS.—If the Secretary makes a determination under this section that is, in whole or in part, inconsistent with any previous determination issued by the Secretary under this title, the Secretary shall include in the determination a detailed explanation and justification for any such difference.

"(c) DETERMINATIONS OF OTHER SUBSTANTIAL NONCOMPLIANCE.—

"(1) AT TIME OF PLAN OR AMENDMENT SUBMITTAL.—

"(A) IN GENERAL.—If the Secretary, during the 30-day period beginning on the date of submittal of a State plan or plan amendment—

"(i) determines that the plan or amendment substantially violates (within the meaning of paragraph (5)) a requirement of this title, and

"(ii) provides written notice of such determination to the State,

the Secretary shall issue an order specifying that the plan or amendment, insofar as it is in substantial violation of such a requirement, shall not be effective, ex-

cept as provided in subsection (d), beginning at the end of a period of not less than 30 days (or 120 days in the case of the initial submission of the State plan) specified in the order beginning on the date of the notice of the determination.

"(B) EXTENSION OF TIME PERIODS.—The time periods specified in subparagraph (A) may be extended by written agreement of the Secretary and the State involved.

"(2) VIOLATIONS IN ADMINISTRATION OF PLAN.—

"(A) IN GENERAL.—If the Secretary determines, after reasonable notice and opportunity for a hearing for the State, that in the administration of a State plan there is a substantial violation of a requirement of this title, the Secretary shall provide the State with written notice of the determination and with an order to remedy such violation. Such an order shall become effective prospectively, as specified in the order, after the date of receipt of such written notice. Such an order may include the withholding of funds, consistent with subsection (g), for parts of the State plan affected by such violation, until the Secretary is satisfied that the violation has been corrected.

"(B) EFFECTIVENESS.—If the Secretary issues an order under paragraph (1), the order shall become effective, except as provided in subsection (d), beginning at the end of a period (of not less than 30 days) specified in the order beginning on the date of the notice of the determination to the State.

"(C) TIMELINESS OF DETERMINATIONS RELATING TO REPORT-BASED COMPLIANCE.—The Secretary shall make determinations under this paragraph respecting violations relating to information contained in an annual report under section 1522, an independent evaluation under section 1523, or an audit report under sec-

tion 1551 not later than 30 days after the date of transmittal of the report or evaluation to the Secretary.

"(3) CONSULTATION WITH STATE.—Before making a determination adverse to a State under this section, the Secretary shall (within any time periods provided under this section)—

"(A) reasonably consult with the State involved,

"(B) offer the State a reasonable opportunity to clarify the submission and submit further information to substantiate compliance with the requirements of this title, and

"(C) reasonably consider any such clarifications and information submitted.

"(4) JUSTIFICATION OF ANY INCONSISTENCIES IN DETERMINATIONS.—If the Secretary makes a determination under this section that is, in whole or in part, inconsistent with any previous determination issued by the Secretary under this title, the Secretary shall include in the determination a detailed explanation and justification for any such difference.

"(5) SUBSTANTIAL VIOLATION DEFINED.—For purposes of this title, a State plan (or amendment to such a plan) or the administration of the State plan is considered to 'substantially violate' a requirement of this title if a provision of the plan or amendment (or an omission from the plan or amendment) or the administration of the plan—

"(A) is material and substantial in nature and effect, and

"(B) is inconsistent with an express requirement of this title.

A failure to meet a strategic objective or performance goal (as described in section 1521) shall not be considered to substantially violate a requirement of this title.

"(6) RELATION TO OTHER PROVISION.—This subsection shall not apply to violation of a requirement of subsection (a) or (b) of section 1501.

"(d) STATE RESPONSE TO ORDERS.—

"(1) STATE RESPONSE BY REVISING PLAN.—

"(A) IN GENERAL.—Insofar as an order under subsection (b)(1) or (c)(1) relates to a violation by a State plan or plan amendment, a State may respond (before the date the order becomes effective) to such an order by submitting a written revision of the State plan or plan amendment to comply with the requirements of this title.

"(B) REVIEW OF REVISION.—In the case of submission of such a revision, the Secretary shall promptly review the submission and shall, in the case of an order under subsection (c)(1), withhold any action on the order during the period of such review.

"(C) SECRETARIAL RESPONSE.—

"(i) ORDERS RELATING TO GUARANTEES.—In the case of a revision submitted in response to an order under subsection (b)(1), the revision shall not be considered to have corrected the deficiency unless the Secretary determines and notifies the State that the State plan or amendment, as proposed to be revised complies with the requirements of subsections (a) and (b) of section 1501. If the Secretary determines that the revision does not correct the deficiency, the Secretary shall notify the State in writing of such determination and the State may respond by seeking reconsideration or a hearing under paragraph (2).

