PART TWO: DUTIES OF NEW FEDERAL ENTITIES TO BE CREATED UNDER THE ACT

J. ADVISORY COMMISSION ON REGIONAL VARIATIONS IN HEALTH EXPENDITURES

116. Premiums -- Determination of Amount -- Health Care Expenditures

(See App. A, Office No. 28.)

(490) Examine methods of eliminating variations in regional alliance per capita premium targets due to variations in practice patterns (not due to other factors, such as health care input prices and demographic factors) by the year 2002. § 6006(c)(1), p. 1006.

(491) Submit to the Board a report specifying one or more methods for eliminating the variations described in § 6006(c)(1). § 6006(c)(2), p. 1006.

(492) Submit to Congress detailed recommendations on the specific method to be used to eliminate the variations described in § 6006(c)(1) by the year 2002. § 6006(c)(3), p. 1006.

(493) Examine methods of reducing variations among the states in the level of aggregate state payments due to (a) practice patterns, (b) historical differences in provider reimbursement rates, and (c) the amount, duration, and scope of benefits covered under state Medicaid plans. § 6006(e)(1), p. 1009.

(494) Submit to the Board a report specifying one or more methods of reducing the variation described in § 6006(e)(1). § 6006(e)(2), p. 1010.

(495) Submit to Congress detailed recommendations with respect to the specific method to be used to reduce the variation described in § 6006(e)(1) by 2002 in a budget neutral manner with respect to total government payments and payments by the federal government. § 6006(e)(3), p. 1010.

(496) Provide the Board, states, and regional alliances with information about regional differences in health care costs and practice patterns. § 6006(f), p. 1011.

K. ADVISORY COUNCIL ON BREAKTHROUGH DRUGS

117. Breakthrough Drugs

(See App. A, Office No. 34.)

(497) Determine the reasonableness of breakthrough drug launch prices. § 1572(b), p. 291.

L. CENTRAL LOAN UNIT (WITHIN HHS)

118. Centralized Loan Unit

(See App. A, Office No. 21.)

(498) Process all loans and loan guarantees to be provided by HHS under the Act. § 3446, p. 605.

(499) Make loans, and guarantee loan repayment, for the capital costs of developing qualified community health plans and practice networks. § 3441(a). Review capital cost loan applications. § 3442(a), p. 598.

(500) Pursue collection and foreclosure procedures with respect to defaulted loans to qualified community health plans and practice networks. § 3443(a)(1), (a)(2), p. 600.

(501) Prescribe the form of application for capital costs loans for qualified community health plans and practice networks. § 3445, p. 604.

(502) Make loans and guarantee payments for capital costs incurred by entities in developing non-acute residential treatment centers and ambulatory clinics (for mental health and substance abuse treatment). § 3503(a), p. 621.

(503) Make loans to state health agencies and local community partnerships for the capital costs of developing projects for school health-related services and sites. Guarantee the repayment of such loans. § 3691(a), p. 666.

(504) Establish and administer a revolving loan program within the Indian Health Service to provide guaranteed loans to providers within the Indian Health Service system to improve and expand health care facilities. § 8310(b), p. 1259.

(505) Make available to regional alliances loans to cover any period of temporary cash-flow shortfall attributable to estimation discrepancies, administrative error, or timing. § 9201(a), p. 1308.

(506) Specify, in consultation with the Treasury Department, the terms and conditions of loans to regional alliances to cover temporary shortfalls. § 9201(b)(1), p. 1309.

(507) Report to Congress annually on loans made, including repayment status, to regional alliances to cover temporary shortfalls, taking into consideration the current average rate on outstanding marketable obligations of the U.S. § 9201(d), p. 1310.

M. COMMISSION ON INTEGRATION OF HEALTH BENEFITS

119. Workers Compensation & Automobile Insurance

(See App. A, Office No. 41.)

(508) Study the feasibility and appropriateness of transferring financial responsibility for all medical benefits currently covered under workers compensation and automobile insurance to health plans. § 10201(c), p. 1332.

(509) Submit a report to the President containing recommendations with respect to the integration of financial responsibility for all medical benefits in health plans, including a detailed report as to how and when such an integration should be effected under the Act. § 10201(e), p. 1332.

N. CORPORATE ALLIANCE HEALTH PLAN INSOLVENCY FUND

120. Plans -- Insolvency -- Corporate Health Plan Insolvency Fund

(See App. A, Office No. 39.)

(510) Maintain funds for guaranteed benefits payments owed by insolvent corporate alliance health plans. § 1396(c)(1), (2)(A), p. 217.

(511) Disburse funds necessary to pay guaranteed benefits. § 1396(c)(2)(B), p. 217.

(512) Issue notes or other obligations to the Treasury Department to finance the payment of guaranteed benefits. § 1396(c)(3), p. 218.

(513) Invest excess funds in U.S. obligations. § 1396(c)(4), p. 219.

O. FEDERAL ADVISORY GROUP FOR STATE DISABILITY PROGRAMS

121. Long-Term Care -- State Disability Programs

(See App. A, Office No. 35.)

(514) Advise HHS on all aspects of programs for home and community-based services for individuals with disabilities. § 2107(a)(1), p. 410.

P. FEDERAL HEALTH PLAN REVIEW BOARD

122. Dispute Resolution -- Federal Health Plan Review Board

(See App. A, Office No. 40.)

(515) Issue regulations prescribing the form and manner of appeals of decisions of the Complaint Review Offices. § 5204(e)(1), p. 904.

(516) Review appeals from decisions of the Complaint Review Offices. § 5204(e)(1), p. 904.

(517) Conduct the review process in open proceedings. Issue decisions. § 5205(c), (d), p. 906.

(518) Ensure that reasonable notice is provided of each appeal before the Review Board of a hearing officer's decision under § 5304, p. 942.

Q. NATIONAL COUNCIL ON GRADUATE MEDICAL EDUCATION

123. Education & Training -- Graduate Education & Specialty Training

(See App. A, Office No. 36.)

(519) Designate for each academic year the number of individuals nationwide who under § 3011 are authorized to be enrolled in eligible approved physician training programs. § 3012(a), p. 509.

(520) Ensure for each year that at least 55% of those completing eligible training programs specialize in primary care. § 3012(b)(1), p. 509.

(521) Make annual three-year designations for each medical specialty. § 3012(c)(1), p. 510.

(522) Determine whether a need exists for additional practitioners in each specialty, based on the factors set forth in § 3012(d)(1). § 3012(d)(1), p. 510.

(523) Consider the recommendations of organizations representing (i) physicians in each specialty and (ii) consumers in designating the annual number of specialty positions for an academic year. § 3012(d)(2), p. 511.

(524) Allocate specialty positions among the annual number of specialty programs. § 3013(a), p. 513.

