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CHILD HEALTH ASSESSMENT ACT OF 1979 AND MEDICAID FUNDING FOR THE TERRITORIES

JULY 30 (legislative day, JUNE 21), 1979.—Ordered to be printed

Mr. LONG, from the Committee on Finance, submitted the following

REPORT

[To accompany S. 1204]

The Committee on Finance, to which was referred the bill (S. 1204) to strengthen and improve medicaid services to low-income children and pregnant women, and for other purposes, having considered the same, reports favorably thereon with an amendment and an amendment to the title and recommends that the bill, as amended, do pass.

I. SUMMARY

The bill as reported by the Finance Committee incorporates, in the nature of a substitute, the provisions of title I and II of H.R. 9434, 95th Congress, as reported by the Finance Committee (with later effective dates).

Title I of the bill increases the ceiling on Federal funding for the medicaid programs in Puerto Rico, the Virgin Islands, and Guam, and deletes the existing 50-percent limit on the Federal medical assistance percentage rate applicable to these jurisdictions. The bill further provides for Federal matching to the new ceilings to be determined by a formula based on per capita income and extends the proposal to include the Northern Marianas.

Title II of the bill would amend title XIX of the Social Security Act (which establishes the medicaid program) to make additional children eligible for medicaid coverage; increase the proportionate share of the costs of health assessments and outpatient treatment for medicaid children which is paid for by the Federal Government; provide incentives for more successful operation of health assessment and follow-up programs by the States; assure that all types of eligible health care practitioners and agencies may serve as CHAP providers

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for medicaid children; provide for penalties (in the form of reduced matching of administrative costs) for States which do not meet minimum performance standards in their child health assessment programs (CHAP), and bonuses, in the form of increased matching for medicaid administrative costs, for those that perform exceptionally well; and for other purposes.

Specifically, the legislation would do the following:

1. Require States to provide medicaid for all individuals age 6 and under who are financially eligible under the State welfare or medicaid income standard, regardless of whether they are members of an intact family. (Current law requires States only to cover children in families where one parent is absent or incapacitated.) Additionally, it makes Federal matching available to cover mandated services (as well as those covered in the State plan) to all financially eligible individuals up to the age of 21 if a State elects to provide medicaid to persons in this age group. All of these children are eligible for the medicaid services normally included in the State plan, including assessment services. Once a child has been assessed, that child would also be eligible for all medically necessary services (with some exceptions) whether or not the State plan makes specific provision for them.

2. Provides a 4-month extension of eligibility for medicaid beyond the point when the income and resources of the family exceed the financial eligibility standard for the program for any child who has received a health assessment, in order to assure adequate time to receive necessary services.

3. Allows Federal matching for medicaid coverage for adopted children who have been in foster care, and who were hard to place for adoption because of a handicapping or medical condition requiring medical care, regardless of the income level of the adopting family. This coverage would be at the option of a State.

4. Allows children who are inmates of public institutions to remain eligible for medicaid if they were eligible before entry into the facility. (Current law provides that eligibility ceases when a person becomes an inmate of a public institution which is not a medical institution.)

5. Provides that all children who have received a health assessment are eligible for all treatment and services which could be paid for under medicaid, whether or not such treatment is included in the State plan except that no State would be required to provide services for mental illness except as covered in the State plan, care for the mentally retarded in an intermediate care facility, or dental care which is not routine. An assessed child would not be required to make copayments for any medicaid service.

6. Provides for an increase in the Federal matching rate for assessments, and for all noninpatient services provided to children who have been assessed (and reassessed at appropriate intervals). The new Federal matching rate is the greater of 75 percent or halfway between the current medicaid matching rate and 90 percent.

7. Requires a maintenance of effort by States relative to services for children, as a condition for receiving the higher

Federal matching rate; that is, for a 2-year period, the receipt of the increased Federal matching would be conditioned on a State taking no action that would reduce both the scope and extent of medicaid coverage and State share of spending for children.

8. Repeals (retroactive to original enactment) the penalty provision of current law for States which fail to meet certain requirements of the early and periodic screening, diagnosis, and treatment (EPSDT) program and replaces it with a provision for a 20-percent decrease in the Federal share of medicaid administrative costs for States which fail to meet certain minimum CHAP performance standards established by the Secretary. The Secretary would have the authority to delay imposition of the penalty for 6 months where he found a State was making a good faith effort to comply and to waive it if compliance is achieved in that time period. The legislation also provided for a bonus in the form of a 25-percent increase in matching for administrative costs for States which meet standards for outstanding performance.

9. Requires States to offer written agreements to all qualified health care providers who will agree to do assessments and necessary follow-up on terms as will reasonably be expected to elicit adequate provider involvement, including private practitioners, public health departments, community health center, Head Start agencies, rural health clinics, and maternal and child health centers. Additionally, provision was made to allow States to sign agreements with student health service and school systems which have made arrangements for assessments.

10. Requires providers who do assessments of medicaid children to provide them with routine dental care or information on dentists who participate in medicaid.

11. Requires States to designate a lead agency which must establish and maintain a health profile for each child so as to insure appropriate coordination and nonduplication in the provision of care and services to the child.

II. General Explanation of the Bill

TITLE I—MEDICAID PROGRAMS IN PUERTO RICO, THE VIRGIN ISLANDS, GUAM, AND THE NORTHERN MARIANA ISLANDS

Section 101—Adjustments of dollar limitation on medicaid payments to Puerto Rico, the Virgin Islands, Guam, and the Northern Mariana Islands

The bill increases the ceiling on Federal funding for the medicaid programs in Puerto Rico, the Virgin Islands, and Guam. It further establishes a ceiling on Federal funding for the Northern Mariana Islands.

Under section 1108 of the Social Security Act, absolute ceilings are placed on Federal matching payments for medicaid programs in Puerto Rico, the Virgin Islands, and Guam. These fiscal year limits are $30 million for Puerto Rico, $1 million for the Virgin Islands, and $900,000 for Guam.

The original justifications for the limitation on Federal matching funds for the jurisdictions was based on their tax status. The Commonwealth of Puerto Rico has been exempt from Federal personal and corporate income taxes, and excise taxes have been rebated intact to the Commonwealth government. The Federal income tax laws apply to the territories of Guam, and the Virgin Islands; however, the Federal income tax revenues are rebated intact for the use of the territorial government.

The committee notes that the current ceilings on Federal expenditures have severely affected the amount of funds available to operate adequate medicaid programs in the jurisdictions, primarily because they have not been increased to reflect inflation in the economy in general and in medical care costs in particular. In fact, the amount of Federal dollars available in constant terms is less than 60 percent of what it was when the ceilings (for Puerto Rico and the Virgin Islands) were changed in 1972.

The committee bill increases the fiscal year ceiling on Federal funding for medicaid programs beginning in fiscal year 1980 to $60 million for Puerto Rico, $2 million for the Virgin Islands, and $1.8 million for Guam. The bill also establishes a payment ceiling of $500,000 for the Commonwealth of the Northern Mariana Islands which is added to the medicaid program by section 102 of this bill.

Section 102—Elimination of special limitation on the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, and Guam

The bill deletes the existing limit on the Federal medical assistance percentage rate applicable to Puerto Rico, the Virgin Islands, and Guam and extends medicaid coverage to the Northern Mariana Islands.

The medicaid program is designed to provide relatively greater Federal assistance to areas which have limited resources. The Federal matching rate established under title XIX is determined by a statutory formula designed to provide a higher percentage of Federal matching to States with low per capita incomes, and a lower percentage of Federal matching to States with higher per capita incomes. No State may have a matching rate lower than 50 percent or higher than 83 percent. The rationale for the formula is to assist low income States in meeting the medical needs for their low income citizens through a greater infusion of Federal funds. However, the committee notes that the artificial 50-percent limitation on Federal matching for the jurisdictions has meant that they can not benefit from the variable Federal matching as States with low per capita incomes do.

The committee bill provides that after September 30, 1979, the Federal matching rate for the jurisdictions would be determined in the same manner as it is determined for the 50 States and the District of Columbia up to the new ceilings established under section 101 of the bill. This would allow Federal matching to be determined by a formula based on per capita income. Currently, this would provide for a Federal matching rate of 81.59 percent for Guam, 83 percent for Puerto Rico, and 74.2 percent for the Virgin Islands.

Under current law the Northern Mariana Islands are excluded from coverage under the medicaid program. The committee bill extends medicaid coverage to this jurisdiction.

TITLE II—CHILD HEALTH ASSESSMENT ACT

Title II of the committee bill amends title 19 of the Social Security Act to create a new child health assessment program (CHAP) under medicaid.

The primary purpose of the program is to increase the availability of quality health care for low income children. The aim of the child health assessment program is to enroll children in a program of health care which provides them comprehensive preventive services and needed subsequent care. Essentially, CHAP expands eligibility for the present early and periodic screening, diagnosis, and treatment (EPSDT) program and medicaid services, seeks to improve participation in the program, and increases the Federal matching rates.

Medicaid eligibility for poor and hard-to-place adopted children

Section 203 of the committee bill assures the eligibility of needy children age 6 or under for medicaid in all States regardless of the structure of the family of which the child is a member, provides for reasonable continuity of eligibility for children on medicaid, makes provision for a child to retain medicaid eligibility while in a public institution for juveniles, and allows medicaid coverage for hard-to-place adopted children.

