Subsec. (b)(7) to (9). Pub. L. 111–148, §6403(b)(2)(D), (E), added par. (7) and redesignated former pars. (7) and (8) as (8) and (9), respectively.

Subsecs. (d) to (g). Pub. L. 111–148, §6403(b)(3), added subsecs. (d) to (g). Former subsec. (d) redesignated (h).

Subsec. (h). Pub. L. 111–148, §6403(b)(3), (4), redesignated subsec. (d) as (h) and substituted ''In implementing this section, the Secretary shall provide for the maximum appropriate coordination with part B of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11131 et seq.) and section 1320a–7e of this title.'' for ''The Secretary shall provide for the maximum appropriate coordination in the implementation of subsection (a) of this section and section 422 of the Health Care Quality Improvement Act of 1986.''

1990—Subsec. (a)(1). Pub. L. 101–508, §4752(f)(1)(A), inserted ''(or any peer review organization or private accreditation entity reviewing the services provided by health care practitioners)'' after ''health care practitioners'' in introductory provisions.

Subsec. (a)(1)(D). Pub. L. 101–508, §4752(f)(1)(B), added subpar. (D).

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by Pub. L. 111–148 effective on the first day after the final day of the transition period defined in section 6403(d)(5) of Pub. L. 111–148, see section 6403(d)(6) of Pub. L. 111–148, set out as a Transition Process; Regulations; Effective Date of 2010 Amendment note under section 1320a–7e of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, §4752(f)(2), Nov. 5, 1990, 104 Stat. 1388– 208, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to State information reporting systems as of January 1, 1992, without regard to whether or not the Secretary of Health and Human Services has promulgated any regulations to carry out such amendments by such date.''

EFFECTIVE DATE

Section applicable, with certain exceptions, to payments under subchapter XIX of this chapter for calendar quarters beginning more than thirty days after Aug. 18, 1987, without regard to whether or not final regulations to carry out this section have been published by that date, see section 15(c)(1), (2) of Pub. L. 100–93 set out as an Effective Date of 1987 Amendment note under section 1320a–7 of this title.

§ 1396r–3. Correction and reduction plans for intermediate care facilities for mentally retarded

(a) Written plans to remedy substantial deficiencies; time for submission

If the Secretary finds that an intermediate care facility for the mentally retarded has substantial deficiencies which do not pose an immediate threat to the health and safety of residents (including failure to provide active treatment), the State may elect, subject to the limitations in this section, to—

(1) submit, within the number of days specified by the Secretary in regulations which apply to submission of compliance plans with respect to deficiencies of such type, a written plan of correction which details the extent of the facility's current compliance with the standards promulgated by the Secretary, including all deficiencies identified during a validation survey, and which provides for a timetable for completion of necessary steps to correct all staffing deficiencies within 6 months, and a timetable for rectifying all physical plant deficiencies within 6 months; or

(2) submit, within a time period consisting of the number of days specified for submissions under paragraph (1) plus 35 days, a written plan for permanently reducing the number of certified beds, within a maximum of 36 months, in order to permit any noncomplying buildings (or distinct parts thereof) to be vacated and any staffing deficiencies to be corrected (hereinafter in this section referred to as a ''reduction plan'').

(b) Conditions for approval of reduction plans

As conditions of approval of any reduction plan submitted pursuant to subsection (a)(2), the State must—

(1) provide for a hearing to be held at the affected facility at least 35 days prior to submission of the reduction plan, with reasonable notice thereof to the staff and residents of the facility, responsible members of the residents' families, and the general public;

(2) demonstrate that the State has successfully provided home and community services similar to the services proposed to be provided under the reduction plan for similar individuals eligible for medical assistance; and

(3) provide assurances that the requirements of subsection (c) shall be met with respect to the reduction plan.

(c) Contents of reduction plan

The reduction plan must—

(1) identify the number and service needs of existing facility residents to be provided home or community services and the timetable for providing such services, in 6 month intervals, within the 36-month period;

(2) describe the methods to be used to select such residents for home and community services and to develop the alternative home and community services to meet their needs effectively;

(3) describe the necessary safeguards that will be applied to protect the health and welfare of the former residents of the facility who are to receive home or community services, including adequate standards for consumer and provider participation and assurances that applicable State licensure and applicable State and Federal certification requirements will be met in providing such home or community services;

(4) provide that residents of the affected facility who are eligible for medical assistance while in the facility shall, at their option, be placed in another setting (or another part of the affected facility) so as to retain their eligibility for medical assistance;

(5) specify the actions which will be taken to protect the health and safety of, and to provide active treatment for, the residents who remain in the affected facility while the reduction plan is in effect;

(6) provide that the ratio of qualified staff to residents at the affected facility (or the part thereof) which is subject to the reduction plan will be the higher of—

(A) the ratio which the Secretary determines is necessary in order to assure the health and safety of the residents of such facility (or part thereof); or

(B) the ratio which was in effect at the time that the finding of substantial defi-

ciencies (referred to in subsection (a)) was made; and

(7) provide for the protection of the interests of employees affected by actions under the reduction plan, including—

(A) arrangements to preserve employee rights and benefits;

(B) training and retraining of such employees where necessary;

(C) redeployment of such employees to community settings under the reduction plan; and

(D) making maximum efforts to guarantee the employment of such employees (but this requirement shall not be construed to guarantee the employment of any employee).