(525) Notify each eligible program of allocations made for the program for each of the academic years of the 3-year period. § 3013(b)(2), p. 513.

(526) Determine the historical distribution among areas of approved physician training programs for consideration in making specialty position allocations. § 3013(c), p. 514.

(527) Determine minority populations and the extent of under-representation of minority groups for consideration in making specialty position allocations. § 3013(c)(2), p. 514.

(528) Consider the recommendations of organizations representing physicians in medical specialties and consumer organizations in making specialty position allocations. § 3013(c)(3), p. 514.

R. NATIONAL COUNCIL ON GRADUATE NURSE EDUCATION

124. Education & Training -- Graduate Education & Specialty Training

(See App. A, Office No. 37.)

(529) Designate for each academic year the number of individuals nationwide who under § 3011 are authorized to be enrolled in approved eligible nurse training programs. § 3062(a), incorporating § 3012(a), p. 535.

(530) Ensure for each year that at least 55% of those completing eligible training programs specialize in primary care. § 3062(a), incorporating § 3012(b)(1), p. 535.

(531) Make annual three-year designations for each nurse specialty. § 3062(a), incorporating § 3012(c)(1), p. 535.

(532) Determine whether a need exists for additional nurse practitioners in each specialty, based on the factors set forth in § 3012(d)(1). § 3062(a), incorporating § 3012(d)(1), p. 535.

(533) Consider the recommendations of organizations representing (i) nurses in each specialty and (ii) consumers in designating the annual number of specialty positions for an academic year. § 3062(a), incorporating § 3012(d)(2), p. 535.

(534) Allocate specialty positions among the annual number of specialty programs. § 3062(a), incorporating § 3013(a), p. 535.

(535) Notify each eligible program of allocations made for the program for each of the academic years of the 3-year period. § 3062(a), incorporating § 3013(b)(2), p. 535.

(536) Determine the historical distribution among areas of approved nurse training programs for consideration in making nurse specialty position allocations. § 3062(a), incorporating § 3013(c), p. 535.

(537) Determine minority populations and the extent of under-representation of minority groups for consideration in making nurse specialty position allocations. § 3062(a), incorporating § 3013(c)(2), p. 535.

(538) Consider the recommendations of organizations representing nurses in medical specialties and consumer organizations in making nurse specialty position allocations. § 3062(a), incorporating § 3013(c)(3), p. 535.

S. NATIONAL HEALTH INFORMATION SYSTEM/ELECTRONIC DATA NETWORK REGIONAL CENTERS (WITHIN NATIONAL HEALTH BOARD)

125. National Health Information System -- Data Collection & Transmission

(See App. A, Office No. 20.)

(539) Specify information to be provided annually by employers to the Board concerning their employment of eligible individuals. § 1602(b)(4), p. 309.

(540) Develop, specify standards for, and implement a National Health Information System by which the Board shall collect, report, and regulate the collection and dissemination of health care information. §§ 1503(e), 5101(a), p. 859.

(541) Specify the form, manner, and frequency in and with which individuals and entities are required to collect or transmit health care information for or to the Board. § 5102(b), p. 864.

(542) Determine in specific instances whether exceptions to federal preemption of state "pen and quill" laws should be allowed. § 5102(c), p. 865.

(543) Oversee the establishment of an Electronic Data Network consisting of Regional Centers which will collect, compile, and transmit information. § 5103(a), p. 865.

(544) Provide information and technical assistance to participating states, alliances, plans, and providers with respect to the establishment and operation of automated health information systems. § 5106, p. 870.

126. National Health Information System -- Demonstration Projects

(See App. A, Office No. 20.)

(545) Undertake demonstration projects to test the National Health Information System's Electronic Data Network before full implementation. § 5103(c), p. 867.

127. National Health Information System -- Education & Awareness Programs
(See App. A, Office No. 20.)

(546) Establish education and awareness programs to foster information security practices, to train personnel with respect to such practices, and to inform individuals and employers of their information security rights. § 5121(c), p. 875.

128. National Health Information System -- Health Security Cards
(See App. A, Office No. 17.)

(547) Establish a system to provide a "unique identifier number" for each eligible individual, employer, plan, and provider. § 5104(a), p. 867.

(548) Register the card, the name of the card, and other indicia relating to the card as a trade- or service-mark under the Trademark Act of 1946. § 5105(d), p. 869.

(549) Promulgate regulations establishing the purposes for which a unique identifier number may be used. § 5104(c), p. 868.

(550) Promulgate regulations governing and limiting use of health security cards. § 5105(a), p. 868.

(551) Promulgate regulations governing the form and information to be encoded on health security cards. § 5105(b), p. 869.

129. National Health Information System -- Privacy
(See App. A, Office No. 17.)

(552) Promulgate "health information privacy standards" to govern the protection of privacy in the transmittal of individually-identifiable health care information. §§ 1413(b)(2), 241; 5103(d), p. 867; 5120(a), p. 871.

(553) Make determinations regarding specific exceptions to the rule prohibiting the linkage of individually identifiable health information obtained with a unique identifier number with individually identifiable information from other sources. § 5104(b), p. 867.

(554) Promulgate regulations establishing manner in which enrollees can authorize the disclosure of individually identifiable health information. § 5120(c)(1)(B), p. 872.

(555) Sponsor research relating to the privacy and security of individually identifiable health information, the development of consent forms to govern disclosure of individually identifiable health information, and the development of technology to implement standards regarding such information. § 5121(a), p. 875.

(556) Submit to the President and Congress a detailed proposal for legislation to provide a comprehensive scheme of federal privacy protection for individually identifiable health information. § 5122(a), p. 876. Include in the proposal a Code of Fair Information Practices. § 5122(b), p. 876.

(557) Provide the National Privacy and Health Data Advisory Council with necessary staff, information, and other assistance. § 5140(i), p. 885.

130. National Health Information System -- Standardized Forms

(See App. A, Office No. 20.)

(558) Develop, promulgate, and publish in the Federal Register standard health care benefit forms, to include an enrollment and disenrollment form, clinical encounter record, and a claim form. § 5130(a), p. 878.

(559) Promulgate regulations specifying additional categories of insurance plans and policies not subject to the standard form requirements. § 5130(d)(1)(B)(iv), p. 881.

T. NATIONAL INSTITUTE FOR HEALTH CARE WORKFORCE DEVELOPMENT

131. Education & Training -- Workforce Training & Development

(See App. A, Office No. 42.)

(560) Make recommendations to HHS and Labor concerning health care workforce supply, the impact of regional and corporate alliance health plans on health care workers, the needs of health care workers, and the development of health care delivery systems. § 3073(c), p. 543.

(561) Administer programs with respect to retraining, advanced career positions, and job banks. § 3073(c), p. 543.

U. NATIONAL LONG-TERM CARE INSURANCE ADVISORY COUNCIL

132. Long-Term Care -- Private Insurance

(See App. A, Office No. 38.)