"(ii) OTHER ORDERS.—In the case of a revision submitted in response to an order under subsection (c)(1), the revision shall be considered to have corrected the deficiency (and the order rescinded insofar as it relates to such deficiency) unless the Secretary determines and notifies the State in writing, within 15 days after the date the Secretary receives the revision, that the State plan or

amendment, as proposed to be revised, still substantially violates a requirement of this title. In such case the State may respond by seeking reconsideration or a hearing under paragraph (2).

"(D) REVISION RETROACTIVE.—If the revision provides for compliance (in the case of an order under subsection (b)(1)) or substantial compliance (in the case of an order under subsection (c)(1)), the revision may be treated, at the option of the State, as being effective either as of the effective date of the provision to which it relates or such later date as the State and Secretary may agree.

"(2) STATE RESPONSE BY SEEKING RECONSIDERATION OR AN ADMINISTRATIVE HEARING.—A State may respond to an order under subsection (b) or (c) by filing a request with the Secretary for—

"(A) a reconsideration of the determination, pursuant to subsection (e)(1), or

"(B) a review of the determination through an administrative hearing, pursuant to subsection (e)(2).

In such case for an order under subsection (c), the order shall not take effect before the completion of the reconsideration or hearing.

"(3) STATE RESPONSE BY CORRECTIVE ACTION PLAN.—

"(A) IN GENERAL.—In the case of an order described in subsection (b)(2) or (c)(2) that relates to a violation in the administration of the State plan, a State may respond to such an order by submitting a corrective action plan with the Secretary to correct deficiencies in the administration of the plan which are the subject of the order.

"(B) REVIEW OF CORRECTIVE ACTION PLAN.—In the case of a corrective action plan submitted in response to an order under subsection (c)(2), the Secretary shall withhold any action on the order for a pe-

riod (not to exceed 30 days) during which the Secretary reviews the corrective action plan.

"(C) SECRETARIAL RESPONSE.—

"(i) ORDERS RELATING TO GUARANTEES.—In the case of a corrective action plan submitted in response to an order under subsection (b)(2), the plan shall not be considered to have corrected the deficiency unless the Secretary determines and notifies the State that the State's administration of the State plan, as proposed to be corrected in the plan, will not violate a requirement of subsection (a) or (b) of section 1501. If the Secretary determines that the plan does not correct the deficiency, the Secretary shall notify the State in writing of such determination and the State may respond by seeking reconsideration or a hearing under paragraph (2).

"(ii) OTHER ORDERS.—In the case of a corrective action plan submitted in response to an order under subsection (c)(2), the corrective action plan shall be considered to have corrected the deficiency (and the order rescinded insofar as it relates to such deficiency) unless the Secretary determines and notifies the State in writing, within 15 days after the date the Secretary receives the corrective action plan, that the State's administration of the State plan, as proposed to be corrected in the plan, will still substantially violate a requirement of this title. In such case the State may respond by seeking reconsideration or a hearing under paragraph (2).

"(4) STATE RESPONSE BY WITHDRAWAL OF PLAN AMENDMENT; FAILURE TO RESPOND.—Insofar as an order relates to a violation in a plan amendment submitted, a State may respond to such an order by withdrawing the

plan amendment and the State plan shall be treated as though the amendment had not been made.

"(e) ADMINISTRATIVE REVIEW AND HEARING.—

"(1) RECONSIDERATION.—Within 30 days after the date of receipt of a request under subsection (d)(2)(A), the Secretary shall notify the State of the time and place at which a hearing will be held for the purpose of reconsidering the Secretary's determination. The hearing shall be held not less than 20 days nor more than 60 days after the date notice of the hearing is furnished to the State, unless the Secretary and the State agree in writing to holding the hearing at another time. The Secretary shall affirm, modify, or reverse the original determination within 60 days of the conclusion of the hearing.

"(2) ADMINISTRATIVE HEARING.—Within 30 days after the date of receipt of a request under subsection (d)(2)(B), an administrative law judge shall schedule a hearing for the purpose of reviewing the Secretary's determination. The hearing shall be held not less than 20 days nor more than 60 days after the date notice of the hearing is furnished to the State, unless the Secretary and the State agree in writing to holding the hearing at another time. The administrative law judge shall affirm, modify, or reverse the determination within 60 days of the conclusion of the hearing.