(d) Notice and comment; approval of more than 15 reduction plans in any fiscal year; corrections costing $2,000,000 or more

(1) The Secretary must provide for a period of not less than 30 days after the submission of a reduction plan by a State, during which comments on such reduction plan may be submitted to the Secretary, before the Secretary approves or disapproves such reduction plan.

(2) If the Secretary approves more than 15 reduction plans under this section in any fiscal year, any reduction plans approved in addition to the first 15 such plans approved, must be for a facility (or part thereof) for which the costs of correcting the substantial deficiencies (referred to in subsection (a)) are $2,000,000 or greater (as demonstrated by the State to the satisfaction of the Secretary).

(e) Termination of provider agreements; disallowance of percentage amounts for purposes of Federal financial participation

(1) If the Secretary, at the conclusion of the 6-month plan of correction described in subsection (a)(1), determines that the State has substantially failed to correct the deficiencies described in subsection (a), the Secretary may terminate the facility's provider agreement in accordance with the provisions of section 1396i(b) of this title.

(2) In the case of a reduction plan described in subsection (a)(2), if the Secretary determines, at the conclusion of the initial 6-month period or any 6-month interval thereafter, that the State has substantially failed to meet the requirements of subsection (c), the Secretary shall—

(A) terminate the facility's provider agreement in accordance with the provisions of section 1396i(b) of this title; or

(B) if the State has failed to meet such requirements despite good faith efforts, disallow, for purposes of Federal financial participation, an amount equal to 5 percent of the cost of care for all eligible individuals in the facility for each month for which the State fails to meet such requirements.

(f) Applicability of section limited to plans approved by January 1, 1990

The provisions of this section shall apply only to plans of correction and reduction plans approved by the Secretary by January 1, 1990.

(Aug. 14, 1935, ch. 531, title XIX, § 1922, formerly § 1919, as added Pub. L. 99–272, title IX, § 9516(a), Apr. 7, 1986, 100 Stat. 213; renumbered § 1922 and amended Pub. L. 100–203, title IV, §§ 4211(a)(2), 4212(e)(5), Dec. 22, 1987, 101 Stat. 1330–182; amended Pub. L. 100–360, title IV, § 411(*l*)(6)(E), July 1, 1988, 102 Stat. 804; Pub. L. 100–647, title VIII, § 8433(a), Nov. 10, 1988, 102 Stat. 3804.)

PRIOR PROVISIONS

A prior section 1922 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

AMENDMENTS

1988—Subsec. (a). Pub. L. 100–647, § 8433(a)(1), inserted ''(including failure to provide active treatment)'' after ''residents'' in introductory provisions.

Subsec. (c)(5). Pub. L. 100–647, § 8433(a)(2), inserted '', and to provide active treatment for,'' after ''safety of''.

Subsec. (e)(1), (2)(A). Pub. L. 100–360, § 411(*l*)(6)(E), substituted ''1396i(b)'' for ''1396i(c)''.

Subsec. (f). Pub. L. 100–647, § 8433(a)(3), substituted ''by January 1, 1990'' for ''within 3 years after the effective date of final regulations implementing this section''.

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–647, title VIII, § 8433(b), Nov. 10, 1988, 102 Stat. 3805, provided that: ''The amendments made by subsection (a) [amending this section] shall become effective on the date of the enactment of this Act [Nov. 10, 1988], and shall apply to any proceeding where there has not yet been a final determination by the Secretary (as defined for purposes of judicial review) as of the date of the enactment of this Act.''

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE

Pub. L. 99–272, title IX, § 9516(b), Apr. 7, 1986, 100 Stat. 215, provided that:

''(1) The amendment made by this section [enacting this section] shall become effective on the date of the enactment of this Act [Apr. 7, 1986].

''(2) The Secretary of Health and Human Services shall issue a notice of proposed rulemaking with respect to section 1919 of the Social Security Act [42 U.S.C. 1396r–3] within 60 days after the date of the enactment of this Act, and shall allow a period of 30 days for comment thereon prior to promulgating final regulations implementing such section.''