(562) Meet at least twice per year. § 2302(e), p. 432.

(563) Provide advice, recommendations and assistance to HHS on long-term care insurance matters. § 2302(g)(1), p. 432.

(564) Collect, analyze and disseminate information about long-term care insurance. § 2302(g)(2), p. 433.

(565) Develop proposed models, standards, requirements and procedures for HHS relating to long-term care insurance, including insurance policy formats and marketing practice guidelines. § 2302(g)(3), p. 433.

(566) Monitor the development of the long-term care insurance market and advise HHS on the need for regulatory change. § 2302(g)(4), p. 433.

(567) Consider and provide views and recommendations to HHS concerning (i) long-term care insurance policy uniform terms, definitions and formats; (ii) standard outlines for policy coverage; (iii) the appropriateness of establishing federal premium rating standards; (iv) the appropriateness of establishing federal standards to govern coverage upgrades; (v) the appropriateness of establishing federal standards for threshold conditions for payment of benefits; (vi) the institution of dispute resolution procedures; (vii) the regulation of agents and marketing practices; and (viii) the regulation of continuing-care retirement communities. § 2302(h), p. 433.

V. NATIONAL PRIVACY AND HEALTH DATA ADVISORY COUNCIL

133. National Health Information System -- Privacy

(See App. A, Office No. 29.)

(568) Advise the Board with respect to the Board's duties under Subtitle B of Title V (information systems and privacy, §§ 5101-5142). § 5140(b), p. 833.

W. NATIONAL QUALITY CONSORTIUM

134. Quality Management & Improvement

(See App. A, Office No. 30.)

(569) Oversee the foundation of Regional Professional Foundations, membership requirements, and internal operation. § 5008(b)(1), p. 851.

(570) Advise the Board in demarcating the territories for each Regional Professional Foundation. § 5008(c), p. 852.

(571) Establish programs for the continuing education for health professionals. § 5009(b)(1), p. 853.

(572) Advise the National Quality Management Council and the Administrator for Health Care Policy and Research on research priorities. § 5009(b)(2), p. 853.

(573) Oversee the development of the Regional Professional Foundations. § 5009(b)(3), p. 853.

(574) Advise the National Quality Management Council with respect to funding of proposals to establish such Foundations. § 5009(b)(4), p. 853.

(575) Advise the National Quality Management Council regarding the selection of national measures of quality performance under § 5003(c). § 5009(b)(5), p. 853.

X. NATIONAL QUALITY MANAGEMENT COUNCIL

135. National Health Information System -- Privacy

(See App. A, Office No. 31.)

(576) Consult with the Board in developing the National Health Information System. § 5103(b)(2), p. 866.

(577) Consult with the Board in its development of standards with respect to the privacy of individually identifiable health information in the National Health Information System. § 5120(a)(2), p. 871.

136. Providers -- Certification

(See App. A, Office No. 31.)

(578) Implement demonstration projects to determine the impact of the licensing standards developed by the Board under § 5011(a) governing quality of care, cost reduction, and the reduction of the burdens on health care providers. § 5011(b), p. 856.

(579) Revise the standards in accordance with the Council's findings with respect to the demonstration projects. § 5011(b), p. 856.

(580) Recommend to the President and Congress revisions to federal statutes to conform such statutes to the licensing standards approved by the Council. § 5011(c), p. 857.

(581) Undertake research efforts to develop a system for carrying out, through grant or contract, a single, consolidated, annual audit and inspection of each health care institution and provider for the combined purposes of federal, state, local, and private licensure, accreditation, and certification. § 5011(d), p. 857.

137. Quality Management & Improvement

(See App. A, Office No. 31.)

(582) Administer the National Quality Management Program. §§ 5001, p. 835; 5002(b)(1), p. 836.

(583) Advise the Board with respect to its duties under the Quality Management Program provisions of Title V. § 5002(b)(3), p. 836.

(584) Develop a set of national measures of quality performance, which shall be used to assess the provision of health care services and access to such services. § 5003(a), p. 838.

(585) Consult with the states, health plans, employers, alliances, providers, and health care experts in developing and selecting the national measures of quality performance. § 5003(c)(1), p. 839.

(586) Review and update the set of national measures of quality performance annually to reflect changing goals for quality improvement. § 5003(d), p. 842.

(587) Conduct periodic surveys of health care consumers to gather information concerning access to care, use of health services, health outcomes, and patient satisfaction. § 5004(a), p. 842.

(588) Develop and approve a standard design for the consumer surveys. § 5004(a), p. 842.

(589) Develop sampling strategies that ensure that survey samples adequately measure populations that are considered to be at risk of receiving inadequate health care and may be difficult to reach through consumer sampling methods. § 5004(c), p. 843.

(590) Provide to Congress and each alliance annually a "national quality report" outlining in standard format the performance of each alliance and plan, discussing state-level and national trends relating to health care quality, and presenting data for each health alliance from consumer surveys described in § 5004 that were conducted during the year that is the subject of the report. § 5005(c)(2)(C), p. 845.

(591) Determine whether sufficient information and consensus exist, and, if so, recommend to the Board that it establish goals for performance by health plans and providers on a subset of the national measures of quality performance. § 5005(a), p. 843.

(592) Evaluate the impact of implementation of the Act on the quality of health care services in the U.S. and the access of consumers to such services. § 5005(b), p. 843.

(593) Direct the Administrator for Health Care Policy and Research to develop and periodically review and update clinically relevant guidelines for use by providers to assist in determining how diseases, disorders, and other health conditions can most effectively be prevented, diagnosed, treated, and managed. § 5006(a)(1), p. 846.

(594) Establish standards and procedures for evaluating the clinical appropriateness of protocols used to manage health service utilization. § 5006(a)(3), p. 848.

(595) Direct the Administrator for Health Care Policy and Research to develop and publish standards relating to methodologies for developing the practice guidelines in § 5006(a)(1). § 5006(b)(1), p. 848.

(596) Direct the Administrator for Health Care Policy and Research to establish a procedure by which individuals and entities may submit practice guidelines to the Council for evaluation using the standards set forth in § 5006(b)(1). § 5006(b)(2), p. 848.

(597) Direct the Administrator for Health Care Policy and Research to establish and oversee a clearinghouse and dissemination program for practice guidelines that are developed or certified under this section. § 5006(c), p. 849.

(598) Disseminate information documenting clinically ineffective treatments and procedures. § 5006(d), p. 849.

(599) Direct the Administrator for Health Care Policy and Research to support research directly related to the five-year priority list of performance measures described in § 5003(d). § 5007(a), p. 849.

Y. REGIONAL PROFESSIONAL FOUNDATIONS

138. Quality Management & Improvement

(See App. A, Office No. 32.)