The committee bill requires all State medicaid programs to extend eligibility to children through age 6 who are determined to be needy regardless of whether that child is alone, is in a broken family, is in a family with an unemployed parent, or is in an intact family.

Eighteen States as well as Puerto Rico and the Virgin Islands now provide medicaid to all financially eligible children under 21. It was not the intention of the committee to require any reduction of coverage for this group; in fact, throughout its deliberations the committee was intent on assuring that the legislation result in expansions of coverage, not cutbacks (see the section on maintenance of effort). The committee was particularly concerned that existing coverage of mental health care and dental care for children not be terminated or reduced. Therefore, the reported legislation specifically allows any State to provide coverage for needy children up to the age of 21. If a State elects this option, Federal matching will be available for all covered medical assistance provided. The committee expects that if the State opts for this broader coverage, any children age 7 to 21 brought into coverage would be eligible for the same services and under the same conditions as children age 6 and under covered under the State plan.

The bill allows medicaid coverage for children with special needs placed for adoption. The committee was concerned with the effect of the provision of the current medicaid program which allows a State to cover children in foster care, but does not allow coverage if these children are placed for adoption in a family with income even slightly higher than the medicaid standard.

HEW estimates that there are approximately 250,000 children currently in foster care. A significant portion of those children have not

been adopted because of their special needs. A large number of these children have handicapping conditions—often multiple handicaps—which require continuing care and treatment. Although often eligible for medicaid while in foster care, these children frequently would lose such eligibility if adopted and probably would also be ineligible for coverage under the insurance policies of adoptive parents because their handicaps constitute a preexisting condition. The absence of medicaid coverage for such children following placement for adoption serves as a fiscal disincentive to finding permanent adoptive homes for these children and keeps them in foster care at public expense. The purpose of allowing States to cover these adopted children with special needs under medicaid is to encourage and facilitate their adoption.

It should be noted that the decision whether to cover these children would be the State's. The committee bill simply makes Federal matching funds available if they wish to do so.

The committee allows the State to determine whether to provide coverage for these children only until they find the need for the continuing medical care and services no longer exists, or up to the age of eligibility for children under the State plan. The committee believes the certainty of the time of coverage of the second option, and the greater ease of administering it, justifies providing this option to the States.

Required services

Section 204 of the committee bill clarifies the services which must be provided to children under the medicaid program by requiring States to provide comprehensive health assessments for all children and requiring that States cover all services (with limited exceptions, as noted below) for which payment may be made under the medicaid program, as needed by an assessed child.

The committee bill provides that any individual under 21 who has received a timely periodic child health assessment is eligible for all care and services for which Federal matching funds are available under title XIX, without regard to whether such care and services are included in the State plan, and without regard to any limits on the amount, duration or scope of services included in the State plan, with exceptions. Entitlement to inpatient services in an institution for mental diseases, to inpatient services in an intermediate care facility for the mentally retarded, and to routine dental care is limited to the extent of coverage of those services in the State medicaid plan. States would not be required to provide services for mental illness nor inpatient care in an intermediate care facility for the mentally retarded except as covered in the State medicaid plan. Nor would States be required to provide other than routine dental care as defined in the bill.

The bill also provides for referral for appropriate care and services not available under title XIX.

The bill specifies that the making available of child health assessments and services beyond those covered in the State plan for assessed children shall not require that these services be available to all other persons eligible under the medicaid program.

The bill provides that all State medicaid plans must include the following required services: child health assessments, diagnosis, treat-

ment, referral and medical case management of individuals under 21 who are included under the plan.

The bill defines a child health assessment as an assessment provided for an individual under 21 for such health problems and at such periods as the Secretary specifies in regulations, and provides that such assessments may only be provided by a health care provider who enters into a written agreement with the State medicaid agency. The written agreement must meet standards established by the Secretary and include an agreement that the provider will:

(1) provide timely and appropriate child health assessments,

(2) provide assessed individuals with basic diagnostic and treatment services (including immunizations) or refer assessed individuals to other health care providers for basic diagnostic and treatment services and follow-up to insure the services have been provided,

(3) refer assessed children to dentists, using a list provided by the State agency on dentists who will provide services to medicaid children,

(4) refer assessed children to other providers for any corrective treatment found to be necessary during the assessment which is not available directly from the provider doing the assessment, and follow-up to assure the services are received,

(5) take responsibility for the management of the medical care of each assessed child,

(6) be reasonably accessible on an ongoing basis to assessed individuals in order to provide continuing and available care,

(7) make such reports as are necessary.

The bill specifies that the term health care provider includes (but is not limited to), a private practitioner, public health department, community health clinic or center, primary care center, day care or Head Start program, rural health clinic, maternal and child health center, student health service, a school system, for purposes of doing assessments and carrying out other requirements of the CHAP program. Further the bill clarifies that providers carrying out assessments and providing other medical care and services to children are eligible for payment through the medicaid program whether such provider ordinarily bills other third party payors for the provision of similar services or not.

The committee intends the child health assessment program to move beyond a mass screening program where the emphasis is on conditions that can be found by a single, rapid test or procedure. The intent is to introduce children to an ongoing source of primary care where they receive comprehensive health assessments (at regular intervals to be determined by their age) and subsequent care. The assessment should be individualized to the greatest extent possible. Parents of young children, in particular, should be involved in providing relevant health history and in receiving thorough counseling about the child's development and health needs.

Standards for the frequency and content of health assessments would be established by the Department. At a minimum, assessments should include the full array of assessment procedures recommended in current EPSDT guidelines plus counseling and the modified approach to developmental assessments as directed below by the com-

mittee. The Department should also establish standards for the frequency with which children of various ages should be assessed and the procedures necessary at each visit. The schedule is expected to be based on the American Academy of Pediatrics' "Master Schedule for Screening." A public comment period on proposed standards will provide ample opportunity for professional and other representatives or spokesmen to recommend any changes to revise standards in accordance with medical advances.

Several facts have convinced the committee to call for a "comprehensive health assessment" rather than a separate assessment for physical and mental problems: The opportunities for misclassifying children are great and have serious consequences for children; according to many professionals, we do not know how to assess children in the area of mental defects; and in many parts of the country there are not adequate resources to care for problems found through such a process. Therefore the committee intends that the assessment of a child's growth and development should be performed comprehensively in the context of routine assessment procedures. Growth and development should be evaluated through a thorough health history, physical examination and such observation of the child as is possible in the course of performing routine procedures. Such an approach will uncover common problems which impair development.

In replacing the separate "screening for mental defects" with a "comprehensive assessment," the committee in no way intends to limit the program's charge to identify and care for developmental problems. Rather, the committee has chosen this approach because it minimizes the danger of careless implementation which could result in damage to children. At the same time, it does not dilute the benefits children can derive from assessments of selected and better understood aspects of development and growth.

It is not the committee's intent to reduce services available to children in the area of mental health. The committee hopes that children will continue to receive at least current services.

Treatment of copayments for assessed children

Section 205 prohibits States from imposing cost-sharing charges on any individuals who have received a timely health assessment. The committee intends that no impediments be placed in the way of children who have received assessment services from obtaining health care needed to correct or ameliorate identified health problems.

Continuation of eligibility

Section 206 of the committee bill provides that a child who has received a timely health assessment and then loses medicaid eligibility for any reason other than attaining the maximum age of coverage for children under the State plan will be entitled to an additional four-months of eligibility under medicaid. The committee believes this provision can eliminate many of the problems of children going on and off medicaid eligibility which has in the past complicated program administration, burdened providers, and resulted in children not receiving the care their health assessments have shown to be necessary. The committee notes that for children in AFDC families, this extension of eligibility would operate in place of, not in addition to, the 4-month extension of eligibility for AFDC families who would otherwise lose medical eligibility because of employment.

Section 207—Federal reimbursements

Section 207 of the bill establishes increased matching rates for the costs of health assessments and all services (other than dental or inpatient care) provided to children who have been assessed and reassessed at appropriate intervals. It requires States to develop implementation plans. The section also requires the Secretary to establish standards for acceptable and outstanding performance for CHAP programs and to base penalties (if necessary) and bonuses, (where warranted) on the success of each State in achieving these standards. The section also includes a 2-year maintenance of effort provision.

The committee bill establishes an increased Federal matching rate for the costs of health assessments and all noninpatient services provided to children who have been assessed and reassessed at appropriate intervals. This higher matching rate, termed the Federal CHAP percentage, is the greater of 75 percent or halfway between the current medicaid matching rate and 90 percent.

The committee was concerned that some States have been slow to implement the EPSDT program because of a fear that, whatever its long-run savings, the program could result in a short-term increase in costs. This concern was believed to be a contributing factor to the inadequate outreach and screening efforts that have characterized some State programs. By making the increased match available only for noninpatient services for assessed children, it hopes to (a) encourage the use of ambulatory care wherever possible, and (b) provide a strong incentive to the States to assess as many medicaid children as possible.

The increase in the matching rate is shown in the following table.

