(2) Section 1396a(a)(10) of this title, insofar as such section relates to comparability of services among different population groups.

(3) Sections 1396a(a)(23) and 1396n(b)(4) of this title, relating to freedom of choice of providers under a PACE program.

(4) Section 1396b(m)(2)(A) of this title, insofar as it restricts a PACE provider from receiving prepaid capitation payments.

(5) Such other provisions of this subchapter that, as added or amended by the Balanced Budget Act of 1997, the Secretary determines are inapplicable to carrying out a PACE program under this section.

(h) Demonstration project for for-profit entities

(1) In general

In order to demonstrate the operation of a PACE program by a private, for-profit entity, the Secretary (in close consultation with State administering agencies) shall grant waivers from the requirement under subsection (a)(3) that a PACE provider may not be a for-profit, private entity.

(2) Similar terms and conditions

(A) In general

Except as provided under subparagraph (B), and paragraph (1), the terms and conditions for operation of a PACE program by a provider under this subsection shall be the same as those for PACE providers that are nonprofit, private organizations.

(B) Numerical limitation

The number of programs for which waivers are granted under this subsection shall not exceed 10. Programs with waivers granted under this subsection shall not be counted against the numerical limitation specified in subsection (e)(1)(B).

(i) Post-eligibility treatment of income

A State may provide for post-eligibility treatment of income for individuals enrolled in PACE programs under this section in the same manner as a State treats post-eligibility income for individuals receiving services under a waiver under section 1396n(c) of this title.

(j) Miscellaneous provisions

Nothing in this section or section 1395eee of this title shall be construed as preventing a PACE provider from entering into contracts with other governmental or nongovernmental payers for the care of PACE program eligible individuals who are not eligible for benefits under part A, or enrolled under part B, of subchapter XVIII or eligible for medical assistance under this subchapter.

(Aug. 14, 1935, ch. 531, title XIX, §1934, as added Pub. L. 105–33, title IV, §4802(a)(3), Aug. 5, 1997, 111 Stat. 539; amended Pub. L. 106–554, §1(a)(6) [title IX, §902(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–583; Pub. L. 108–173, title II, §236(b)(2), Dec. 8, 2003, 117 Stat. 2211.)

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (a)(3)(A)(i), is classified generally to Title 26, Internal Revenue Code.

The Balanced Budget Act of 1997, referred to in subsecs. (a)(3)(B)(ii) and (g)(5), is Pub. L. 105–33, Aug. 5, 1997, 111 Stat. 251. Section 4804(b) of the Act is set out as a note under section 1395eee of this title. For complete classification of this Act to the Code, see Tables.

Section 603(c) of the Social Security Amendments of 1983, referred to in subsec. (a)(7)(A), is section 603(c) of Pub. L. 98–21, title VI, Apr. 20, 1983, 97 Stat. 168, which was not classified to the Code and was repealed by Pub. L. 105–33, title IV, §4803(d), Aug. 5, 1997, 111 Stat. 550, subject to transition provisions.

Section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985, referred to in subsec. (a)(7)(A), is section 9220 of Pub. L. 99–272, title IX, Apr. 7, 1986, 100 Stat. 183, which was not classified to the Code and was repealed by Pub. L. 105–33, title IV, §4803(d), Aug. 5, 1997, 111 Stat. 550, subject to transition provisions.

Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, referred to in subsecs. (a)(7)(B) and (e)(1)(B)(i), is section 9412(b) of Pub. L. 99–509, title IX, Oct. 21, 1986, 100 Stat. 2062, which was not classified to the Code and was repealed by Pub. L. 105–33, title IV, §4803(d), Aug. 5, 1997, 111 Stat. 550, subject to transition provisions.

For the effective date of this section, referred to in subsec. (a)(9)(B), see section 4803 of Pub. L. 105–33, set out as a Transition; Regulations note under section 1395eee of this title.

PRIOR PROVISIONS

A prior section 1934 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

AMENDMENTS

2003—Subsec. (b)(3), (4). Pub. L. 108–173 added pars. (3) and (4).

2000—Subsec. (f)(2)(C). Pub. L. 106–554 added subpar. (C).

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by Pub. L. 108–173 applicable to services furnished on or after Jan. 1, 2004, see section 236(c) of Pub. L. 108–173, set out as a note under section 1395cc of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by Pub. L. 106–554 effective as if included in the enactment of Pub. L. 105–33, see section 1(a)(6) [title IX, §902(c)] of Pub. L. 106–554, set out as a note under section 1395eee of this title.