(600) Develop programs in lifetime learning for health professionals to ensure the delivery of quality health care. § 5008(c)(1), p. 852.

(601) Foster collaboration among health plans and health care providers to improve the quality of primary and specialized health care. § 5008(c)(2), p. 852.

(602) Disseminate information about successful quality improvement programs, practice guidelines, and research findings. § 5008(c)(3), p. 852.

(603) Disseminate information about innovative uses of health professionals. § 5008(c)(4), p. 852.

(604) Develop innovative patient education systems that enhance patient involvement in decisions relating to their health care. § 5008(c)(5), p. 852.

(605) Apply for and conduct the health care quality research prioritized by the National Quality Management Council under § 5007(b). § 5008(c)(6), p. 853.

Z. TECHNICAL ADVISORY COMMITTEE

139. Risk Adjustment & Reinsurance

(See App. A, Office No. 33.)

(606) Provide technical advice and recommendations concerning the development and modification of the risk adjustment and reinsurance methodology developed under §§ 1541-1544. § 1543, p. 285.

PART THREE: DUTIES OF STATES

AA. REGIONAL ALLIANCE STATES

140. Benefit Package -- Fee-for-Service Schedules

(See App. A, Office No. 44.)

(607) Determine whether the state or regional alliances within the state shall be responsible for establishing fee schedules. If the state is responsible, establish, and update annually, state-wide fee schedules to apply to all fee-for-service plans. § 1322(c)(3), (c)(4), p. 135; see also item 735 below.

141. Core Functions & Preventive Care

(See App. A, Office No. 43.)

(608) Submit applications for federal core health function funding. § 3313, p. 570.

(609) Submit reports to HHS on progress made under core function funding grants. § 3314, p. 571.

(610) Consult with HHS on the development of uniform sets of data for monitoring core health functions. § 3316(a), p. 572.

142. Dispute Resolution -- Complaint Review Offices

(See App. A, Office No. 43.)

(611) Establish and maintain a Complaint Review Office for each regional alliance in the state to review grievance claims against plans and alliances. § 5202(a)(1), p. 894.

(612) Employ hearing officers at one Complaint Review Office in each regional alliance region. § 5204(a)(1)(A)(i), p. 899.

(613) Establish an Early Resolution Program in each Complaint Review Office in the state. § 5211(a), p. 911.

143. Education & Training -- School Health Education

(See App. A, Office No. 43.)

(614) Submit applications to HHS for school health education planning grants. § 3621(a), p. 636.

(615) Administer school health education planning grants by applying the federal funds to such activities as planning, statewide and regional coordination, staff development, technical assistance, and assessment of learning objectives. § 3624, p. 639.

(616) Submit to HHS applications for school health education implementation grants. § 3631(a), p. 640.

(617) Prescribe the contents of local education agency applications for school health education implementation subgrants. § 3635(a), p. 644.

(618) Review and approve/disapprove local education agency applications for school health education implementation subgrants. § 3635(a). Select sub-grantees. § 3635(b), p. 645.

(619) Collect and submit to HHS data and other information on state and local school health education programs, as specified by HHS. § 3641(a), p. 646.

(620) Review and comment on local agency applications for school health education planning grants before such local agencies submit their applications to HHS. § 3661(b), p. 647.

(621) Confer with HHS to determine whether local education agency applications for specific school health education grants are consistent with the relevant state plans. § 3662(b), p. 649.

(622) Review and comment on local agency applications for school health education implementation grants before the local agencies submit such applications to HHS. § 3671(b), p. 651.

(623) Consult with HHS to determine whether applications of local education agencies within states for school health education implementation grants are consistent with the states' plans. § 3672(b), p. 653.

144. Education & Training -- School Health Services & Sites

(See App. A, Office No. 43.)

(624) Submit to HHS applications for grants for the development and operation of school-related health services and sites. § 3684(c), (d), p. 660.

145. Enforcement

(See App. A, Office No. 47.)

(625) Initiate proceedings to impose monetary penalties for enumerated plan violations. § 5412(c), p. 965.

146. Financial Management -- of Health Plans

(See App. A, Office No. 50.)

(626) Define financial reporting and auditing requirements adequate to monitor health plan financial status. § 1204(b), p. 106.

(627) Establish capital standards for plans which meet the minimum federal requirements established by the Board under §§ 1503(i) and 1551(a). § 1204(a), p. 106.

(628) Assure the financial solvency of plans in accordance with the capital standards established under § 1204. § 1201(3), p. 97.

(629) Establish reserve fund requirements for plans adequate to assure their financial stability. § 1204(b), p. 106.

147. Long-Term Care -- Consumer Education Grants

(See App. A, Office No. 45.)

(630) Submit applications for consumer education grants. § 2361(b), p. 485.

(631) Evaluate annually the effectiveness of consumer education grants received, and report conclusions to HHS. § 2361(d)(1), p. 487.

148. Long-Term Care -- Private Insurance

(See App. A, Office No. 45.)

(632) Review information reported annually to the state insurance commissioner by insurers on coverage, lapse rates, premiums-to-proceeds ratios, reserves and marketing materials. § 2321(d), p. 447.

(633) Establish, as prerequisite to eligibility for long-term care grants, programs for the regulation of long-term care insurance. § 2342(a), p. 474.

149. Long-Term Care -- Private Insurance -- State Compliance

(See App. A, Office No. 45.)

(634) Monitor on an ongoing basis long-term care insurer and policy compliance. § 2342(b)(1), p. 475.

(635) Establish a program for the review and certification of every policy sold in the state. § 2342(b)(1)(A), p. 475.

(636) Establish the form for submission and information to be provided annually by long-term care insurers to demonstrate their compliance. Review insurer filings annually. § 2342(b)(1)(B), p. 475.

(637) Establish data collection procedures for insurers, service providers, insured individuals, and others with respect to long-term care insurance. § 2342(b)(1)(C), p. 476.

(638) Establish marketing oversight procedures, including sampling, to monitor insurer and agent compliance with marketing practices requirements. § 2342(b)(1)(D), p. 476.

(639) Establish benefit administration oversight procedures to monitor insurer compliance with respect to administration of benefits. § 2342(b)(1)(E), p. 476.

(640) Provide long-term care insurers operating within the state with information regarding conditions of eligibility for and benefits under the public long-term care program administered by the state. § 2342(b)(2), p. 477.

(641) Establish administrative procedures for the investigation and resolution of consumer complaints and consumer-insurer disputes with respect to long-term care insurance. § 2342(b)(3), p. 477.

(642) Provide technical assistance to insurers to help them understand and comply with the Act's long-term care insurance requirements. § 2342(b)(4), p. 478.

(643) Assess penalties for violations of long-term care insurance requirements. § 2342(c)(4), p. 479.

(644) Maintain records and prepare and file reports determined by HHS to be necessary to enable HHS to determine the state's compliance with the state's long-term care insurance program. § 2342(d), p. 479.