CURRENT MEDICAID FEDERAL MATCHING RATES AND RATES UNDER CHAP, BY STATE

[Federal percentage]

State	For services		State	For services	
	Current law	Under CHAP [1]		Current law	Under CHAP [1]
Alabama	71	81	Montana	64	79
Alaska	50	75	Nebraska	58	75
Arkansas	73	81	Nevada	50	75
California	50	75	New Hampshire	60	76
Colorado	53	75	New Jersey	50	75
Connecticut	50	75	New Mexico	69	80
Delaware	50	75	New York	50	75
District of Columbia	50	75	North Carolina	68	79
Florida	59	75	North Dakota	61	76
Georgia	67	78	Ohio	55	75
Hawaii	50	75	Oklahoma	64	77
Idaho	66	78	Oregon	56	75
Illinois	50	75	Pennsylvania	55	75
Indiana	57	75	Rhode Island	58	75
Iowa	57	75	South Carolina	71	80
Kansas	54	75	South Dakota	69	79
Kentucky	68	79	Tennessee	69	80
Louisiana	69	79	Texas	58	75
Maine	70	80	Utah	68	79
Maryland	50	75	Vermont	68	79
Massachusetts	52	75	Virginia	57	75
Michigan	50	75	Washington	50	75
Minnesota	56	75	West Virginia	67	79
Mississippi	78	84	Wisconsin	58	75
Missouri	60	75	Wyoming	50	75

[1] Matching rate for health assessments, and for all outpatient services provided to a child who has been assessed (and reassessed) at appropriate intervals.

The committee bill requires States to develop and make available for public comment their plans for implementation of a child health assessment program.

The committee recognizes that unlike other medicaid services, CHAP's mandate includes assuring that children actually receive an array of health services. Therefore the committee has established a different planning mechanism than that used for other parts of medicaid. States will be expected to develop and continually revise a program plan for CHAP which demonstrates how the major requirements of the program will be met. In meeting the State plan requirements set out in the legislation, implementation plans should identify and make provision for written agreements with qualified providers on terms which can reasonably be expected to elicit their involvement in the program; assure coordination with other programs providing health care services to children; assure availability of appropriate support services including outreach and followup; and provide for the establishment and maintenance of health profiles on each eligible child.

It is clear that in order for the needs of CHAP children to be cared for properly, all qualified health resources must be utilized in the program. A recipient's right to "freedom of choice" among providers is an additional reason why the committee expects States to make vigorous efforts to elicit the participation of the range of providers in each community who are qualified to fulfill the responsibilities as set forth in the legislation and who agree to comply with the cost and service requirements of the program.

To obtain the widest possible provider participation, the committee expects the States to work with provider organizations to educate them about the program, to determine the most effective way of identifying all qualified providers, and to establish contractual terms capable of eliciting broad provider participation. Contractual terms should include: reimbursement levels which reasonably cover the cost or are competitive with prevailing rates for all services provided (including reporting as well as outreach and followup services if provided by the provider); reasonable reporting arrangements; and prompt payment of claims.

It is the committee's intent that the State plan describe how families will be informed of the program, what arrangements will be made to assist them in finding and getting an appointment with a qualified provider, how followup will be assured, and how necessary transportation will be arranged.

The committee bill requires the Secretary to establish standards for acceptable and superior performance for CHAP programs, and to base penalties (if necessary) and bonuses (where warranted) on the success of each State in achieving these standards.

The committee recognizes that the program requirements under EPSDT have often failed to extend the intended benefits to eligible children. In response to this deficiency, the committee has structured CHAP to place an emphasis on actually reaching needy children with assessments and subsequent care.

Much has been learned about what constitutes an effective EPSDT program. The committee believes that the considerable experience EPSDT has provided should serve as the basis for defining further the performance criteria and reasonable numerical standards. On the

basis of past experience, performance criteria have been selected related to key CHAP services: informing families about the program; providing comprehensive health assessments and medical care for problems disclosed; bringing children up to date on immunizations; and assuring that providers offer services in accordance with agreed-upon terms. The intent is to enroll children in the CHAP program and assure they receive appropriate covered preventive and needed subsequent care.

These performance criteria will be used to determine superior performance worthy of the financial bonus as well as inadequate performance which warrants the financial penalty. Numerical standards should be set for each State for both minimum adequate performance and for exceptional performance regarding informing, assessing, treating and immunizing children. Because States vary widely now on the proportion of eligible children receiving such services, the committee expects that initially the exact numerical standards may vary by State. The standard, however, should represent a reasonable increase in performance each year, and within 5 years of enactment, it is expected that all States be required to operate at a uniform minimum level, and that at least 80 percent of eligible children should be enrolled in CHAP.

Regarding "informing families in a timely manner" of the availability of CHAP, the committee expects that eligible families will receive an explanation of what services are available, of the value of receiving them, and information on where and how to seek services.

Regarding the proportion of children who are provided assessments, as defined, in a timely fashion, the committee intends that a reasonable proportion of all eligible children receive preventive services as a result of CHAP.

Studies of EPSDT suggest that when services are provided properly (effective informing, assistance in using services) roughly 60 to 80 percent of families contacted will use services. Therefore the committee believes it is realistic to expect 80 percent of eligible children to be enrolled in CHAP or a program providing equivalent services 5 years after enactment of CHAP. At that time, 50 percent should be the standard for minimum acceptable performance and 90 percent should represent exceptional performance.

The outcome standard for CHAP assessments neither changes nor interferes with the voluntary nature of this program. Recipients retain the right to decline services and States are prohibited from using any form of coercion to get families to use services. The committee has included a standard for assessments because the experience of EPSDT shows that it is possible to establish an expected level of participation which accommodates for the fact that some eligible families will decline service. Given the voluntary nature of CHAP, States found not to meet the minimum standard should not be penalized if they can show that, in spite of providing the requisite information and other forms of assistance, the nonmandatory nature of CHAP essentially accounted for the failure to reach the outcome standard.

Taking shortages of medical resources into account, the committee believes that in the majority of cases assessments and treatment can be provided within 120 days of a request for an assessment.

Regarding immunization, the Department, through its immunization initiative is committed to raising immunization levels among all children to above 90 percent by the fall of 1979. The committee be-

lieves that CHAP standards should be consistent with these Departmental goals and look to HEW to set timetables and numerical levels for CHAP.

Regarding compliance of providers with contractual terms, the committee expects States to monitor provider contracts so that every organized provider and a representative sample of providers in solo practice is audited at least once each year. It intends that providers who are not substantially adhering to the terms of the agreement will be decertified and that the State will take reasonable steps to identify providers with the capacity to care for children affected by decertification of such providers.

The committee expects the Department to evaluate States' performance for purposes of the bonus or penalty through the use of standard reporting and random samples of client and provider records in each State. Samples should be statistically valid. We also expect the Department to monitor data reported on outcome standards to assure they accurately reflect the level of services provided in accordance with CHAP requirements.

The committee bill establishes standards for the frequency and timeliness of HEW determinations of State performance and the timely resolution of appeals. HEW is expected to review each State program at least twice a year to assure that all statutorily established performance standards are met. Reviews are expected to be completed promptly; the bill therefore requires their completion within 180 days of the close of the quarter under review. States desiring to appeal a finding of noncompliance must request a hearing within 60 days of the notice of noncompliance, and the review by an impartial party must be completed within 180 days of the State's filing its petition for review.

The committee bill is an opportunity for States to correct program deficiencies and thereby avoid imposition of the financial penalty. However, the committee intends that the correction period be used in a serious manner by States committed and able to achieve compliance within a reasonable time. To assure that the correction period not be used as a means of delay when little concrete progress is made, States requesting correction time should be expected to demonstrate to the Secretary a remedial plan capable of achieving compliance by the end of the correction period. The 6-month correction period should be granted based on the Secretary's judgment that the proposed plan will accomplish satisfactory performance and that the State is capable of carrying out the proposed plan. In opting for a correction period, a State is admitting it has deficiencies to correct. After seeking a correction period it is expected that States would generally not appeal HEW's finding of noncompliance.

The committee believes the program reporting failures in EPSDT which have made it impossible to assess the adequacy of the program, State by State, and nationally must be corrected. The guiding principle in devising reporting requirements should be to allow determination of the proportion of eligible children who receive program benefits (assessments and treatment for problems found in assessments as well as subsequent care) and the quality of care provided. Data should be reported:

(1) In terms of children. not procedures (that is number of assessments), as is currently the case;

(2) In a way that makes it possible to determine for any given period of time and portion of assessed children needing treatment who have received such treatment on a timely basis; and

(3) In a way that makes it possible to assure that children are moving in a timely fashion through the CHAP system.

Data on conditions found should be reported in sufficient detail to allow States to determine the adequacy of resources in an area with reference to the specific health needs uncovered through CHAP. Data on procedures performed during an assessment should be recorded in sufficient detail to allow audits by HEW and the States regarding the thoroughness of health assessments performed.

The committee is fully aware of the danger that excessive and irrational reporting demands could adversely affect providers' willingness to participate in CHAP. But the Department should devise and utilize only those reporting requirements which allow adequate program planning and monitoring without creating excessive burdens for providers. It is customary medical practice to keep thorough patient records on problems found and services provided, by date and by child. To meet the committee's requirements, providers would need to report to the State only selected data from these records so long as complete documentation is available locally for audit purposes. In addition, the committee intends that States establish reimbursement levels for providers which cover the reasonable costs of keeping adequate records and forwarding necessary information to the State on a regular basis.

