models tested under subsection (b), including the number of individuals described in subsection (a)(4)(A)(i) and of individuals described in subsection (a)(4)(A)(ii) participating in such models and payments made under applicable subchapters for services on behalf of such individuals, any models chosen for expansion under subsection (c), and the results from evaluations under subsection (b)(4). In addition, each such report shall provide such recommendations as the Secretary determines are appropriate for legislative action to facilitate the development and expansion of successful payment models.

(Aug. 14, 1935, ch. 531, title XI, § 1115A, as added and amended Pub. L. 111–148, title III, § 3021(a), title X, § 10306, Mar. 23, 2010, 124 Stat. 389, 939.)

REFERENCES IN TEXT

Section 4016 of the Balanced Budget Act of 1997, referred to in subsec. (b)(2)(B)(xx), is section 4016 of Pub. L. 105–33, which is set out as a note under section 1395b–1 of this title.

AMENDMENTS

2010—Subsec. (a)(5). Pub. L. 111–148, § 10306(1), added par. (5).

Subsec. (b)(2)(A). Pub. L. 111–148, § 10306(2)(A), inserted ''The Secretary shall focus on models expected to reduce program costs under the applicable subchapter while preserving or enhancing the quality of care received by individuals receiving benefits under such subchapter.'' after the first sentence and substituted ''this subparagraph may include, but are not limited to,'' for ''the preceding sentence may include''.

Subsec. (b)(2)(B)(xix), (xx). Pub. L. 111–148, § 10306(2)(B), added cls. (xix) and (xx).

Subsec. (b)(2)(C)(viii). Pub. L. 111–148, § 10306(2)(C), added cl. (viii).

Subsec. (b)(4)(C). Pub. L. 111–148, § 10306(3), added subpar. (C).

Subsec. (c). Pub. L. 111–148, § 10306(4)(C), inserted concluding provisions.

Subsec. (c)(1)(B). Pub. L. 111–148, § 10306(4)(A), substituted ''patient care without increasing spending;'' for ''care and reduce spending; and''.

Subsec. (c)(2). Pub. L. 111–148, § 10306(4)(B), substituted ''reduce (or would not result in any increase in) net program spending under applicable subchapters; and'' for ''reduce program spending under applicable subchapters.''

Subsec. (c)(3). Pub. L. 111–148, § 10306(4)(C), added par. (3).

MEDICAID GLOBAL PAYMENT SYSTEM DEMONSTRATION PROJECT

Pub. L. 111–148, title II, § 2705, Mar. 23, 2010, 124 Stat. 324, provided that:

''(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the 'Secretary') shall, in coordination with the Center for Medicare and Medicaid Innovation (as established under section 1115A of the Social Security Act [42 U.S.C. 1315a], as added by section 3021 of this Act), establish the Medicaid Global Payment System Demonstration Project under which a participating State shall adjust the payments made to an eligible safety net hospital system or network from a fee-for-service payment structure to a global capitated payment model.

''(b) DURATION AND SCOPE.—The demonstration project conducted under this section shall operate during a period of fiscal years 2010 through 2012. The Secretary shall select not more than 5 States to participate in the demonstration project.

''(c) ELIGIBLE SAFETY NET HOSPITAL SYSTEM OR NETWORK.—For purposes of this section, the term 'eligible safety net hospital system or network' means a large, safety net hospital system or network (as defined by the Secretary) that operates within a State selected by the Secretary under subsection (b).

''(d) EVALUATION.—

''(1) TESTING.—The Innovation Center shall test and evaluate the demonstration project conducted under this section to examine any changes in health care quality outcomes and spending by the eligible safety net hospital systems or networks.

''(2) BUDGET NEUTRALITY.—During the testing period under paragraph (1), any budget neutrality requirements under section 1115A(b)(3) of the Social Security Act [42 U.S.C. 1315a(b)(3)] (as so added) shall not be applicable.

''(3) MODIFICATION.—During the testing period under paragraph (1), the Secretary may, in the Secretary's discretion, modify or terminate the demonstration project conducted under this section.

''(e) REPORT.—Not later than 12 months after the date of completion of the demonstration project under this section, the Secretary shall submit to Congress a report containing the results of the evaluation and testing conducted under subsection (d), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.''

§ 1315b. Providing Federal coverage and payment coordination for dual eligible beneficiaries

(a) Establishment of Federal Coordinated Health Care Office

(1) In general

Not later than March 1, 2010, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a Federal Coordinated Health Care Office.