(645) Cooperate with audits determined by HHS to be necessary to ascertain the state's compliance with its long-term care insurance program. § 2342(d), p. 479.

150. Long-Term Care -- State Disability Programs

(See App. A, Office No. 45.)

(646) Submit to HHS a state plan for home and community-based services to individuals with disabilities. §§ 2101(a), p. 389; 2102, p. 390.

(647) Consult with individuals with disabilities and representatives of groups of such individuals in developing the state plan. § 2102(b)(1), p. 398.

(648) Prior to implementing the state disability program, negotiate with labor unions representing the employees of the affected hospitals or other facilities to address (a) the impact of program implementation on the workforce and (b) methods to redeploy workers affected by the proposed program to positions in the proposed system. § 3074(a), p. 546.

(649) Furnish HHS with reports, audits, data and information specified by HHS concerning the state's administration of its plan for home and community-based services to individuals with disabilities. § 2102(a)(10)(A), (B), p. 397.

(650) Establish a hearing process for appeals of state determinations as to status as an "individual with disabilities." § 2103(b)(1), p. 401.

(651) Establish a State Advisory Group for State Disability Programs for each state to advise the state on all aspects of programs for home and community-based services for individuals with disabilities. § 2107(b), p. 411.

(652) Establish a process whereby all residents of the state, including individuals with disabilities and their representatives, shall be given the opportunity to nominate members to the Advisory Group. § 2107(b)(3), p. 411.

(653) File a quarterly report with HHS estimating the total sum to be expended during the quarter for programs for home and community-based services for individuals with disabilities. § 2108(c)(1), p. 415.

(654) Provide HHS with information concerning offsets and reductions in the state's Medicaid program resulting from home and community-based services provided for under the Act that would have otherwise been paid for under the state's Medicaid plan. § 2109(a)(5)(A), p. 417.

(655) Submit reports to HHS to enable HHS to monitor state compliance with offsets and reductions under § 2109(a)(5)(A). § 2109(a)(5)(B), p. 418.

151. Malpractice Reform -- Enterprise Liability Demonstration Project

(See App. A, Office No. 46.)

(656) Prepare, and file with HHS, reports on the operation of enterprise liability demonstration projects. § 5311(b)(3), p. 946.

152. Mental Health & Substance Abuse Care

(See App. A, Office No. 46.)

(657) Submit to HHS applications for supplemental formula grants for mental health care. § 3502(a)(1), p. 616.

(658) Submit to HHS applications for supplemental formula grants for substance abuse care. § 3502(b)(1), p. 617.

(659) Submit to HHS a report which includes a plan for the integration of state mental illness and substance abuse programs into the comprehensive benefit package. § 3511(a), p. 622.

153. Mental Health & Substance Abuse Care -- Demonstration Project

(See App. A, Office No. 46.)

(660) Prior to implementing the integration of mental health and substance abuse services within the state, negotiate with labor unions representing the employees of affected hospitals or other facilities to address (a) the impact of the proposed changes on the workforce and (b) methods to redeploy affected workers to positions in the proposed system. § 3074(b), p. 547.

154. National Health Information System -- Data Collection & Transmission

(See App. A, Office No. 51.)

(661) Transmit to HHS information necessary to verify income. § 1375(g)(1), p. 198.

(662) Consult with the Board in developing the Electronic Data Network. § 5103(b)(3), p. 866.

155. National Health Information System -- Privacy

(See App. A, Office No. 51.)

(663) Consult with the Board in its development of standards with respect to the privacy of individually identifiable health information in the National Health Information System. § 5120(a)(3), p. 871.

156. Plans -- Certification

(See App. A, Office No. 50.)

(664) Establish and publish criteria for use in certifying plans. § 1203(a)(1), p. 101.

(665) Determine whether each plan within the state meets the certification criteria. § 1203(b), p. 102. Certify each plan within the state that meets the certification criteria. §§ 1400(c), p. 225; 1201(2), p. 97; 1203(b), p. 102; 1522(b), p. 275.

157. Plans -- Compliance & Oversight

(See App. A, Office No. 50.)

(666) Establish plan governance rules. § 1203(a), p. 101.

(667) Monitor the performance of each state-certified plan to ensure ongoing compliance with the certification criteria. § 1203(c), p. 102.

(668) Work with the Board to develop marketing and antitrust standards applicable to plans. § 1422(c)(1), p. 245.

158. Plans -- Insolvency -- Guaranty Funds for Insolvent Regional Alliance Plans

(See App. A, Office No. 54.)

(669) Ensure the existence of a guaranty fund conforming to Board requirements (to protect providers and others in case of the failure of a regional alliance plan). § 1204(c), p. 106.

159. Plans -- Insolvency -- Operation of Insolvent Regional Alliance Plans

(See App. A, Office No. 54.)

(670) Assure that enrollees in failed plans receive continuity in coverage for the comprehensive benefit package. § 1204(d)(1), p. 107.

(671) Designate a state agency to supervise and assume operating control over failed plans. § 1204(d)(2), p. 107.

160. Premiums -- Collection & Transfer Among Plans & Alliances

(See App. A, Office No. 48.)

(672) Assure that regional alliances within the state collect all amounts owed. § 1202(d), p. 100.

(673) Act as agent for the collection of employer premium payments for Indian Health Service programs. § 1351(e)(3)(B), p. 178.

161. Premiums -- Determination of Amount -- Alliance Per Capita Premium Targets

(See App. A, Office No. 51.)

(674) Consult with the Board to assist it in establishing regional alliance premium adjustments under § 6003(c). § 6003(c), p. 996.

162. Premiums -- Determination of Amount -- Blended Plan Payments

(See App. A, Office No. 51.)

(675) Make available to each regional alliance information necessary to determine and verify whether an individual is an AFDC or SSI recipient. § 1343(e), p. 161.

163. Premiums -- Determination of Amount -- Discounts and Cost Sharing Reductions

(See App. A, Office No. 51.)

(676) Assure that cost sharing assistance eligibility determinations are made by regional alliances based on the best information available to alliances and the state. § 1202(e)(1), p. 100.

(677) Utilize, and make available to regional alliances, information available under Internal Revenue Code § 6103(1)(7)D)(x) in making cost sharing assistance eligibility determinations. § 1202(e)(2), p. 100.

(678) Designate an agency or the regional alliances to handle cost sharing and premium reduction applications. § 1374(b), p. 193.

164. Premiums -- Determination of Amount -- Health Care Expenditures

(See App. A, Office No. 43.)

(679) If the state is participating in state financial incentives for the containment of health care expenditures, submit annual reports to the Board on activities undertaken by the state to contain such expenditures. § 6005(a), p. 1004.

165. Premiums -- Determination of Amount -- Plan & Provider Payment Reductions

(See App. A, Office No. 43.)