The Secretary shall report to the Congress by February 1 of each year (beginning in 1982) on the actual levels of performance of each State's CHAP program in relation to the applicable performance standards.

The committee bill provides that during the first 2 years after enactment, a State will be ineligible for the increased Federal matching if it reduces both the scope and extent of medicaid coverage and the level of State spending for children. The committee does not intend that the increase in Federal matching be a windfall to States which then act to reduce their current program coverage. However, the committee did not want to lock States into any particular pattern of spending. For instance, if a State finds that a particular service which it is providing is not as useful or productive as it had anticipated or if a greater need for another service is found, the committee believes that the State should be free to make the appropriate adjustments in its program. Therefore, the reduced matching rate will come into play only if the level of State spending and scope and extent of coverage is reduced.

The 2-year limitation on the maintenance of effort requirement is included because of the committee's belief that once 2 years of expanded coverage at the higher match rate has passed, cutbacks are unlikely, and the consequent need for the provision with the administrative problems it would entail is so reduced as to make it unnecessary.

Repeal of penalty

Section 208 of the committee bill repeals section 403(g) of the Social Security Act which required a 1-percent reduction in the Federal share of medicaid funds for States failing to implement child health

screening services under medicaid. A new penalty is authorized under section 207 of the committee bill.

Report on coordination of child health program

Section 209 of the committee bill requires the Secretary of Health, Education, and Welfare to submit a report to Congress on the child health assessment program. The bill calls for a report (to be submitted to the Congress not later than October 1, 1980) on the coordination of services to children under titles V and XIX of the Social Security Act as well as on actions undertaken and to be undertaken to integrate services under other federally funded programs. Such a study then should target not only title V and XIX child health programs, but all federally funded child health programs. It should identify gaps in services as well as duplication of efforts between and among programs. It should recommend action to be taken by the Federal Government to coordinate and integrate child health programs.

Continuing medicaid eligibility for certain children placed in certain juvenile institutions

Section 210 of the committee bill provides that the provision barring Federal matching payments for care or services for any individual who is an inmate of a public institution (except a patient in a medical institution) shall not apply to individuals under 21 who are inmates of a public institution for juveniles if the individual was eligible for CHAP under the State plan before he entered the institution.

The committee was concerned that its intent to provide good health care to all needy children would be contradicted by the provision of current law which would terminate CHAP coverage for persons who become inmates of public institutions that are not medical institutions. This provision would result in denial of CHAP to children who are in State operated homes, detention or correctional facilities, halfway houses, and the like. The committee believes it is appropriate to allow coverage to continue for these children if they are in a public institution for juveniles, and either were eligible for CHAP when they entered the facility or would have been eligible if they remaind in the family.

Effective dates

Section 211 specifies effective dates for the CHAP program. Except as otherwise provided the amendments included in the act shall apply to medical assistance provided on or after September 1, 1980. It further provides that if legislative action is required to change a State plan for medical assistance to meet the requirements of the act, the State plan will not be considered out of compliance with requirements of the law resulting from this act before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment.

The amendment relating to medicaid coverage for adopted children with special needs shall apply to individuals placed for adoption on or the date of enactment.

The section relating to the repeal of the penalty provision of current law is applicable to quarters beginning after June 30, 1974. Any individual under the age of 21 who has been screened pursuant to the

requirements of the current law shall be deemed to have had a timely health assessment, in accordance with regulations established by the Secretary.

The Secretary shall establish final regulations to carry out the amendments made by the act not later than May 1, 1980.

III. Budgetary Impact of the Bill

In compliance with section 252(a) of the Legislative Reorganization Act, and section 403 of the Congressional Budget Act, the following statements are made relative to the cost and revenue impact of the bill.

In its budget discussions, the committee indicated its anticipation that some version of the Child Health Assistance Plan (CHAP) would be reported. A similar expectation was expressed with respect to increased medicaid matching for Puerto Rico, the Virgin Islands, Guam and the Northern Marianas. It was reasonable to anticipate that the committee would not do less in these areas than it had previously favorably reported on H.R. 9434 during the second session of the last Congress.

The committee does not anticipate that it will be able to report amendments to the health care programs under the Social Security Act which, on a net basis, would achieve savings of $1.8 billion (the amount allocated under the first budget resolution) in fiscal year 1980.

Nonetheless, the committee reasonably anticipates significant savings in fiscal 1980. Amendments to H.R. 934, which the committee has ordered reported, are estimated (preliminary) by the Congressional Budget Office to save $700 million. While the committee does not believe $1.8 billion in savings can be achieved, it will continue to actively seek other reasonable and equitable methods of achieving program savings.

The estimate of the Congressional Budget Office on S. 1204 appears below. The committee acepts this estimate.

U.S. Congress,
Congressional Budget Office,
Washington, D.C., July 25, 1979.

Hon. Russell Long,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

Dear Mr. Chairman: Pursuant to Section 403 of the Congressional Budget Act of 1974, the Congressional Budget Office has prepared the attached cost estimate for S. 1204, the Medicaid Amendments relating to federal Medicaid matching in Puerto Rico, Guam, and the Virgin Island and to the child health assessment program.

Should the Committee so desire, we would be pleased to provide further details on the attached cost estimate.

Sincerely,

Alice M. Rivlin,
Director.

CONGRESSIONAL BUDGET OFFICE—COST ESTIMATE

JULY 23, 1979.

1 Bill number: S. 1204.

2. Bill title: An Act to increase the dollar limitations and federal medical assistance percentages applicable to the Medicaid programs of Puerto Rico, the Virgin Islands, Guam, and the Northern Mariana Islands, and to strengthen and improve the early and periodic screening, diagnoisis, and treatment program.

3. Bill status: As ordered reported by the Committee on Finance, July 12, 1979.

4. Bill purpose: For the Medicaid programs of Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands, Title I would raise the ceilings on federal funding and alter the computation of the federal medical assistance percentages. These percentages would be computed henceforth in the same manner as for the Medicaid programs of the states and the District of Columbia.

Title II would make additional low-income children eligible for Medicaid benefits and would modify and rename the early and periodic screening, diagnosis, and treatment program (EPSDT). Specifically, Title II would mandate Medicaid coverage for any child under age 7 who is a member of a family whose income is below the state Medicaid standard (regardless of whether the family is receiving cash assistance). The revamped EPSDT program would be called the Child Health Assessment Program (CHAP). Under CHAP, the federal medical assistance percentage for assessments and for all ambulatory services for appropriately assessed children would be increased to the greater of 75 percent or halfway between the current percentage and 90 percent. Assessed children would be eligibble for all medical care which is federally reimbursable under Medicaid, except for certain mental and dental services. A system of bonuses and penalties in the form of increased and decreased federal sharing of Medicaid administrative costs would be established. A bonus would be awarded or a penalty assessed according to the performance of a state's CHAP program as measured against specified criteria for acceptable and exceptional performance.

[By fiscal years; in millions of dollars]

	1980	1981	1982	1983	1984
Required budget authority	41.7	261.0	426.2	553.7	599.8
Outlays:					
I. Increased matching for the territories	32.4	32.4	32.4	32.4	32.4
II. Child health assessment program:					
Benefits for currently eligible children	6.9	126.9	188.4	208.4	209.2
Benefits for newly eligible children	1.8	49.9	86.2	126.6	135.3
Grace period extension	.1	4.9	6.3	6.8	7.8
Administration	.5	10.9	16.9	20.5	21.1
Bonus payments	0	36.0	96.0	159.0	194.0
Total outlays	41.7	261.0	426.2	553.7	599.8

The costs of this bill fall within budget function 550. This bill would increase future federal obligations through extension of an existing entitlement, and would therefore requqire subsequent appropriation action to provide the necessary budget authority. The figures

shown as "Required Budget Authority" represent that amount of budget authority needed to cover the estimated outlays that would result from enactment.

6. Basis of estimate:

Increased matching for the territories

Projections of Medicaid expenditures in Guam, Puerto Rico, and the Virgin Islands indicate that for fiscal years 1980 to 1984 the proposed ceilings on federal Medicaid spending in these jurisdictions would be binding (that is, annual federal Medicaid expenditures in these territories would be identical to the proposed ceilings). Because the current ceilings are likewise binding today, the cost estimates are the sums of the differences between the current and proposed ceilings. It is assumed that federal Medicaid spending for the Northern Mariana Islands would also equal the proposed ceiling.

Child health assessment program

Benefits for Children.—Estimates of CHAP costs are the product of four variables: numbers of children currently and newly eligible for Medicaid; Medicaid and CHAP participation rates; costs of benefits per recipient; and federal matching rates. Estimates of eligible children are derived from the 1976 Survey of Income and Education. Medicaid and CHAP participation rates are based on evaluation of the incentives provided by the bill (relative to current incentives) to encourage participation in Medicaid and CHAP. Medicaid benefits per child are drawn from program data for fiscal year 1976. Estimates of incremental CHAP benefits per assessed child are derived from a study of EPSDT costs made for the Social and Rehabilitation Service. Both Medicaid and CHAP costs are inflated at rates consistent with CBO projections of overall Medicaid benefit costs. New federal matching rates for ambulatory services for assessed children are calculated from current rates according to the formula specified in the bill. The costs in fiscal year 1980 are for one month of program operations only, since the effective date of Title II is September 1, 1980.