§ 1396u–5. Special provisions relating to medicare prescription drug benefit

(a) Requirements relating to medicare prescription drug low-income subsidies, medicare transitional prescription drug assistance, and medicare cost-sharing

As a condition of its State plan under this subchapter under section 1396a(a)(66) of this title and receipt of any Federal financial assistance under section 1396b(a) of this title subject to subsection (e), a State shall do the following:

(1) Information for transitional prescription drug assistance verification

The State shall provide the Secretary with information to carry out section 1395w–141(f)(3)(B)(i) of this title.

(2) Eligibility determinations for low-income subsidies

The State shall—

(A) make determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1395w–114 of this title;

(B) inform the Secretary of such determinations in cases in which such eligibility is established; and

(C) otherwise provide the Secretary with such information as may be required to carry out part D, other than subpart 4, of subchapter XVIII (including section 1395w–114 of this title).

(3) Screening for eligibility, and enrollment of, beneficiaries for medicare cost-sharing

As part of making an eligibility determination required under paragraph (2) for an individual, the State shall make a determination of the individual's eligibility for medical assistance for any medicare cost-sharing described in section 1396d(p)(3) of this title and, if the individual is eligible for any such medicare cost-sharing, offer enrollment to the individual under the State plan (or under a waiver of such plan).

(4) Consideration of data transmitted by the Social Security Administration for purposes of Medicare Savings Program

The State shall accept data transmitted under section 1320b–14(c)(3) of this title and act on such data in the same manner and in accordance with the same deadlines as if the data constituted an initiation of an application for benefits under the Medicare Savings Program (as defined for purposes of such section) that had been submitted directly by the applicant. The date of the individual's application for the low income subsidy program from which the data have been derived shall constitute the date of filing of such application for benefits under the Medicare Savings Program.

(b) Regular Federal subsidy of administrative costs

The amounts expended by a State in carrying out subsection (a) are expenditures reimbursable under the appropriate paragraph of section 1396b(a) of this title.

(c) Federal assumption of medicaid prescription drug costs for dually eligible individuals

(1) Phased-down State contribution

(A) In general

Each of the 50 States and the District of Columbia for each month beginning with January 2006 shall provide for payment under this subsection to the Secretary of the product of—

(i) the amount computed under paragraph (2)(A) for the State and month;

(ii) the total number of full-benefit dual eligible individuals (as defined in paragraph (6)) for such State and month; and

(iii) the factor for the month specified in paragraph (5).

(B) Form and manner of payment

Payment under subparagraph (A) shall be made in a manner specified by the Secretary that is similar to the manner in which State payments are made under an agreement entered into under section 1395v of this title, except that all such payments shall be deposited into the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund.

(C) Compliance

If a State fails to pay to the Secretary an amount required under subparagraph (A), interest shall accrue on such amount at the rate provided under section 1396b(d)(5) of this title. The amount so owed and applicable interest shall be immediately offset against amounts otherwise payable to the State under section 1396b(a) of this title subject to subsection (e), in accordance with the Federal Claims Collection Act of 1996[1] and applicable regulations.

(D) Data match

The Secretary shall perform such periodic data matches as may be necessary to identify and compute the number of full-benefit dual eligible individuals for purposes of computing the amount under subparagraph (A).

(2) Amount

(A) In general

The amount computed under this paragraph for a State described in paragraph (1) and for a month in a year is equal to—

(i) 1/12 of the product of—

(I) the base year State medicaid per capita expenditures for covered part D drugs for full-benefit dual eligible individuals (as computed under paragraph (3)); and

(II) a proportion equal to 100 percent minus the Federal medical assistance percentage (as defined in section 1396d(b) of this title) applicable to the State for the fiscal year in which the month occurs; and

(ii) increased for each year (beginning with 2004 up to and including the year involved) by the applicable growth factor specified in paragraph (4) for that year.

(B) Notice

The Secretary shall notify each State described in paragraph (1) not later than October 15 before the beginning of each year (beginning with 2006) of the amount computed under subparagraph (A) for the State for that year.

(3) Base year state medicaid per capita expenditures for covered part D drugs for full-benefit dual eligible individuals

(A) In general

For purposes of paragraph (2)(A), the ''base year State medicaid per capita expenditures for covered part D drugs for full-benefit dual eligible individuals'' for a State is equal to the weighted average (as weighted under subparagraph (C)) of—

(i) the gross per capita medicaid expenditures for prescription drugs for 2003, determined under subparagraph (B); and

[1] See References in Text note below.