REGULATIONS

Pub. L. 100–203, title IV, § 4217, Dec. 22, 1987, 101 Stat. 1330–220, provided that:

''(a) IN GENERAL.—Not later than 30 days after the date of enactment of this Act [Dec. 22, 1987], the Secretary of Health and Human Services shall promulgate final regulations to implement the amendments made by section 9516 of the Consolidated Omnibus Budget Reconciliation Act of 1985 [enacting this section].

''(b) The regulations promulgated under paragraph (1) shall be effective as if promulgated on the date of enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985 [Apr. 7, 1986].''

REPORT TO CONGRESS ON IMPLEMENTATION AND RESULTS OF THIS SECTION

Pub. L. 99–272, title IX, § 9516(c), Apr. 7, 1986, 100 Stat. 215, as amended by Pub. L. 100–203, title IV, § 4211(*l*), Dec. 22, 1987, 101 Stat. 1330–207, directed Secretary of Health and Human Services to submit a report to Con-

gress on implementation and results of this section, such report to be submitted not later than 30 months after the effective date of final regulations promulgated to implement this section.

§ 1396r–4. Adjustment in payment for inpatient hospital services furnished by disproportionate share hospitals

(a) Implementation of requirement

(1) A State plan under this subchapter shall not be considered to meet the requirement of section 1396a(a)(13)(A)(iv) of this title (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs), as of July 1, 1988, unless the State has submitted to the Secretary, by not later than such date, an amendment to such plan that—

(A) specifically defines the hospitals so described (and includes in such definition any disproportionate share hospital described in subsection (b)(1) which meets the requirements of subsection (d)), and

(B) provides, effective for inpatient hospital services provided not later than July 1, 1988, for an appropriate increase in the rate or amount of payment for such services provided by such hospitals, consistent with subsection (c).

(2)(A) In order to be considered to have met such requirement of section 1396a(a)(13)(A) of this title as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, the State plan amendment described in paragraph (1), consistent with subsection (c), effective for inpatient hospital services provided on or after July 1, 1989.

(B) In order to be considered to have met such requirement of section 1396a(a)(13)(A) of this title as of July 1, 1990, the State must submit to the Secretary by not later than April 1, 1990, the State plan amendment described in paragraph (1), consistent with subsections (c) and (f), effective for inpatient hospital services provided on or after July 1, 1990.

(C) If a State plan under this subchapter provides for payments for inpatient hospital services on a prospective basis (whether per diem, per case, or otherwise), in order for the plan to be considered to have met such requirement of section 1396a(a)(13)(A) of this title as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, a State plan amendment that provides, in the case of hospitals defined by the State as disproportionate share hospitals under paragraph (1)(A), for an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1989, involving exceptionally high costs or exceptionally long lengths of stay for individuals under one year of age.

(D) A State plan under this subchapter shall not be considered to meet the requirements of section 1396a(a)(13)(A)(iv) of this title (insofar as it requires payments to hospitals to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs), as of October 1, 1998, unless the State has submitted to the Secretary by such date a description of the methodology used by the State to identify and to make payments to disproportionate share hospitals, including children's hospitals, on the basis of the proportion of low-income and medicaid patients (including such patients who receive benefits through a managed care entity) served by such hospitals. The State shall provide an annual report to the Secretary describing the disproportionate share payments to each such disproportionate share hospital.

(3) The Secretary shall, not later than 90 days after the date a State submits an amendment under this subsection, review each such amendment for compliance with such requirement and by such date shall approve or disapprove each such amendment. If the Secretary disapproves such an amendment, the State shall immediately submit a revised amendment which meets such requirement.

(4) The requirement of this subsection may not be waived under section 1396n(b)(4) of this title.

(b) Hospitals deemed disproportionate share

(1) For purposes of subsection (a)(1), a hospital which meets the requirements of subsection (d) is deemed to be a disproportionate share hospital if—

(A) the hospital's medicaid inpatient utilization rate (as defined in paragraph (2)) is at least one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State; or

(B) the hospital's low-income utilization rate (as defined in paragraph (3)) exceeds 25 percent.

(2) For purposes of paragraph (1)(A), the term ''medicaid inpatient utilization rate'' means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under a State plan approved under this subchapter in a period (regardless of whether such patients receive medical assistance on a fee-for-service basis or through a managed care entity), and the denominator of which is the total number of the hospital's inpatient days in that period. In this paragraph, the term ''inpatient day'' includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

(3) For purposes of paragraph (1)(B), the term ''low-income utilization rate'' means, for a hospital, the sum of—

(A) the fraction (expressed as a percentage)—

(i) the numerator of which is the sum (for a period) of (I) the total revenues paid the hospital for patient services under a State plan under this subchapter (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) and (II) the amount of the cash subsidies for patient services received directly from State and local governments, and