Grace Period Extension.—The estimates of the costs of the grace period extension are based on HEW estimates for a similar provision in another bill.

Administration.—Administrative costs for this bill are assumed to bear the same relationship to benefits as administrative costs to benefits for Medicaid generally.

Bonus Payments.—Estimates are based on projections of those Medicaid administrative costs for which increased federal matching could be awarded and on estimates of the proportion of Medicaid administrative expenditures in states assumed to be eligible for performance bonuses.

7. Estimate comparison: None.

8. Previous CBO estimate: These estimates of the costs of S. 1204 are somewhat lower than previous CBO cost estimates for a similar bill (H.R. 9434) reported by the Committee on Finance during the previous Congress on October 3, 1978. The revisions result from an improved method for estimating numbers of eligible children and ad-

ditional information about the incremental costs of assessment-related medical care.

9. Estimate prepared by: Malcolm J. Curtis.

10. Estimate approved by:

C. G. Nuckols
(For James L. Blum,
Assistant Director for Budget Analysis).

IV. Vote of the Committee in Reporting the Bill

In compliance with section 133 of the Legislative Reorganization Act of 1946, the following statement is made relative to the vote by the committee to report the bill. The bill was ordered favorably reported by voice vote.

V. Regulatory Impact

In accordance with paragraph 5 of rule XXIX of the Standing Rules of the Senate, the following statement of the regulatory impact of the bill is made.

In implementing the provisions of the bill, there will be an increase in Federal regulatory activity with respect to the child health assessment program due to the establishment of contractural agreements with providers of services and increased program evaluation, monitoring and reporting requirements.

The increased regulatory activity under the CHAP program will have implications primarily for the agencies administering the program and providers of services. The proposal will have minimal regulatory effect on eligible individuals.

The provision for increased medicaid funding for the territories will not significantly add to the regulatory activity of the medicaid program.

Since the bill would provide increased medicaid funds for services to additional eligible individuals, there would be a positive effect on those individuals as well as the entities providing services under the medicaid program.

VI. Changes in Existing Law Made by the Bill, as Reported

In compliance with paragraph (4) of rule XXIX of the Standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown below (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

Social Security Act

* * * * * * *

TITLE IV—GRANTS TO STATES FOR AID AND SERVICES TO NEEDY FAMILIES WITH CHILDREN AND FOR CHILD-WELFARE SERVICES

* * * * * * *

PART A—AID TO FAMILIES WITH DEPENDENT CHILDREN

* * * * * * *

SEC. 403. (a) * * *

[(g) Notwithstanding any other provision of this section, the amount payable to any State under this part for quarters in a fiscal year shall with respect to quarters in fiscal years beginning after June 30, 1974, be reduced by 1 per centum (calculated without regard to any reduction under section 403(f)) of such amount if such State fails to—

[(1) inform all families in the State receiving aid to families with dependent children under the plan of the State approved under this part of the availability of child health screening services under the plan of such State approved under title XIX,

[(2) provide or arrange for the provision of such screening services in all cases where they are requested, or

[(3) arrange for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services.]

* * * * * * *

TITLE XI—GENERAL PROVISIONS AND PROFESSIONAL STANDARDS REVIEW

PART A—GENERAL PROVISIONS

DEFINITIONS

SEC. 1101. (a) When used in this Act—

(1) The term "State", except where otherwise provided, includes the District of Columbia and the Commonwealth of Puerto Rico, and when used in titles IV, V, VII, XI, and XIX includes the Virgin Islands and Guam. Such term when used in titles III, IX, and XII also includes the Virgin Islands. Such term when used in title V and in part B of this title also includes American Samoa and the Trust Territory of the Pacific Islands. In the case of Puerto Rico, the Virgin Islands, and Guam, title I, X, and XIV, and title XVI, (as in effect without regard to the amendment made by section 301 of the Social Security Amendments of 1972) shall continue to apply, and the term "States" when used in such titles (but not in title XVI as in effect pursuant to such amendment after December 31, 1973) includes Puerto Rico, the Virgin Islands, and Guam. *Such term when used in title XIX includes the Commonwealth of the Northern Mariana Islands.*

* * * * * * *

LIMITATION ON PAYMENTS TO PUERTO RICO, THE VIRGIN ISLANDS, AND GUAM

SEC. 1108. (a) Except as provided in 2002(a)(2)(D), the total amount certified by the Secretary of Health, Education, and Welfare under title I, X, XIV, and XVI, and under part A of title IV (exclu-

sive of any amounts on account of services and items to which subsection (b) applies)—

(1) for payment to Puerto Rico shall not exceed—

(A) $12,500,000 with respect to the fiscal year 1968,

(B) $15,000,000 with respect to the fiscal year 1969,

(C) $18,000,000 with respect to the fiscal year 1970,

(D) $21,000,000 with respect to the fiscal year 1971,

(E) $24,000,000 with respect to the fiscal year 1972 and each fiscal year thereafter other than the fiscal year 1979, or

(F) $72,000,000 with respect to the fiscal year 1979;

(2) for payment to the Virgin Islands shall not exceed—

(A) $425,000 with respect to the fiscal year 1968,

(B) $500,000 with respect to the fiscal year 1969,

(C) $600,000 with respect to the fiscal year 1970,

(D) $700,000 with respect to the fiscal year 1971,

(E) $800,000 with respect to the fiscal year 1972 and each fiscal year thereafter other than the fiscal year 1979, or

(F) $2,400,000 with respect to the fiscal year 1979;

(3) for payment to Guam shall not exceed—

(A) $575,000 with respect to the fiscal year 1968,

(B) $690,000 with respect to the fiscal year 1969,

(C) $825,000 with respect to the fiscal year 1970,

(D) $960,000 with respect to the fiscal year 1971,

(E) $1,100,000 with respect to the fiscal year 1972 and each fiscal year thereafter other than the fiscal year 1979, or

(F) $3,300,000 with respect to the fiscal year 1979.

(b) The total amount certified by the Secretary under part A of title IV, on account of family planning services and services provided under section 402(a)(19) with respect to any fiscal year—

(1) for payment to Puerto Rico shall not exceed $2,000,000,

(2) for payment to the Virgin Islands shall not exceed $65,000, and

(3) for payment to Guam shall not exceed $90,000.

[(c) The total amount certified by the Secretary under title XIX with respect to any fiscal year—

[(1) for payment to Puerto Rico shall not exceed $30,000,000,

[(2) for payment to the Virgin Islands shall not exceed $1,000,000, and

[(3) for payment to Guam shall not exceed $900,000.

[(d) Notwithstanding the provisions of section 502(a) and 512(a) of this Act, and the provisions of sections 421, 503(1), and 504(1) of this Act as amended by the Social Security Amendments of 1967, and until such time as the Congress may by appropriation or other law otherwise provide, the Secretary shall, in lieu of the initial allotment specified in such sections, allot such smaller amounts to Guam, American Samoa, and the Trust Territory of the Pacific Islands as he may deem appropriate.]

(c) The total amount certified by the Secretary under title XIX—

(1) for payment to Puerto Rico shall not exceed $60,000,000 with respect to the fiscal year 1980 and each succeeding fiscal year;

(2) for payment to the Virgin Islands shall not exceed $2,000,000 with respect to the fiscal year 1980 and each succeeding fiscal year;

(3) for payment to Guam shall not exceed $1,800,000 for the fiscal year 1980 and each succeeding fiscal year; and

(4) for payment to the Commonwealth of the Northern Mariana Islands shall not exceed $500,000 for the fiscal year 1980 and each succeeding fiscal year.

* * * * * * *

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A state plan for medical assistance must—

* * * * * * *

(A) *(i)* for making medical assistance available to all individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI;

(ii) for making medical assistance available to any individual who is age 6 or under and (at the option of the State) to any individual over the age of 6 and under the age of 21 (or within a reasonable classification of such individuals), if the individual is a member of a family—

(I) Which, on the basis of resources, either is eligible for aid under the State plan approved under part A of title IV or would be eligible for aid under such State plan but for the fact that the individual is not a dependent child under part A of title IV, and

(II) the income of which does not exceed the income standard for such a family to be eligible for any medical assistance under the State plan;

(B) that the medical assistance made available to any individual described in [clause] *subparagraph* (A)—

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in [clause] *subparagraph* (A); and

(C) if medical assistance is included for any group of individuals who are not described in [clause] *subparagraph* (A) and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under title XVI, as the case may be, as determined in accordance with standards prescribed by the Secretary—

(i) for making medical assistance available to all individuals who would, except for income and resources, be eligible for aid or assistance under any such State plan or to have paid with respect to them supplemental security income benefits under title XVI, and who have insufficient (as determined

in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services, and

(ii) that the medical assistance made available to all individuals not described in clause (A) shall be equal in amount, duration, and scope;

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1905(a) *or services described in paragraph (13)(A)(iii)* to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of title XVIII to individuals eligible therefor (either pursuant to an agreement entered into under section 1843 or by reason of the payment of premiums under such title by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of title XVIII for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, and (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary, with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A);