(2) Establishment and reporting to CMS administrator

The Federal Coordinated Health Care Office—

(A) shall be established within the Centers for Medicare & Medicaid Services; and

(B) have as the Office[1] a Director who shall be appointed by, and be in direct line of authority to, the Administrator of the Centers for Medicare & Medicaid Services.

(b) Purpose

The purpose of the Federal Coordinated Health Care Office is to bring together officers and employees of the Medicare and Medicaid programs at the Centers for Medicare & Medicaid Services in order to—

(1) more effectively integrate benefits under the Medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] and the Medicaid program under title XIX of such Act [42 U.S.C. 1396 et seq.]; and

(2) improve the coordination between the Federal Government and States for individuals eligible for benefits under both such programs in order to ensure that such individuals get full access to the items and services to which they are entitled under titles XVIII and XIX of the Social Security Act.

(c) Goals

The goals of the Federal Coordinated Health Care Office are as follows:

[1] So in original.

(1) Providing dual eligible individuals full access to the benefits to which such individuals are entitled under the Medicare and Medicaid programs.

(2) Simplifying the processes for dual eligible individuals to access the items and services they are entitled to under the Medicare and Medicaid programs.

(3) Improving the quality of health care and long-term services for dual eligible individuals.

(4) Increasing dual eligible individuals' understanding of and satisfaction with coverage under the Medicare and Medicaid programs.

(5) Eliminating regulatory conflicts between rules under the Medicare and Medicaid programs.

(6) Improving care continuity and ensuring safe and effective care transitions for dual eligible individuals.

(7) Eliminating cost-shifting between the Medicare and Medicaid program and among related health care providers.

(8) Improving the quality of performance of providers of services and suppliers under the Medicare and Medicaid programs.

(d) Specific responsibilities

The specific responsibilities of the Federal Coordinated Health Care Office are as follows:

(1) Providing States, specialized MA plans for special needs individuals (as defined in section 1859(b)(6) of the Social Security Act (42 U.S.C. 1395w–28(b)(6))), physicians and other relevant entities or individuals with the education and tools necessary for developing programs that align benefits under the Medicare and Medicaid programs for dual eligible individuals.

(2) Supporting State efforts to coordinate and align acute care and long-term care services for dual eligible individuals with other items and services furnished under the Medicare program.

(3) Providing support for coordination of contracting and oversight by States and the Centers for Medicare & Medicaid Services with respect to the integration of the Medicare and Medicaid programs in a manner that is supportive of the goals described in paragraph (3).[2]

(4) To consult and coordinate with the Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) and the Medicaid and CHIP Payment and Access Commission established under section 1900 of such Act (42 U.S.C. 1396) with respect to policies relating to the enrollment in, and provision of, benefits to dual eligible individuals under the Medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] and the Medicaid program under title XIX of such Act [42 U.S.C. 1396 et seq.].

(5) To study the provision of drug coverage for new full-benefit dual eligible individuals (as defined in section 1935(c)(6) of the Social Security Act (42 U.S.C. 1396u–5(c)(6)),[3] as well as to monitor and report annual total expenditures, health outcomes, and access to benefits for all dual eligible individuals.

(e) Report

The Secretary shall, as part of the budget transmitted under section 1105(a) of title 31, submit to Congress an annual report containing recommendations for legislation that would improve care coordination and benefits for dual eligible individuals.

(f) Dual eligible individual defined

In this section, the term ''dual eligible individual'' means an individual who is entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.], or enrolled for benefits under part B of title XVIII of such Act [42 U.S.C. 1395j et seq.], and is eligible for medical assistance under a State plan under title XIX of such Act or under a waiver of such plan.

(Pub. L. 111–148, title II, § 2602, Mar. 23, 2010, 124 Stat. 315.)

REFERENCES IN TEXT

The Social Security Act, referred to in subsecs. (b), (d)(4), and (f), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Titles XVIII and XIX of the Act are classified generally to subchapters XVIII (§ 1395 et seq.) and XIX (§ 1396 et seq.), respectively, of this chapter. Parts A and B of title XVIII of the Act are classified generally to parts A (§ 1395c et seq.) and B (§ 1395j et seq.), respectively, of subchapter XVIII of this chapter. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

CODIFICATION

Section was enacted as part of the Patient Protection and Affordable Care Act, and not as part of the Social Security Act which comprises this chapter.

§ 1316. Administrative and judicial review of public assistance determinations

(a) Determination of conformity with requirements for approval; petition for reconsideration; hearing; time limitations; review by court of appeals

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

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

[2] So in original. Probably should be ''subsection (c).''

[3] So in original. Another closing parenthesis probably should precede the comma.