"(f) JUDICIAL REVIEW.—

"(1) IN GENERAL.—A State which is dissatisfied with a final determination made by the Secretary under subsection (e)(1) or a final determination of an administrative law judge under subsection (e)(2) 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 the 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 and, in the case of a determination under subsection (e)(2), to the adminis-

trative law judge involved. The Secretary (or judge involved) thereupon shall file in the court the record of the proceedings on which the final determination was based, as provided in section 1502 of title 28, United States Code. Except as provided in section 1507, only the Secretary, in accordance with this title, may compel a State under Federal law to comply with the provisions of this title or a State plan, or otherwise enforce a provision of this title against a State, and no action may be filed under Federal law against a State in relation to the State's compliance, or failure to comply, with the provisions of this title or of a State plan except under section 1507 or by the Secretary as provided under this subsection.

"(2) STANDARD FOR REVIEW.—The findings of fact by the Secretary or administrative law judge, if supported by substantial evidence, shall be conclusive, but the court, for good cause shown, may remand the case to the Secretary or judge to take further evidence, and the Secretary or judge may thereupon make new or modified findings of fact and may modify a previous determination, 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.

"(3) JURISDICTION OF APPELLATE COURT.—The court shall have jurisdiction to affirm the action of the Secretary or judge 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.

"(g) WITHHOLDING OF FUNDS.—

"(1) IN GENERAL.—Any order under this section relating to the withholding of funds shall be effective not earlier than the effective date of the order and shall only relate to the portions of a State plan or administration thereof which violate a requirement of subsection (a) or (b) of

section 1501 or substantially violate another requirement of this title. In the case of a failure to meet a set-aside requirement under section 1502(c), any withholding shall only apply to the extent of such failure.

"(2) SUSPENSION OF WITHHOLDING.—The Secretary may suspend withholding of funds under paragraph (1) during the period reconsideration or administrative and judicial review is pending under subsection (e) or (f).

"(3) RESTORATION OF FUNDS.—Any funds withheld under this subsection under an order shall be immediately restored to a State—

"(A) to the extent and at the time the order is—

"(i) modified or withdrawn by the Secretary upon reconsideration,

"(ii) modified or reversed by an administrative law judge, or

"(iii) set aside (in whole or in part) by an appellate court; or

"(B) when the Secretary determines that the deficiency which was the basis for the order is corrected;

"(C) when the Secretary determines that violation which was the basis for the order is resolved or the amendment which was the basis for the order is withdrawn; or

"(D) at any time upon the initiative of the Secretary.

"(h) INDIVIDUAL COMPLAINT PROCESS.—The Secretary shall provide for a process under which an individual may notify the Secretary concerning a State's failure to provide medical assistance as required under the State plan or otherwise comply with the requirements of this title or such plan, including any failure to comply with a requirement of subsection (a) or (b) of section 1501. If the Secretary finds that there is a pattern of complaints with respect to a State or that a particular failure or finding of noncompliance is egregious, the Secretary shall notify the chief executive officer of the State of

such finding and shall notify the Congress if the State fails to respond to such notification within a reasonable period of time.

"SEC. 1530. SECRETARIAL AUTHORITY.

"(a) NEGOTIATED AGREEMENT AND DISPUTE RESOLUTION.—

"(1) NEGOTIATIONS.—Nothing in this part shall be construed as preventing the Secretary and a State from at any time negotiating a satisfactory resolution to any dispute concerning the approval of a State plan (or amendments to a State plan) or the compliance of a State plan (including its administration) with requirements of this title.

"(2) COOPERATION.—The Secretary shall act in a cooperative manner with the States in carrying out this title. In the event of a dispute between a State and the Secretary, the Secretary shall, whenever practicable, engage in informal dispute resolution activities in lieu of formal enforcement or sanctions under section 1529.

"(b) LIMITATIONS ON DELEGATION OF DECISIONMAKING AUTHORITY.—The Secretary may not delegate (other than to the Administrator of the Health Care Financing Administration) the authority to make determinations or reconsiderations respecting the approval of State plans (or amendments to such plans) or the compliance of a State plan (including its administration) with requirements of this title. Such Administrator may not further delegate such authority to any individual, including any regional official of such Administration.

"(c) REQUIRING FORMAL RULEMAKING FOR CHANGES IN SECRETARIAL ADMINISTRATION.—The Secretary shall carry out the administration of the program under this title only through a prospective formal rulemaking process, including issuing notices of proposed rulemaking, publishing proposed rules or modifications to rules in the Federal Register, and soliciting public comment.

"PART D—PROGRAM INTEGRITY AND QUALITY

"SEC. 1551. USE OF AUDITS TO ACHIEVE FISCAL INTEGRITY.