(680) Promulgate rules modifying the application of the maximum complying bid rules applicable to new plans to prevent abusive premium practices by entities already offering plans and to encourage the offering of a variety of plan options. § 6011(d)(3)(B), p. 1016.

166. Premiums -- Federal Payments to Alliances

(See App. A, Office No. 51.)

(681) Provide information periodically as required by HHS to perform reconciliation of amounts paid and due from the federal government to regional alliances to cover premiums for cash assistance recipients. § 9101(b)(3), p. 1297.

(682) Pay regional alliances amounts attributable to administrative errors. §§ 1202(g), p. 101; 9102(b)(4)(B), p. 1301.

167. Premiums -- State Payments to Alliances

(See App. A, Office No. 51.)

(683) Provide annually for the payment to regional alliances in the state of the state maintenance-of-effort payment relating to non-cash assistance recipients (calculated under § 9001(b)). § 9001(a), p. 1296.

(684) Distribute the state maintenance-of-effort payment relating to non-cash assistance recipients equitably among multiple regional alliances in the state. In determining the equitable distribution, calculate and take into account the proportional non-cash baseline amount attributable to the individuals in each regional alliance area in the state. § 9001(c), p. 1278.

(685) Provide annually for the payment to each regional alliance in the state of an amount equal to the state medical cash assistance recipient percentage for that regional alliance. § 9011(a), p. 1285.

(686) Report annually to HHS the number of AFDC and SSI recipients in the state. § 9014(a), p. 1292.

(687) Determine annually a regional alliance adjustment factor for each regional alliance in the state. § 9015, p. 1293.

168. Providers -- Centers of Excellence

(See App. A, Office No. 49.)

(688) Designate centers of excellence within the state. § 1203(e)(2), p. 103.

169. Providers -- Certification

(See App. A, Office No. 49.)

(689) Establish licensing and certification standards for health care providers. § 1411(2), p. 240.

170. Providers -- Hospitals Serving Vulnerable Populations

(See App. A, Office No. 49.)

(690) Identify hospitals qualifying as "hospitals serving vulnerable populations, and provide a list of the same to HHS." § 3482(b), p. 612.

171. Quality Management & Improvement

(See App. A, Office No. 49.)

(691) Consult with the National Quality Management Council in developing national measures of quality performance. § 5003(c)(1), p. 839.

172. Regional Alliances -- Compliance & Oversight

(See App. A, Office No. 48.)

(692) Ensure that regional alliances within the state comply with the Act. § 1202(a)(1)(A), p. 98.

173. Regional Alliances -- Determination of Alliance Areas

(See App. A, Office No. 48.)

(693) Designate alliance areas within the state. § 1202(a)(1)(B), (b), p. 98.

174. Regional Alliances -- Establishment

(See App. A, Office No. 48.)

(694) Establish regional alliances in accordance with § 1202. §§ 1201(1), p. 97; 1202(a)(1)(A), p. 98.

175. Risk Adjustment & Reinsurance

(See App. A, Office No. 51.)

(695) Establish reinsurance systems to reinsure benefit package items and services for high-cost enrollees or specified high-cost treatments or diagnoses. §§ 1203(g), p. 105; 1541(c)(3), p. 284.

176. State Systems -- Compliance & Oversight

(See App. A, Office No. 43.)

(696) Appeal in the U.S. Court of Appeals adverse determinations of the Board. § 5231(a), p. 920.

(697) Designate a state agency or official responsible for coordinating the state's responsibilities under the Act. § 1201(4), p. 97.

177. State Systems -- Planning & Start-Up Support Grants

(See App. A, Office No. 43.)

(698) Apply for, and administer, federal planning grants. § 1515(a), p. 273.

(699) Apply for, and administer, federal start-up support grants. § 1515(b), p. 274.

178. State Systems -- State System Documents

(See App. A, Office No. 43.)

(700) Submit to the Board a document describing the state health care system. § 1200(b)(1), p. 96.

(701) Submit to the Board by February 15 of each year an annual update to the state system document. § 1200(b)(3), p. 96.

179. Workers Compensation & Automobile Insurance

(See App. A, Office No. 43.)

(702) Conform state workers compensation and automobile insurance laws to meet the requirements of Subtitles A and B of Title X (regarding medical benefits under workers compensation and automobile insurance). § 1201(5), p. 97.

(703) Comply with the requirements of Subtitles A and B of Title X (regarding workers compensation and automobile insurance). § 1203(f), p. 104.

(704) Coordinate access to specialized workers compensation providers on behalf of health plans providing access to state residents. § 10011(a), p. 1320.

(705) Develop a supplemental fee schedule applicable to payment of workers compensation services for which a fee is not included in the applicable fee schedule under §§ 1322(c), p. 134; 10013, p. 1322.

(706) Review workers compensation carrier filings describing the manner in which the carrier has modified or intends to modify its premium rates for workers compensation insurance to reflect the changes brought about by the enactment of Subtitle X of the Act. § 10022(b)(1), p. 1324.

(707) Submit to the Secretary of Labor a report summarizing the information obtained from workers compensation premium modification filings under § 10022(b)(1). § 10022(b)(2), p. 1325.

(708) Develop a supplemental fee schedule applicable to payments for automobile insurance medical services for which a fee is not included in the applicable fee schedule established under § 1322(c). § 10111, p. 1330.

(709) Develop protocols, in consultation with HHS and the Labor Department, for the treatment of work-related conditions. § 10032(a), p. 1325.

BB. SINGLE PAYER STATES

180. Plans -- Enrollment

(710) Apply to HHS for the integration of Medicare-eligible individuals into state system. § 1222(3)(B), p. 110.

(711) Enroll all state residents (or non-corporate alliance eligible individuals in case of alliance-specific single-payer system). § 1222(3)(A), p. 110.

181. Premiums -- Collection & Transfer Among Plans & Alliances

(712) Make payments directly to providers and assume all financial risk of nonpayment. § 1222(4)(A), p. 111.

182. State Systems -- Compliance & Oversight

(713) If the state operates an alliance-specific single payer system (§§ 1221-1224), assure that the regional alliance complies with § 1224(b), which requires alliance-specific single-payer state compliance with all alliance requirements, except choice-of-plans and contracts-with-plans provisions. § 1202(f), p. 100.

(714) Conform state law so that state law provides mechanisms to enforce the system. § 1222(1), p. 109.

(715) Designate state agency to operate the system. § 1222(2), p. 109.

(716) Assume the functions of a regional alliance. § 1223(a)(3), (c), p. 114.

PART FOUR: DUTIES OF NEW STATE ENTITIES TO BE CREATED UNDER THE ACT

CC. COMPLAINT REVIEW OFFICES

183. Dispute Resolution -- Complaint Review Offices

(See App. A, Office No. 53.)