* * * * * * *

(13) provide—

(A)(i) for the inclusion of some institutional and some noninstitutional care and services, and

(ii) for the inclusion of home health services for any individual who, under the State plan, is entitled to skilled nursing facility services, and

(iii) in the case of any individual under the age of 21 who has received a timely periodic child health assessment (as defined in section 1905(n)), (I) for inclusion of all necessary care and services (other than (a) those for the treatment of mental illness, where the care or service for such condition is not otherwise provided under the State's plan, (b) inpatient care in an intermediate care facility for the mentally retarded, and (c) dental care which is not routine dental care as defined in section 1905(o)), without regard to any limitation in the amount, duration, or scope of medical assistance, for which payment is available under this title, whether or not under the State plan for the State such care and services are provided to individuals who have not been so periodically as-

sessed, and (II) for referral for all other necessary care and services; and;

[(B) in the case of individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, for the inclusion of at least the care and services listed in clauses (1) through (5) of section 1905(a), and]

(B) in the case of any individual described in paragraph (10) (A), for the inclusion of at least the care and services listed in paragraphs (1) through (5) of section 1905(a), and

(C) in the case of individuals not included under subparagraph (B) for the inclusion of at least—

(i) the care and services listed in [clauses] *paragraphs* (1) through (5) of section 1905(a) or

(ii) (I) the care and services listed in any 7 of the [clauses numbered] *paragraphs* (1) through (16) of such section and (II) in the event the care and services provided under the State plan include hospital or skilled nursing facility services, physicians' services to an individual in a hospital or skilled nursing facility during any period he is receiving hospital services from such hospital or skilled nursing facility services from such home, and

(D) for payment of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards, consistent with section 1122, which shall be developed by the State and reviewed and approved by the Secretary and (after notice of approval by the Secretary) included in the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1861(v) as the reasonable cost of such services for purposes of title XVIII; and

(E) effective July 1, 1976, for payment of the skilled nursing facility and intermediate care facility services provided under the plan on a reasonable cost related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary; and

(F) for payment for services described in section 1905(a)(2) (B) provided by a rural health clinic under the plan of 100 percent of costs which are reasonable and related to the cost of furnishing such services or based on such other tests of reasonableness, as the Secretary may prescribe in regulations under section 1833 (a)(3), or, in the case of services to which those regulations do not apply, on such tests of reasonableness as the Secretary may prescribe in regulations under this subparagraph;

(14) effective January 1, 1973, provide that—

(A) in case of individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or who meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under title XVI, as

the case may be, *individuals described in paragraph (10)(A)(ii)*, and individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in paragraph (10)(A)—

(i) no enrollment fee, premium, or similar charge, and no deduction, cost sharing, or similar charge with respect to the care and services listed in [clauses] *paragraphs* (1) through (5) and (7) of section 1905(a), will be imposed under the plan, and

(ii) any deduction, cost sharing, or similar charge imposed under the plan with respect to other care and services will be nominal in amount (as determined in accordance with standards approved by the Secretary and included in the plan), [and]

(B) with respect to individuals (other than individuals with respect to whom there is being paid, or who are eligible or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in paragraph (10)(A)) who are not receiving aid or assistance under any such State plan and with respect to whom supplemental security income benefits are not being paid under title XVI and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under title XVI, as the case may be,

(i) there may be imposed an enrollment fee, premium, or similar charge which (as determined in accordance with standards prescribed by the Secretary) is related to the individual's income, and

(ii) any deductible, cost-sharing, or similar charge imposed under the plan will be nominal[;], *and*

(C) in the case of individuals under the age of 21 who have received a timely child health assessment (as defined in section 1905(n)), no enrollment fee, premium, deduction, cost sharing, or similar charge with respect to any of the care and services listed in section 1905(a) will be imposed under the plan;

(39) provide that, subject to subsection (g), whenever the single State agency which administers or supervises the administration of the State plan is notified by the Secretary under section 1862 (e)(2)(A) that a physician or other individual practitioner has been suspended from participation in the program under title XVIII, the agency shall promptly suspend such physician or practitioner from participation in the plan for not less than the period specified in such notice, and no payment may be made under the plan with respect to any item or service furnished by such physician or practitioner during the period of the suspension under this title; [and]

(40) require each health services facility or organization which receives payments under the plan and of a type for which a uni-

form reporting system has been established under section 1121(a) to make reports to the Secretary of information described in such section in accordance with the uniform reporting system (established under such section) for that type of facility or organization[.] *; and*

(41) provide that the State will develop (and make available to the public for review and comment) a plan for the implementation of a child health assessment program described in section 1905(n) which will meet the applicable level of acceptable performance established under section 1903(r)(1)(B) and which will—

(A) identify and make provision for written agreements described in section 1905(n)(3) with all qualified health care providers on such terms as will reasonably be expected to elicit their involvement in child health assessments,

(B) assure coordination between State and local agencies participating in such assessments and federally-funded programs in the State providing health care services to children,

(C) assure the availability of appropriate support services (including outreach and follow-up services), and

(D) provide for the establishment and maintenance of such a health profile for each child provided medical care and services under the plan as will ensure the appropriate coordination and nonduplication in the provision of such care and services to the child,

in accordance with regulations of the Secretary.

Notwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State submits its plan for approval under this title, the State agency which administered or supervised the administration of the plan of such State approved under title X (or title XVI, insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under title I (or title XVI, insofar as it relates to the aged), the State agency which administered or supervised the administration of such plan approved under title X (or title XVI, insofar as it relates to the blind) may be designated to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and a different State agency may be established or designated to administer or supervise the administration of the rest of the State plan for medical assistance; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this title (except for purposes of paragraph (10)). For purposes of paragraphs (9)(A), (29), (31), and (33), and of section 1903(i)(4), the term "skilled nursing facility" and "nursing home" do not include a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

For purposes of paragraph (10) any individual who, for the month of August 1972, was eligible for or receiving aid or assistance under a State plan approved under title I, X, XIV, or XVI, or part A of title IV and who for such month was entitled to monthly insurance benefits under title II shall for purposes of this title only be deemed to be eligible for financial aid or assistance for any month thereafter if such

individual would have been eligible for financial aid or assistance for such month had the increase in monthly insurance benefits under title II resulting from enactment of Public Law 92–336 not been applicable to such individual.

The requirement of clause (A) of paragraph (37) with respect to a State plan may be waived by the Secretary if he finds that the State has exercised good faith in trying to meet such requirement.

(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) of this section, except that she shall not approve any plan which imposes as a condition for eligibility for medical assistance under the plan—

(1) an age requirement of more than 65 years; or

[(2) effective July 1, 1967, any age requirement which excludes any individual who has not attained the age of 21 and is or would, except for the provisions of section 406(a)(2), be a dependent child under part A of subchapter IV of this chapter; or]

[(3)] *(2)* any residence requirement which excludes any individual who resides in the State; or

[(4)] *(3)* any citizenship requirement which excludes any citizens of the United States.

(c) Notwithstanding subsection (b), the Secretary shall not approve any State plan for medical assistance if he determines that the approval and operation of the plan will result in a reduction in aid or assistance in the form of money payments (other than so much, if any, of the aid or assistance in such form as was, immediately prior to the effective date of the State plan under this title, attributable to medical needs) provided for eligible individuals under a plan of such State approved under title I, X, XIV, or XVI, or part A of title IV.

(d) [Repealed].

(e) *(1)* Notwithstanding any other provision of this title, effective January 1, 1974, each State plan approved under this title must provide that each family which was receiving aid pursuant to a plan of the State approved under part of A of title IV in at least 3 of the 6 months immediately preceding the month in which such family became ineligible for such aid because of increased hours of, or increased income from, employment, shall, while a member of such family is employed, remain eligible for assistance under the plan approved under this title (as though the family was receiving aid under the plan approved under part A of title IV) for 4 calendar months beginning with the month in which such family became ineligible for aid under the plan approved under part A of title IV because of income and resources or hours of work limitations contained in such plan.

(2) Notwithstanding any other provision of this title, each State plan approved under this title must provide that any individual under the age of 21 who, having had a timely child health assessment (as defined in section 1905(n)), becomes ineligible (for a reason other than age) to receive care and services provided under the State plan shall, nonetheless, remain eligible for all such care and services provided under the State plan to individuals who have had a timely child health assessment until the end of the four-calendar-month period beginning with the month following the month in which the individual became ineligible.

(f) Notwithstanding any other provision of this title, except as provided in subsection (e), no State not eligible to participate in the State plan program established under title XVI shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of title XVI) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this title and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such individual as determined in accordance with section 1903(f) (after deducting any supplemental security income payment and State supplementary payment made with respect to such individual and incurred expenses for medical care as recognized under State law) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972. In States which provide medical assistance to individuals pursuant to [clause] *paragraph* (10)(C) of subsection (a) of this section, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under [clause] *paragraph* (10)(A)(*i*) of that subsection if that individual is, or is eligible to be (1) an individual with respect to whom there is payable a State supplementary payment on the basis of which similarly situated individuals are eligible to receive medical assistance equal in amount, duration, and scope to that provided to individuals eligible under [clause] *paragraph* (10)(A)(*i*), or (2) an eligible individual or eligible spouse, as defined in title XVI, with respect to whom supplemental security income benefits are payable; otherwise that individual shall be considered to be an individual eligible for medical assistance under [clause] *paragraph* (10)(C) of that subsection. In States which do not provide medical assistance to individuals pursuant to [clause] *paragraph* (10)(C) of that subsection, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under [clause] *paragraph* (10)(A)(*i*) of that subsection.