"(a) FINANCIAL AUDITS OF PROGRAM.—

"(1) IN GENERAL.—Each State plan shall provide for an annual audit of the State's expenditures from amounts received under this title, in compliance with chapter 75 of title 31, United States Code.

"(2) VERIFICATION AUDITS.—If, after consultation with the State and the Comptroller General and after a fair hearing, the Secretary determines that a State's audit under paragraph (1) was performed in substantial violation of chapter 75 of title 31, United States Code, the Secretary may—

"(A) require that the State provide for a verification audit in compliance with such chapter, or

"(B) conduct such a verification audit.

"(3) AVAILABILITY OF AUDIT REPORTS.—Within 30 days after completion of each audit or verification audit under this subsection, the State shall—

"(A) provide the Secretary with a copy of the audit report, including the State's response to any recommendations of the auditor, and

"(B) make the audit report available for public inspection in the same manner as proposed State plan amendments are made available under section 1525.

"(b) FISCAL CONTROLS.—

"(1) IN GENERAL.—With respect to the accounting and expenditure of funds under this title, each State shall adopt and maintain such fiscal controls, accounting procedures, and data processing safeguards as the State deems reasonably necessary to assure the fiscal integrity of the State's activities under this title.

"(2) CONSISTENCY WITH GENERALLY ACCEPTED ACCOUNTING PRINCIPLES.—Such controls and procedures shall be generally consistent with generally accepted ac-

counting principles as recognized by the Governmental Accounting Standards Board or the Comptroller General.

"(c) AUDITS OF PROVIDERS.—Each State plan shall provide that the records of any entity providing items or services for which payment may be made under the plan may be audited as necessary to ensure that proper payments are made under the plan.

"SEC. 1552. FRAUD PREVENTION PROGRAM.

"(a) ESTABLISHMENT.—Each State plan shall provide for the establishment and maintenance of an effective program for the detection and prevention of fraud and abuse by beneficiaries, providers, and others in connection with the operation of the program.

"(b) PROGRAM REQUIREMENTS.—The program established pursuant to subsection (a) shall include at least the following requirements:

"(1) DISCLOSURE OF INFORMATION.—Any disclosing entity (as defined in section 1124(a)) receiving payments under the State plan shall comply with the requirements of section 1124.

"(2) SUPPLY OF INFORMATION.—An entity (other than an individual practitioner or a group of practitioners) that furnishes, or arranges for the furnishing of, an item or service under the State plan shall supply upon request specifically addressed to the entity by the Secretary or the State agency the information described in section 1128(b)(9).

"(3) EXCLUSION.—

"(A) IN GENERAL.—The State plan shall exclude any specified individual or entity from participation in the plan for the period specified by the Secretary when required by the Secretary 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.

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

"(4) NOTICE.—The State plan shall provide that whenever a provider of services or any other person is terminated, suspended, or otherwise sanctioned or prohibited from participating under the plan, the State agency responsible for administering the plan shall promptly notify the Secretary and, in the case of a physician, the State medical licensing board of such action.

"(5) ACCESS TO INFORMATION.—The State plan shall 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 1553.

"SEC. 1553. INFORMATION CONCERNING SANCTIONS TAKEN BY STATE LICENSING AUTHORITIES AGAINST HEALTH CARE PRACTITIONERS AND PROVIDERS.

"(a) INFORMATION REPORTING REQUIREMENT.—The requirement referred to in section 1552(b)(5) 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 fraud control units (as defined in section 1534),

"(6) to hospitals and other health care entities (as defined in section 431 of the Health Care Quality Improvement Act of 1986), 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 im-

plementation of subsection (a) of this section and section 422 of the Health Care Quality Improvement Act of 1986 and section 1128E.

"SEC. 1554. STATE FRAUD CONTROL UNITS.

"(a) IN GENERAL.—Each State plan shall provide for a State fraud control unit described in subsection (b) that effectively carries out the functions and requirements described in such subsection, 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 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.

"(b) UNITS DESCRIBED.—For purposes of this section, the term 'State fraud control unit' means a single identifiable entity of the State government which meets the following requirements:

"(1) ORGANIZATION.—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 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 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) INDEPENDENCE.—The entity is separate and distinct from any State agency that has principal responsibilities for administering or supervising the administration of the State plan.

"(3) FUNCTION.—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 any aspect of the provision of medical assistance and the activities of providers of such assistance under the State plan.

"(4) REVIEW OF COMPLAINTS.—The entity has procedures for reviewing complaints of the abuse and neglect of patients of health care facilities which receive payments under the State plan under this title, and, where appropriate, for acting upon such complaints under the criminal laws of the State or for referring them to other State agencies for action.