(ii) the estimated actuarial value of prescription drug benefits provided under a capitated managed care plan per full-benefit dual eligible individual for 2003, as determined using such data as the Secretary determines appropriate.

(B) Gross per capita medicaid expenditures for prescription drugs

(i) In general

The gross per capita medicaid expenditures for prescription drugs for 2003 under this subparagraph is equal to the expenditures, including dispensing fees, for the State under this subchapter during 2003 for covered outpatient drugs, determined per full-benefit-dual-eligible-individual for such individuals not receiving medical assistance for such drugs through a medicaid managed care plan.

(ii) Determination

In determining the amount under clause (i), the Secretary shall—

(I) use data from the Medicaid Statistical Information System (MSIS) and other available data;

(II) exclude expenditures attributable to covered outpatient prescription drugs that are not covered part D drugs (as defined in section 1395w–102(e) of this title, including drugs described in subparagraph (K) of section 1396r–8(d)(2) of this title); and

(III) reduce such expenditures by the product of such portion and the adjustment factor (described in clause (iii)).

(iii) Adjustment factor

The adjustment factor described in this clause for a State is equal to the ratio for the State for 2003 of—

(I) aggregate payments under agreements under section 1396r–8 of this title; to

(II) the gross expenditures under this subchapter for covered outpatient drugs referred to in clause (i).

Such factor shall be determined based on information reported by the State in the medicaid financial management reports (form CMS–64) for the 4 quarters of calendar year 2003 and such other data as the Secretary may require.

(C) Weighted average

The weighted average under subparagraph (A) shall be determined taking into account—

(i) with respect to subparagraph (A)(i), the average number of full-benefit dual eligible individuals in 2003 who are not described in clause (ii); and

(ii) with respect to subparagraph (A)(ii), the average number of full-benefit dual eligible individuals in such year who received in 2003 medical assistance for covered outpatient drugs through a medicaid managed care plan.

(4) Applicable growth factor

The applicable growth factor under this paragraph for—

(A) each of 2004, 2005, and 2006, is the average annual percent change (to that year from the previous year) of the per capita amount of prescription drug expenditures (as determined based on the most recent National Health Expenditure projections for the years involved); and

(B) a succeeding year, is the annual percentage increase specified in section 1395w–102(b)(6) of this title for the year.

(5) Factor

The factor under this paragraph for a month—

(A) in 2006 is 90 percent;
(B) in 2007 is 88⅓ percent;
(C) in 2008 is 86⅔ percent;
(D) in 2009 is 85 percent;
(E) in 2010 is 83⅓ percent;
(F) in 2011 is 81⅔ percent;
(G) in 2012 is 80 percent;
(H) in 2013 is 78⅓ percent;
(I) in 2014 is 76⅔ percent; or
(J) after December 2014, is 75 percent.

(6) Full-benefit dual eligible individual defined

(A) In general

For purposes of this section, the term ''full-benefit dual eligible individual'' means for a State for a month an individual who—

(i) has coverage for the month for covered part D drugs under a prescription drug plan under part D of subchapter XVIII, or under an MA–PD plan under part C of such subchapter; and

(ii) is determined eligible by the State for medical assistance for full benefits under this subchapter for such month under section 1396a(a)(10)(A) or 1396a(a)(10)(C) of this title, by reason of section 1396a(f) of this title, or under any other category of eligibility for medical assistance for full benefits under this subchapter, as determined by the Secretary.

(B) Treatment of medically needy and other individuals required to spend down

In applying subparagraph (A) in the case of an individual determined to be eligible by the State for medical assistance under section 1396a(a)(10)(C) of this title or by reason of section 1396a(f) of this title, the individual shall be treated as meeting the requirement of subparagraph (A)(ii) for any month if such medical assistance is provided for in any part of the month.

(d) Coordination of prescription drug benefits

(1) Medicare as primary payor

In the case of a part D eligible individual (as defined in section 1395w–101(a)(3)(A) of this title) who is described in subsection (c)(6)(A)(ii), notwithstanding any other provision of this subchapter, medical assistance is not available under this subchapter for such drugs (or for any cost-sharing respecting such drugs), and the rules under this subchapter relating to the provision of medical assistance for such drugs shall not apply. The provision of benefits with respect to such drugs shall not be considered as the provision of care or services under the plan under this subchapter. No

payment may be made under section 1396b(a) of this title for prescribed drugs for which medical assistance is not available pursuant to this paragraph.

