viduals, 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; Pub. L. 114–10, title I, § 101(e)(4), Apr. 16, 2015, 129 Stat. 122; Pub. L. 114–85, § 1, Nov. 5, 2015, 129 Stat. 674; Pub. L. 115–271, title VI, §§ 6001, 6085(a), Oct. 24, 2018, 132 Stat. 3976, 3996.)

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

2018—Subsec. (b)(2)(B)(xxv). Pub. L. 115–271, § 6001, added cl. (xxv).

Subsec. (b)(2)(B)(xxvi), (xxvii). Pub. L. 115–271, § 6085(a), added cls. (xxvi) and (xxvii).

2015—Subsec. (b)(2)(B)(xxi) to (xxiv). Pub. L. 114–10, § 101(e)(4)(A), added cls. (xxi) to (xxiv).

Subsec. (b)(2)(C)(viii). Pub. L. 114–10, § 101(e)(4)(B), substituted ''other public sector payers, private sector payers, or statewide payment models'' for ''other public sector or private sector payers''.

Subsec. (d)(1). Pub. L. 114–85 substituted ''1396b(m)(2)(A)(iii), and 1396u–4 (other than subsections (b)(1)(A) and (c)(5) of such section)'' for ''and 1396b(m)(2)(A)(iii)''.

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).

CONSTRUCTION REGARDING TELEHEALTH SERVICES

Pub. L. 114–10, title I, § 101(e)(5), Apr. 16, 2015, 129 Stat. 122, provided that: ''Nothing in the provisions of, or amendments made by, this title [see Tables for classification] shall be construed as precluding an alternative payment model or a qualifying APM participant (as those terms are defined in section 1833(z) of the Social Security Act [42 U.S.C. 1395*l*(z)], as added by paragraph (1)) from furnishing a telehealth service for which payment is not made under section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)).''

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.

[1] So in original.

(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) 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.

(6) To act as a designated contact for States under subsection (f)(8)(A) of section 1859 of the Social Security Act (42 U.S.C. 1395w–28) with respect to the integration of specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) of such section.

(7) To be responsible, subject to the final approval of the Secretary, for developing regulations and guidance related to the implementation of a unified grievance and appeals process as described in subparagraphs (B) and (C) of section 1859(f)(8) of the Social Security Act (42 U.S.C. 1395w–28(f)(8)).

(8) To be responsible, subject to the final approval of the Secretary, for developing regulations and guidance related to the integration or alignment of policy and oversight under the Medicare program under title XVIII of such 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.] regarding specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) of such section 1859.

(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; Pub. L. 115–123, div. E, title III, §50311(b)(2), Feb. 9, 2018, 132 Stat. 196.)

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

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

REFERENCES IN TEXT

The Social Security Act, referred to in subsecs. (b), (d)(4), (8), 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.

AMENDMENTS

2018—Subsec. (d)(6) to (8). Pub. L. 115–123 added pars. (6) to (8).

§ 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, 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 State, unless the Secretary and such State agree in writing to holding the hearing at another time. The Secretary shall affirm, modify, or reverse his original determination within 60 days of the conclusion of the hearing.

(3) Any State which is dissatisfied with a final determination made by the Secretary on such a reconsideration or a final determination of the Secretary under section 304, 1204, 1354, 1384, or 1396c of this title may, within 60 days after it has been notified of such determination, file with the United States court of appeals for the circuit in which such State is located a petition for review of such determination. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary. The Secretary thereupon shall file in the court the record of the proceedings on which he based his determination as provided in section 2112 of title 28.

(4) The findings of fact by the Secretary, if supported by substantial evidence, shall be conclusive; but the court, for good cause shown, may remand the case to the Secretary to take further evidence, and the Secretary may thereupon make new or modified findings of fact and may modify his previous action, and shall certify to the court the transcript and record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence.

(5) The court shall have jurisdiction to affirm the action of the Secretary or to set it aside, in whole or in part. The judgment of the court shall be subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28.

(b) Amendment of plans

For the purposes of subsection (a), any amendment of a State plan approved under subchapter I, X, XIV, XVI, or XIX, may, at the option of the State, be treated as the submission of a new State plan.

(c) Restitution when Secretary reverses his determination

Action pursuant to an initial determination of the Secretary described in subsection (a) shall not be stayed pending reconsideration, but in the event that the Secretary subsequently determines that his initial determination was incorrect he shall certify restitution forthwith in a lump sum of any funds incorrectly withheld or otherwise denied.

(d) Disallowance of items covered under other subchapters

Whenever the Secretary determines that any item or class of items on account of which Federal financial participation is claimed under subchapter I, X, XIV,[1] XVI, shall be disallowed for such participation, the State shall be entitled to and upon request shall receive a reconsideration of the disallowance.

(e) Disallowance of items covered under subchapter XIX

(1) Whenever the Secretary determines that any item or class of items on account of which Federal financial participation is claimed under subchapter XIX shall be disallowed for such participation, the State shall be entitled to and upon request shall receive a reconsideration of the disallowance, provided that such request is made during the 60-day period that begins on the date the State receives notice of the disallowance.

(2)(A) A State may appeal a disallowance of a claim for federal[2] financial participation under subchapter XIX by the Secretary, or an unfavorable reconsideration of a disallowance, during the 60-day period that begins on the date the State receives notice of the disallowance or of the unfavorable reconsideration, in whole or in part, to the Departmental Appeals Board, established in the Department of Health and Human Services (in this paragraph referred to as the ''Board''), by filing a notice of appeal with the Board.

(B) The Board shall consider a State's appeal of a disallowance of such a claim (or of an unfa-

[1] So in original. Probably should be followed by ''or''.

[2] So in original. Probably should be capitalized.