(g) The Secretary may waive suspension under subsection (a)(39) of a physician's or practitioner's participation in a State plan approved under this title and of the prohibition under such subsection of payment for any item or service furnished by him during the period of such suspension, if the single State agency which administers or supervises the administration of the plan submits a request to the Secretary for such waiver and if the Secretary approves such request.

PAYMENT TO STATES

SEC. 1903. (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966

(1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b), subject to subsections (g) and (h) of this section) of the total amount expended during such quarter as medical assistance under the State plan (including expenditures for premiums under part B of title XVIII, for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A)(*i*), and, except in the case of individuals sixty-five years of age or older and disabled individuals entitled to hospital insurance benefits under title XVIII or who are not enrolled under part B of title XVIII, other insurance premiums for medical or any other type of remedial care or the cost thereof); plus

(2) an amount equal to 75 per centum of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to compensation or training of skilled professional medical personnel, and staff directly supporting such personnel of the State agency or any other public agency; plus

(3) an amount equal to—

(A)(i) 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such mechanized claims processing and information retrieval systems as the Secretary determines are likely to provide more efficient, economical, and effective administration of the plan and to be compatible with the claims processing and information retrieval systems utilized in the administration of title XVIII, including the State's share of the cost of installing such a system to be used jointly in the administration of such State's plan and the plan of any other State approved under this title, and

(ii) 90 per centum of so much of the sums expended during any such quarter in the fiscal year ending June 30, 1972, or the fiscal year ending June 30, 1973, as are attributable to the design, development, or installation of cost determination systems for State-owned general hospitals (except that the total amount paid to all States under this clause for either such fiscal year shall not exceed $150,000), and

(B) 75 per centum of so much of the sums expended during such quarter as are attributable to the operation of systems (whether such systems are operated directly by the State or by another person under a contract with the State) of the type described in subparagraph (A)(i) (whether or not designed, developed, or installed with assistance under such subparagraph) which are approved by the Secretary and which include provision for prompt written notice to each individual who is furnished services covered by the plan,

or to each individual in a sample group of individuals who are furnished such services, of the specific services (other than confidential services) so covered, the name of the person or persons furnishing the services, the date or dates on which the services were furnished, and the amount of the payment or payments made under the plan on account of the services; plus

(4) an amount equal to 100 per centum of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) which are attributable to compensation or training of personnel (of the State agency or any other public agency) responsible for inspecting public or private institutions (or portions thereof) providing long-term care to recipients of medical assistance to determine whether such institutions comply with health or safety standards applicable to such institutions under this Act; plus

(5) an amount equal to 90 per centum of the sums expended during such quarter which are attributable to the offering, arranging, and furnishing (directly or on a contract basis) of family planning services and supplies;

(6) subject to subsection (b)(3), an amount equal to 90 per centum of the sums expended during each quarter beginning on or after October 1, 1977, and ending before October 1, 1980, with respect to cost incurred during such quarter (as found necessary by the Secretary for the elimination of fraud in the provision and administration of medical assistance provided under the State plan) which are attributable to the establishment and operation of (including the training of personnel employed by) a State medicaid fraud control unit (described in subsection (q)); plus

(7) subject to subsection (s), an amount equal to a percent of so much of the sums expended during such quarter as are attributable to child health assessments (as defined in section 1905(n)) and to diagnosis, treatment (other than dental and inpatient care), referral, follow-up, and medical care management of individuals who have been assessed pursuant to that section and regulations of the Secretary promulgated thereunder; which percent shall be equal to the greater of (A) 75 percent or, (B) one-half of the sum of the Federal medical assistance percentage (as calculated for purposes of paragraph (1) of this subsection) and 90 percent; plus

[(7)] *(8) subject to subsection (r)*, an amount equal to 50 per centum of the remainder of the amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

* * * * * * *

(f)(1)(A) Except as provided in paragraph (4), payment under the preceding provisions of this section shall not be made with respect to any amount expended as medical assistance in a calendar quarter, in any State, for any member of a family the annual income of which exceeds the applicable income limitation determined under this paragraph.

(B)(i) Except as provided in clause (ii) of this subparagraph, the applicable income limitation with respect to any family is the amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to 133⅓ percent of the highest amount which would ordinarily be paid to a family of the same size without any income or resources, in the form of money payments, under the plan of the State approved under part A of title IV of this Act.

(ii) If the Secretary finds that the operation of a uniform maximum limits payments to families of more than one size, he may adjust the amount otherwise determined under clause (i) to take account of families of different sizes.

(C) The total amount of any applicable income limitation determined under subparagraph (B) shall, if it is not a multiple of $100 or such other amount as the Secretary may prescribe, be rounded to the next higher multiple of $100 or such other amount, as the case may be.

(2) In computing a family's income for purposes of paragraph (1), there shall be excluded any costs (whether in the form of insurance premiums or otherwise) incurred by such family for medical care or for any other type of remedial care recognized under State law.

(3) For purposes of paragraph (1)(B), in the case of a family consisting of only one individual, the "highest amount which would ordinarily be paid" to such family under the State's plan approved under part A of title IV of this Act shall be the amount determined by the State agency (on the basis of reasonable relationship to the amounts payable under such plan to families consisting of two or more persons) to be the amount of the aid which would ordinarily be payable under such plan to a family (without any income or resources) consisting of one person if such plan (without regard to section 408) provided for aid to such a family.

(4) The limitations on payment imposed by the preceding provisions of this subsection shall not apply with respect to any amount expended by a State as medical assistance for any individual—

(A) who is receiving aid or assistance under any plan of the State approved under title I, X, XIV or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or

(B) who is not receiving such aid or assistance, and with respect to whom such benefits are not being paid, but (i) is eligible to receive such aid or assistance, or to have such benefits paid with respect to him, or (ii) would be eligible to receive such aid or asistance, or to have such benefits paid with respect to him if he were not in a medical institution, or

(C) with respect to whom there is being paid, or who is eligible, or would be eligible if he were not in a medical institution, to have paid with respect to him, a State supplementary payment and is eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A)(*i*), but only if the income of such individual (as determined under section 1612, but without regard to subsection (b) thereof) does not exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1),

at the time of the provision of the medical assistance giving rise to such expenditure.

* * * * * * *

(r)(1)(A) In order to evaluate, and provide penalties and bonuses with respect to, each State's conduct of its child health assessment program (described in section 1905(n)), the Secretary shall establish by regulation performance standards for child health assessment programs, which shall include standards that measure—

(i) the proportion of families of children eligible, under subparagraphs (A) or (B) of section 1902 (a)(10), for services under the State plan who are informed in a timely manner of the availability of such services;

(ii) the proportion of such children who are provided child health assessments (as defined in section 1905(n)) in a timely manner;

(iii) the timely provision of medical care or services the need for which is disclosed by a child health assessment;

(iv) the proportion of such children who are appropriately immunized within a reasonable time following their assessment; and

(v) the compliance of health care providers with the terms of agreements entered into pursuant to section 1905(n).

(B) In order to evaluate the performance of each State's child health assessment program for periods beginning after September 1, 1979, with respect to the standards established under subparagraph (A), the Secretary shall establish, and provide timely notice to the State of, a level of acceptable performance and a level of outstanding performance applicable to the State's program for each such period.

(C) Each State shall cooperate with the Secretary by providing appropriate documentation of the performance of its child health assessment program in relation to the performance standards and levels of performance established under subparagraphs (A) and (B).

(2) The Secretary shall evaluate at least biannually the performance of each State's child health assessment program, with respect to its meeting the levels of performance established under paragraph (1)(B), and shall report his determination evaluating the State's performance for a six-month period to the State not later than six months after the end of the period.

(3)(A) If the Secretary determines, in such an evaluation, that a State has failed to have a child health assessment program which meets the applicable level of acceptable performance established under paragraph (1)(B), the Secretary shall notify the State of such failure and of the fact that the amount otherwise required to be paid to the State, with respect to each fiscal quarter beginning after the date of the notification, pursuant to paragraphs (2), (3), (4), and (8) of subsection (a) for administration of the State plan shall, except as provided in subparagraphs (B) and (C), be reduced by 20 percent of that amount until the State shows to the satisfaction of the Secretary that the failure with respect to which the reduction applies has been corrected.

(B) If the Secretary is satisfied that a State intends to correct a failure established under subparagraph (A), he may withhold the imposition of a reduction under such subparagraph for a period of

time (not exceeding six months) to allow the State to fully achieve applicable level of acceptable performance. If, at the end of the period, the Secretary determines that the failure has been corrected, he may waive the imposition of the reduction in whole or in part with respect to the period.

(C) Any State dissatisfied with a determination of the Secretary under subparagraph (A) may, not later than 60 days after the date it was notified of the determination, file a petition with the Secretary for a review of the determination in accordance with procedures established by the Secretary. Such procedures shall provide that such review shall be conducted by an impartial party and shall be completed, and findings and a final determination made, not later than 180 days after the date the State filed its petition for such review.