(717) Mail notices of complaints filed with the Office to persons alleged within the complaint to have committed violations. § 5202(f), p. 897.

(718) Process complaints through (i) litigation in court, (ii) mediation under the Early Resolution Program, or (iii) a hearing in the Office. § 5203, p. 897.

(719) Assign the complaint and related motions to a hearing officer in the Office. § 5204(a)(1), p. 899.

(720) Conduct hearings on all complaints and motions de novo. § 5204(c)(1), p. 901. Reduce the evidence at such hearings to writing. § 5204(c)(2), p. 901. Issue decisions. § 5204(d), p. 902.

(721) Maintain mediation and arbitration programs as part of the Early Resolution Program. § 5211(a), p. 911.

(722) Recruit and train individuals to serve as facilitators for mediation proceedings under the Early Resolution Program. § 5211(b)(2)(A), p. 912.

(723) Provide meeting sites, maintain records, and provide facilitators, including administrative support staff, for the Early Resolution Program. § 5211(b)(2)(B), p. 912.

(724) Establish and maintain attorney referral panels. § 5211(b)(2)(C), p. 912.

(725) Ensure that a complainant, upon filing a complaint, is adequately apprised of the complainant's options for review. § 5211(b)(3), p. 912.

(726) Monitor the Early Resolution Program on an ongoing basis. § 5211(b)(4), p. 912.

DD. GUARANTY FUNDS

184. Plans -- Insolvency -- Guaranty Funds for Insolvent Regional Alliance Plans

(See App. A, Office No. 54.)

(727) In the event of the failure of a regional alliance health plan in the state, pay health care providers for items and services covered under the comprehensive benefit package for plan enrollees for which the plan is otherwise obligated to pay. § 1204(d)(3)(A), p. 107.

(728) After paying providers, pay for the operational, administrative, and other costs and debts of the failed plan. § 1204(d)(3)(B), p. 107.

EE. STATE ADVISORY GROUPS FOR STATE DISABILITY PROGRAMS

185. Long-Term Care -- State Disability Programs

(See App. A, Office No. 52.)

(729) Advise the states on guiding principles and values, policy directions, and specific components of the plan. § 2107(b)(4)(A), p. 411.

(730) Meet regularly with state officials in developing the state plan. § 2107(b)(4)(B), p. 412.

(731) Participate in public hearings to help assure that public comments are addressed to the extent practicable in developing the plan. § 2107(b)(4)(C), p. 412.

(732) Document any differences between the Group's recommendations and the plan. § 2107(b)(4)(D), p. 412.

(733) Document the degree to which the plan is consumer-directed. § 2107(b)(4)(E), p. 412.

(734) Meet regularly with state officials to advise on plan implementation and evaluation. § 2107(b)(4)(F), p. 412.

PART FIVE: DUTIES OF REGIONAL ALLIANCES

FF. REGIONAL ALLIANCES

186. Benefit Package -- Fee-for-Service Schedules

(See App. A, Office No. 44.)

(735) If the state delegates the establishment of fee schedules to the regional alliances within the state, establish fee schedules for fee-for-service items and services. § 1322(c)(1), p. 134; see also item 607 above.

(736) Negotiate with providers to arrive at fee-for-service amounts. Providers may bargain collectively. § 1322(c)(2), p. 135.

(737) Annually update the fee schedule. § 1322(c)(4), p. 135.

(738) Negotiate a fee-for-service plan prospective budget, including spending targets, with providers. § 1322(d), p. 137.

187. Consumer Assistance

(See App. A, Office No. 58.)

(739) Establish and maintain an office of ombudsman to assist consumers in dealing with problems. § 1326(a), p. 150.

(740) Provide assistance to the public in the filing of cost sharing reduction and premium discount applications and income reconciliation statements. § 1374(h), p. 195.

188. Consumer Protection

(See App. A, Office No. 57.)

(741) Provide comprehensive pricing, services and other consumer information. Publish materials containing the same annually. § 1325(a)(1), (2), p. 148.

(742) Review and approve or disapprove all consumer information and marketing materials used to market plans offered through the alliance. §§ 1325(b), 1404(a)(1), p. 149.

(743) Comply with §§ 5001-5142 concerning quality, information systems and privacy. § 1327, p. 150.

189. Education & Training -- Academic Health Centers

(See App. A, Office No. 55.)

(744) Ensure that health plans enter into contracts with eligible academic health centers to ensure that enrollees have access to specialized treatment expertise. § 3131(a), p. 558.

190. Financial Management -- of Regional Alliances

(See App. A, Office No. 59.)

(745) Establish an alliance accounting system that meets the standards set by HHS. § 1343(g)(1), p. 162.

(746) Have annual financial audits of the alliance conducted by independent auditors. § 1361(b)(1)(B), p. 180.

191. Long-Term Care -- Consumer Education Grants

(See App. A, Office No. 55.)

(747) Submit applications for consumer education grants. § 2361(b), p. 485.

(748) Evaluate annually the effectiveness of consumer education grants received, and report conclusions to HHS. § 2361(d)(1), p. 487.

192. National Health Information System -- Data Collection & Transmission

(See App. A, Office No. 59.)

(749) Consult with the Board in developing the Electronic Data Network. § 5103(b)(4), p. 866.

(750) Make available to HHS (through the National Health Information System or otherwise) information relating to the enrollment of individuals who would be Medicare-eligible but for § 1012(a) (spouses or dependents of qualified employees). § 1343(f)(2), p. 162.

193. National Health Information System -- Health Security Cards

(See App. A, Office No. 56.)

(751) Issue health security cards to all eligible individuals. § 1001(b), p. 14.

194. National Health Information System -- Privacy

(See App. A, Office No. 59.)

(752) Consult with the Board in its development of standards with respect to the privacy of individually identifiable health information in the Health Information System. § 5120(a)(4), p. 871.

195. Plans -- Compliance & Oversight

(See App. A, Office No. 55.)

(753) Take steps to ensure that plans comply with §§ 5001-5142 concerning quality, information systems and privacy. § 1327, p. 150.

196. Plans -- Enrollment

(See App. A, Office No. 56.)

(754) Provide enrollees with a choice of plans among plans having contracts with the alliance. § 1322(a), p. 132.

(755) Coordinate enrollment and disenrollment activities with other alliances in the manner specified by the Board. § 1328(b), p. 151.

(756) Assure that each regional alliance-eligible individual residing in the alliance area is enrolled in an alliance plan. Establish and maintain methods and procedures sufficient to ensure such enrollment. Maintain records of birth, moving, and age eligibility. § 1323(a), p. 138.

(757) Establish a point-of-service enrollment mechanism to enroll unenrolled but eligible individuals when they seek health care services. § 1323(b), p. 138.