(2) Coverage of certain excludable drugs

In the case of medical assistance under this subchapter with respect to a covered outpatient drug (other than a covered part D drug) furnished to an individual who is enrolled in a prescription drug plan under part D of subchapter XVIII or an MA–PD plan under part C of such subchapter, the State may elect to provide such medical assistance in the manner otherwise provided in the case of individuals who are not full-benefit dual eligible individuals or through an arrangement with such plan.

(e) Treatment of territories

(1) In general

In the case of a State, other than the 50 States and the District of Columbia—

(A) the previous provisions of this section shall not apply to residents of such State; and

(B) subject to paragraph (4), if the State establishes and submits to the Secretary a plan described in paragraph (2) (for providing medical assistance with respect to the provision of prescription drugs to part D eligible individuals), the amount otherwise determined under section 1308(f) of this title (as increased under section 1308(g) of this title) for the State shall be increased by the amount for the fiscal period specified in paragraph (3).

(2) Plan

The Secretary shall determine that a plan is described in this paragraph if the plan—

(A) provides medical assistance with respect to the provision of covered part D drugs (as defined in section 1395w–102(e) of this title) to low-income part D eligible individuals;

(B) provides assurances that additional amounts received by the State that are attributable to the operation of this subsection shall be used only for such assistance and related administrative expenses and that no more than 10 percent of the amount specified in paragraph (3)(A) for the State for any fiscal period shall be used for such administrative expenses; and

(C) meets such other criteria as the Secretary may establish.

(3) Increased amount

(A) In general

The amount specified in this paragraph for a State for a year is equal to the product of—

(i) the aggregate amount specified in subparagraph (B); and

(ii) the ratio (as estimated by the Secretary) of—

(I) the number of individuals who are entitled to benefits under part A[1] or enrolled under part B[1] and who reside in the State (as determined by the Secretary based on the most recent available data before the beginning of the year); to

(II) the sum of such numbers for all States that submit a plan described in paragraph (2).

(B) Aggregate amount

The aggregate amount specified in this subparagraph for—

(i) the last 3 quarters of fiscal year 2006, is equal to $28,125,000;

(ii) fiscal year 2007, is equal to $37,500,000; or

(iii) a subsequent year, is equal to the aggregate amount specified in this subparagraph for the previous year increased by annual percentage increase specified in section 1395w–102(b)(6) of this title for the year involved.

(4) Treatment of funding for certain fiscal years

Notwithstanding paragraph (1)(B), in the case that Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa establishes and submits to the Secretary a plan described in paragraph (2) with respect to any of fiscal years 2020 through 2021, the amount specified for such a year in paragraph (3) for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa, as the case may be, shall be taken into account in applying, as applicable, subparagraph (A)(ii), (B)(ii), (C)(ii), (D)(ii), or (E)(ii) of section 1308(g)(2) of this title for such year.

(5) Report

The Secretary shall submit to Congress a report on the application of this subsection and may include in the report such recommendations as the Secretary deems appropriate.

(Aug. 14, 1935, ch. 531, title XIX, § 1935, as added and amended Pub. L. 108–173, title I, § 103(a)(2)(B), (b)–(d)(1), Dec. 8, 2003, 117 Stat. 2154–2158; Pub. L. 109–91, title I, § 104(c), Oct. 20, 2005, 119 Stat. 2093; Pub. L. 110–275, title I, § 113(b), July 15, 2008, 122 Stat. 2506; Pub. L. 116–94, div. N, title I, § 202(b), Dec. 20, 2019, 133 Stat. 3107.)

REFERENCES IN TEXT

No act with the title Federal Claims Collection Act of 1996, referred to in subsec. (c)(1)(C), has been enacted. However, Pub. L. 89–508, July 19, 1966, 80 Stat. 308, was known as the Federal Claims Collection Act of 1966. Sections 2, 3, and 5 of Pub. L. 89–508, which enacted sections 951, 952, and 954, respectively, of former Title 31, Money and Finance, were repealed by Pub. L. 97–258, § 5(b), Sept. 13, 1982, 96 Stat. 877, the first section of which enacted Title 31, Money and Finance. For disposition of sections of former Title 31 into revised Title 31, see Table preceding section 101 of Title 31. For complete classification of Pub. L. 89–508 to the Code, see Tables.

Parts A and B, referred to in subsec. (e)(3)(A)(ii)(I), probably means parts A and B of subchapter XVIII of this chapter. This subchapter does not contain parts.

PRIOR PROVISIONS

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

AMENDMENTS

2019—Subsec. (e)(1)(B). Pub. L. 116–94, §202(b)(1), substituted ''subject to paragraph (4), if the State'' for ''if the State''.