"(5) OVERPAYMENTS.—

"(A) IN GENERAL.—The entity provides for the collection, or referral for collection to a single State agency, of overpayments that are made under the State plan to health care providers and that are discovered by the entity in carrying out its activities.

"(B) TREATMENT OF CERTAIN OVERPAYMENTS.—If an overpayment is the direct result of the failure of the provider (or the provider's billing agent) to adhere to a change in the State's billing instructions, the entity may recover the overpayment only if the entity

demonstrates that the provider (or the provider's billing agent) received prior written or electronic notice of the change in the billing instructions before the submission of the claims on which the overpayment is based.

"(6) PERSONNEL.—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.

"SEC. 1555. RECOVERIES FROM THIRD PARTIES AND OTHERS.

"(a) THIRD PARTY LIABILITY.—Each State plan shall provide for reasonable steps—

"(1) to ascertain the legal liability of third parties to pay for care and services available under the plan, including the collection of sufficient information to enable States to pursue claims against third parties, and

"(2) to seek reimbursement for medical assistance provided to the extent legal liability is established where the amount expected to be recovered exceeds the costs of the recovery.

"(b) BENEFICIARY PROTECTION.—

"(1) IN GENERAL.—Each State plan shall provide that in the case of a person furnishing services under the plan for which a third party may be liable for payment—

"(A) the person may not seek to collect from the individual (or financially responsible relative) payment of an amount for the service more than could be collected under the plan in the absence of such third party liability, and

"(B) may not refuse to furnish services to such an individual because of a third party's potential liability for payment for the service.

"(2) PENALTY.—A State plan 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 3 times the amount of any payment

sought to be collected by that person in violation of paragraph (1)(A).

"(c) GENERAL LIABILITY.—The State shall prohibit any health insurer, including a group health plan as defined in section 607 of the Employee Retirement Income Security Act of 1974, a service benefit plan, or 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 State plan for any State.

"(d) ACQUISITION OF RIGHTS OF BENEFICIARIES.—To the extent that payment has been made under a State plan in any case where a third party has a legal liability to make payment for such assistance, the State shall have in effect laws under which, to the extent that payment has been made under the plan 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.

"(e) ASSIGNMENT OF MEDICAL SUPPORT RIGHTS.—The State plan shall provide for mandatory assignment of rights of payment for medical support and other medical care owed to recipients in accordance with section 1556.

"(f) REQUIRED LAWS RELATING TO MEDICAL CHILD SUPPORT.—

"(1) IN GENERAL.—Each State with a State plan under this title shall have in effect the following laws:

"(A) 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—

"(i) the child was born out of wedlock,

"(ii) the child is not claimed as a dependent on the parent's Federal income tax return, or

"(iii) the child does not reside with the parent or in the insurer's service area.

"(B) 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—

"(i) 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);

"(ii) 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

"(iii) 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.

"(C) 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—

"(i) 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);

"(ii) 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

"(iii) not to disenroll (or eliminate coverage of) any such child unless—

"(I) the employer is provided satisfactory written evidence that such court or administrative order is no longer in effect, or 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

"(iv) 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), 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.

"(D) 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.

"(E) A law that requires an insurer, in any case in which a child has health coverage through the insurer of a noncustodial parent—

"(i) to provide such information to the custodial parent as may be necessary for the child to obtain benefits through such coverage,

"(ii) 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

"(iii) to make payment on claims submitted in accordance with clause (ii) directly to such custodial parent, the provider, or the State agency.

"(F) 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—

"(i) 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,

"(ii) has received payment from a third party for the costs of such services to such child, but

"(iii) 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.

"(2) DEFINITION.—For purposes of this subsection, 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.

"(g) ESTATE RECOVERIES AND LIENS PERMITTED.—A State may take such actions as it considers appropriate to ad-

just or recover from the individual or the individual's estate any amounts paid as medical assistance to or on behalf of the individual under the State plan, including through the imposition of liens against the property or estate of the individual to the extent consistent with section 1506.

"SEC. 1556. ASSIGNMENT OF RIGHTS OF PAYMENT.

"(a) IN GENERAL.—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, each State plan shall—

"(1) provide that, as a condition of eligibility for medical assistance under the 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 the plan 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 a pregnant woman or the individual is found to have good cause for refusing to cooperate as determined by the State, 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 indi-

vidual has good cause for refusing to cooperate as determined by the State; 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 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) USE OF AMOUNTS COLLECTED.—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.

"SEC. 1557. QUALITY ASSURANCE REQUIREMENTS FOR NURSING FACILITIES.

"(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 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 assess-

ment 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 14 days after the date of) admission for each individual admitted;

"(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.

"(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,

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 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.—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.