(4) If the Secretary determines, in such an evaluation, that a State's child health assessment program has met its applicable level of outstanding performance established under paragraph (1)(B) for a calendar quarter, the Secretary shall notify the State of such achievement and of the fact that the amount paid under subsection (a)(8) with respect to the calendar quarter shall be increased by an amount equal to 25 percent of the remainder specified in such subsection.

(5) The Secretary shall report to Congress, not later than February 1 of each year (beginning with 1982), on actual levels of performance of each State's child health assessment program in relation to applicable levels of performance established under paragraph (1)(B).

(s)(1) With respect to the fiscal years 1980 and 1981, the increased Federal percentage available to any State under the provisions of subsection (a)(7) for child health assessments shall not exceed the Federal matching percentage otherwise applicable to such State under subsection (a)(1) with respect to any State which takes any action that reduces (below the level in effect on the date of the enactment of this subsection) both (A) the scope and extent of medical assistance for children under the age of 21 under the State plan, and (B) the level of non-Federal spending for medical assistance for such children under the State plan.

(2) The Secretary may waive the provisions of paragraph (1) with respect to any State which, in the judgment of the Secretary, experiences a fiscal crisis necessitating such action by the State.

OPERATION OF STATE PLANS

SEC. 1904. If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this title, finds—

(1) that the plan has been so changed that it no longer complies with the provisions of section 1902; or

(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to

categories under or parts of the State plan not affected by such failure).

DEFINITIONS

SEC. 1905. For purposes of this title—

(a) The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A)(*i*)) not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, who are

(i) under the age of 21,

(ii) relatives specified in section 406(b)(1) with whom a child is living if such child [, except for section 406(a)(2),] is (or would, if needy, be) a dependent child under part A of title IV,

(iii) 65 years of age or older,

(iv) blind, with respect to States eligible to participate in the State plan program established under title XVI,

(v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under title XVI,

(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under title I, X, XIV, or XVI, or

(vii) blind or disabled as defined in section 1614, with respect to States not eligible to participate in the State plan program established under title XVI,

but whose income and resources are insufficient to meet all of such cost, *or who are adopted children with special needs (as defined in subsection (m))*—

(1) inpatient hospital services (other than services in an institution for tuberculosis or mental diseases);

(2)(A) outpatient hospital services, and (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (l)) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (l)) and which are otherwise included in the plan;

(3) other laboratory and X-ray services;

(4)(A) skilled nursing facility services (other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older [(B) effective July 1, 1969, such early and periodic screening and diagnosis of individuals who are eligible under the plan and are under the age of 21 to ascertain their physical or mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in regulations

of the Secretary;] *; (B) child health assessments (as defined in subsection (n)), diagnosis, treatment, referral, and medical case management of individuals under the age of 21 who are eligible under the plan;* and (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of childbearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies;

(5) physicians' services furnished by a physician (as defined in section 1861(r)(1)), whether furnished in the office, the patient's home, a hospital, or a skilled nursing facility, or elsewhere;

(6) medical care or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;

(7) home health care services;

(8) private duty nursing services;

(9) clinic services;

(10) dental services;

(11) physical therapy and related services;

(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(13) other diagnostic, screening, preventive, and rehabilitative services;

(14) inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases;

(15) intermediate care facility services (other than such services in an institution for tuberculosis or mental diseases) for individuals who are determined, in accordance with section 1902(a)(31)(A), to be in need of such care;

(16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h); and

(17) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary;

except as otherwise provided in paragraph (16) *and in subsection (p)*, such term does not include—

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases.

For purposes of clause (vi) of the preceding sentence, a person shall be considered essential to another individual if such person is the spouse of and is living with such individual, the needs of such person are taken into account in determining the amount of aid or assistance furnished to such individual (under a State plan approved under title I, X, XIV, or XVI), and such person is determined, under such a State plan, to be essential to the well being of such individual.

(b) The term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State per-

centage shall be that percentage which bears the same ratio to 45 per centum 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; except that [(1)] the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum[, and (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, and Guam shall be 50 per centum]. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of subparagraph (B) of section 1101(a)(8). Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act).

* * * * * * *

(m) The term "adopted child with special needs" means an individual who—

(1)(A) is age 6 or under or (B) (at the option of the State) is over the age of 6 and under the age of 21 (or within a reasonable classification of such individuals);

(2) has been placed for adoption;

(3) was living in foster care immediately before the date of his placement for adoption; and

(4) on the date of his placement for adoption suffered from a condition requiring continuing medical care and services which condition the State determines was a contributing factor to the difficulty of placing the individual for adoption,

but only during the period beginning on the date of his placement for adoption and ending on the date the individual turns the age specified in paragraph (1) or, at the State's option and if earlier, the date the State determines that the individual no longer requires the continuing care and services described in paragraph (4).

(n)(1) The term "child health assessment" means such an assessment provided in accordance with this subsection for an individual under the age of 21, who is eligible under the plan, for such health problems and at such periods as the Secretary shall specify in regulations. Such assessments and other services described in section 1905(a)(4)(B) shall be provided under a program (to be known as the "child health assessment program") to be developed by each State in accordance with this title.

(2) Such assessments may only be provided under this title by a health care provider who enters into a written agreement (described in paragraph (3)) with the single State agency responsible for administering or supervising the administration of the State plan under this title.

(3) The written agreement referred to in paragraph (2) must provide, in accordance with standards established by the Secretary, that the provider agrees as follows:

(A) To provide timely and appropriate child health assessments to individuals under the age of 21 and eligible under the State

plan to receive such assessments (such individuals hereinafter in this subsection referred to as "eligible individuals").

(B)(i) To provide directly to eligible individuals whom it has assessed such basic diagnostic and treatment services (including immunization against childhood diseases) as the Secretary shall specify in regulations, or

(ii) to provide to eligible individuals whom it has assessed (I) timely referral to other health care providers for the provision of these basic diagnostic and treatment services, and (II) followup services to insure the provision of the services for which such a referral has been made.

(C)(i) To provide directly to eligible individuals routine dental care (as defined in subsection (o)), or

(ii) to provide to eligible individuals whom it has assessed information, from a list provided by the state agency, on dentists participating in the child health assessment program.

(D)(i) To refer eligible individuals to appropriate providers for any corrective treatment the need for which is disclosed by an assessment but which is not available directly from the provider, and (ii) to follow up to assure the proper provision of such treatment.

(E) To take responsibility for the management of the medical care of each eligible individual whom it has assessed and to assure that child health assessments are performed on a timely and periodic basis.

(F) To be reasonably accessible on an ongoing basis to eligible individuals whom it has assessed in order to provide continuing medical care or to assure the continuing availability of medical care and services.

(G) To make such reports (i) to the State agency as the agency determines to be necessary to provide for the agency's establishment and maintenance of individualized profiles (as required under section 1902(a)(41)(D)) or to assure compliance with the requirements of the contract, and (ii) to the Secretary as he determines to be necessary to assure compliance with the requirements of the contract.

In lieu of the followup services required under subparagraph (B)(ii)(II) or (D)(ii), the written agreement with a health care provider may provide that the provider will furnish the State agency with such information as such agency determines to be necessary to allow followup on the provision of needed services. Such agreement also shall provide for the State agency providing the health care provider with the names, addresses, and telephone numbers of dentists participating in the child health assessment program in the areas in which the provider is located.

(4) As used in this subsection and section 1902(a)(41), the term "health care provider" includes a private practitioner, public health department, community health clinic or center, primary care center, day care or headstart program, rural health clinic, maternal and child health center, student health service, and a school system.

(5) Payment may be made under a State plan to a health care provider for the provision of child health assessments, and other medical care and services to children, under an agreement described in para-

graph (2) notwithstanding the fact that the provider does not ordinarily bill other third-party payers for the provision of such assessments, care, and services.

(o) The term "routine dental care" means necessary diagnostic, preventive, restorative, and emergency dental services, but only includes such orthodontics as the Secretary determines by regulation to be appropriate for different age groups for conditions causing major physical handicap.

(p)(1) Notwithstanding subdivision (A) of subsection (a), a State may include, in its plan for medical assistance under this title, payments with respect to care and services for an individual under 21 years of age while the individual is an inmate of a public institution for juveniles if—

(A) the individual, on the day before he became an inmate of the institution, was eligible for medical assistance under the State's plan, or

(B) the family in which the individual resided (on the day before he became an inmate of the institution) was eligible for medical assistance under the State's plan or would be eligible for medical assistance under the State's plan if the individual was still residing with the family.

(2) Notwithstanding paragraphs (10) and (14) of section 1902(a), an individual for whom payment for care and services is provided under paragraph (1) shall be treated under the plan, with respect to the amount, duration, and scope of medical assistance and to fees, premiums, deductions, cost sharing, and other charges—

(A) in the case described in paragraph (1)(A) in the same manner as the individual was treated on the day before he became an inmate of the public institution, or, in the case of such an individual who was eligible for but not provided medical assistance on that day, would have been treated if provided medical assistance on that day, and

(B) in the case described in paragraph (1)(B), in the same manner as the individual would otherwise be treated if still residing with his family.