Subsec. (e)(4), (5). Pub. L. 116–94, §202(b)(2), (3), added par. (4) and redesignated former par. (4) as (5).

2008—Subsec. (a). Pub. L. 110–275 amended heading to include reference to medicare cost-sharing and added par. (4).

2005—Subsec. (c)(3)(B)(ii)(II). Pub. L. 109–91 inserted '', including drugs described in subparagraph (K) of section 1396r–8(d)(2) of this title'' after ''section 1395w–102(e) of this title''.

2003—Subsec. (a). Pub. L. 108–173, §103(d)(1)(A), inserted ''subject to subsection (e)'' after ''section 1396b(a) of this title'' in introductory provisions.

Subsec. (c). Pub. L. 108–173, §103(b), added subsec. (c).

Subsec. (c)(1)(C). Pub. L. 108–173, §103(d)(1)(B), which directed the amendment of subsec. (c)(1) by inserting ''subject to subsection (e)'' after ''section 1396b(a)(1) of this title'', was executed by making the insertion after ''section 1396b(a) of this title'' in subpar. (C) to reflect the probable intent of Congress.

Subsec. (d). Pub. L. 108–173, §103(c), added subsec. (d).

Subsec. (e). Pub. L. 108–173, §103(d)(1)(C), added subsec. (e).

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110–275 effective Jan. 1, 2010, see section 113(c) of Pub. L. 110–275, set out as a note under section 1320b–14 of this title.

EFFECTIVE DATE OF 2005 AMENDMENT

Amendment by Pub. L. 109–91 applicable to drugs dispensed on or after Jan. 1, 2006, see section 104(d) of Pub. L. 109–91, set out as a note under section 1396b of this title.

§ 1396u–6. Medicaid Integrity Program

(a) In general

There is hereby established the Medicaid Integrity Program (in this section referred to as the ''Program'') under which the Secretary shall promote the integrity of the program under this subchapter by entering into contracts in accordance with this section with eligible entities, or otherwise, to carry out the activities described in subsection (b).

(b) Activities described

Activities described in this subsection are as follows:

(1) Review of the actions of individuals or entities furnishing items or services (whether on a fee-for-service, risk, or other basis) for which payment may be made under a State plan approved under this subchapter (or under any waiver of such plan approved under section 1315 of this title) to determine whether fraud, waste, or abuse has occurred, is likely to occur, or whether such actions have any potential for resulting in an expenditure of funds under this subchapter in a manner which is not intended under the provisions of this subchapter.

(2) Audit of claims for payment for items or services furnished, or administrative services rendered, under a State plan under this subchapter, including—

(A) cost reports;

(B) consulting contracts; and

(C) risk contracts under section 1396b(m) of this title.

(3) Identification of overpayments to individuals or entities receiving Federal funds under this subchapter.

(4) Education or training, including at such national, State, or regional conferences as the Secretary may establish, of State or local officers, employees, or independent contractors responsible for the administration or the supervision of the administration of the State plan under this subchapter, providers of services, managed care entities, beneficiaries, and other individuals with respect to payment integrity and quality of care.

(c) Eligible entity and contracting requirements

(1) In general

An entity is eligible to enter into a contract under the Program to carry out any of the activities described in subsection (b) if the entity satisfies the requirements of paragraphs (2) and (3).

(2) Eligibility requirements

The requirements of this paragraph are the following:

(A) The entity has demonstrated capability to carry out the activities described in subsection (b).

(B) In carrying out such activities, the entity agrees to cooperate with the Inspector General of the Department of Health and Human Services, the Attorney General, and other law enforcement agencies, as appropriate, in the investigation and deterrence of fraud and abuse in relation to this subchapter and in other cases arising out of such activities.

(C) The entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement.

(D) The entity agrees to provide the Secretary and the Inspector General of the Department of Health and Human Services with such performance statistics (including the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment of such activities by the entity) as the Secretary or the Inspector General may request.

(E) The entity meets such other requirements as the Secretary may impose.

(3) Contracting requirements

The entity has contracted with the Secretary in accordance with such procedures as the Secretary shall by regulation establish, except that such procedures shall include the following:

(A) Procedures for identifying, evaluating, and resolving organizational conflicts of interest that are generally applicable to Federal acquisition and procurement.

(B) Competitive procedures to be used—

(i) when entering into new contracts under this section;

(ii) when entering into contracts that may result in the elimination of responsibilities under section 202(b) of the Health Insurance Portability and Accountability Act of 1996; and

(iii) at any other time considered appropriate by the Secretary.

(C) Procedures under which a contract under this section may be renewed without