(758) Establish procedures for enrolling regional alliance-eligible individuals who move into the alliance area. § 1323(c)(1), p. 144.

(759) Hold annual open enrollment period during which eligible enrollees can change plans. § 1323(d)(1), p. 145.

(760) Establish procedures for enrollee disenrollment for good cause at any time. § 1323(d)(2), p. 145.

(761) Establish a method for establishing enrollment priorities for plans lacking the capacity to enroll all eligible individuals seeking enrollment. § 1323(f)(1), p. 146.

(762) Establish special enrollment procedures for changing plans upon the termination of coverage in an existing plan in a manner that ensures continuity of coverage. § 1323(g)(1), p. 147.

(763) Establish special enrollment procedures for enrollees in a failed corporate alliance to enroll promptly in a regional alliance without gaps in coverage. § 1323(g)(2), p. 147.

(764) Select a plan for individuals who fail to enroll voluntarily in a plan, and enroll them in that plan. § 1323(i)(1), p. 148.

197. Plans -- Insolvency -- Guaranty Funds for Insolvent Regional Alliance Plans

(See App. A, Office No. 55.)

(765) Participate in the applicable state guaranty fund established under § 1204(c). § 1408(2), p. 239.

198. Premiums -- Collection & Transfer Among Plans & Alliances

(See App. A, Office No. 59.)

(766) Establish a fair hearing mechanism for the resolution of disputes concerning amounts owed the alliance under §§ 1341-1346. § 1344(e), p. 167.

(767) Mail notices of amounts owed or not owed to families who have or have not paid their family shares for a given year. § 1344(a), p. 163.

(768) The regional alliance for the area in which the family last obtained coverage during the year shall be responsible for the collection of premiums and the distribution of such premiums among alliances that provided coverage during that year. § 1344(c), p. 166.

(769) Provide the final alliance in whose area an enrollee received benefits during a given year with the information necessary for the final alliance to determine its liability and reductions in liability attributable to alliance credits. § 1346(b), p. 172.

(770) Transfer funds representing a student's portion of his or her family's premium to the regional alliance for the area in which the student's school is located. § 1346(e), p. 173.

(771) Collect all amounts owed the alliance. Undertake efforts to collect premiums from nonpaying plan enrollees. §§ 1345(a), p. 168; 6107(b)(2)(A), p. 1046; 9102(b)(4)(A), p. 1300.

(772) With respect to divided families, make proportional payments to the health plans of the qualifying employee and of the employee's spouse and children. § 6121(b)(5)(B), p. 1062.

(773) Estimate premium amounts not likely to be collected. § 6107(b)(2)(A), p. 1046.

199. Premiums -- Determination of Amount -- Alliance Per Capita Premium Targets
(See App. A, Office No. 59.)

(774) Consult with the Board to assist it in establishing regional alliance premium adjustment factors under § 6003(c). § 6003(c), p. 996.

200. Premiums -- Determination of Amount -- Bidding Process
(See App. A, Office No. 59.)

(775) Make available to plans interested in submitting premium bids information necessary for the plan to estimate, based on an accepted bid, the amounts payable to the plan under § 1351. § 1341(a), p. 153.

(776) Solicit and negotiate a bid with each plan for a per capita payment rate for the comprehensive benefit package for all eligible individuals in the alliance area. § 1341(d), p. 155.

(777) Obtain preliminary premium bids from each plan seeking to participate as a plan in the alliance in the following year. § 6004(a)(1)(A), p. 1000.

(778) Negotiate with plans regarding the premiums to be charged by the plans. New bids may be submitted as a result of the negotiations. § 6004(a)(2), p. 1001.

(779) Submit to the Board an annual report disclosing information on final bids obtained under § 6003(a) and the distribution of individuals among constituent plans. § 6004(b), p. 1001.

201. Premiums -- Determination of Amount -- Blended Plan Payments
(See App. A, Office No. 59.)

(780) Compute and publish risk adjustment and reinsurance payment amounts to be used by the regional alliance in computing blended plan per capita rates under § 6201. § 1341(a)(2)(E), (c), p. 154.

(781) Determine the blended plan per capita payment amount. §§ 1341(a)(2)(E), p. 154; 6201(a), p. 1086.

(782) Adjust the blended plan per capita payment amount for past year discrepancies in estimating AFDC and SSI proportions. § 6202(d)(1), p. 1089.

202. Premiums -- Determination of Amount -- Discounts and Cost Sharing Reductions (See App. A, Office No. 56.)

(783) Determine eligibility for cost sharing assistance (i.e., premium discounts and cost sharing reductions) based on the best available information. § 1202(e)(1), p. 100.

(784) Make eligibility determinations for premium discounts, liability reductions, and cost sharing reductions. § 1361(b)(1)(C), p. 181.

(785) Determine information to be included in individual families' applications for cost sharing reductions, consistent with HHS rules on the same. § 1372(a)(2), p. 186.

(786) Approve/disapprove cost sharing reduction applications, and notify applicants of determination. § 1372(b)(2), p. 187.

(787) Periodically confirm/verify family's cost sharing reduction eligibility. § 1372(e)(1), p. 189.

(788) Approve/disapprove premium discount applications. § 1373(c), p. 191.

(789) Periodically confirm/verify family's premium discount eligibility. § 1373(d), p. 192.

(790) Distribute cost sharing and premium reduction applications in public places. § 1374(a), p. 193.

(791) Send annual written notices informing cost sharing reduction and premium discount recipients of the requirement to file income reconciliation statements. § 1375(f), p. 198.

(792) Provide providers and plans with access to information necessary to provide for cost sharing reductions. § 1371(a)(3), p. 184.

203. Premiums -- Determination of Amount -- Employer Payments

(See App. A, Office No. 59.)

(793) Audit the records of each regional alliance employer to assure that employer payments and withholding are appropriate under §§ 6121-6126. § 1361(b)(4)(A), p. 182.

(794) Compute the following components of the general employer premium payment: base employer monthly premium per worker under § 6122; employer collection shortfall add-on under § 6125. § 1342(a)(2), p. 157.

(795) Publish, in December before each year, the general employer premium payment amount. § 1342(b)(2)(A), p. 158.

204. Premiums -- Determination of Amount -- Family Payments & Class Factors

(See App. A, Office No. 59.)

(796) Compute the following components of the general family share of premiums for each family enrollment class: plan premiums; alliance credit amount under § 6103; excess premium credit under § 6105; and corporate alliance opt-in credit under § 6106. § 1342(a)(1), p. 156.

(797) Specify a uniform per capita conversion factor for the regional alliance. § 1341(a)(2)(B), (b), p. 154.

(798) Publish, before open enrollment period, the general family premium share for each plan. § 1342(b)(1)(A), p. 157.

(799) Determine family share of premium under § 6101(a) and repayment of alliance credit under § 6111(a) for families enrolling in plans of that alliance. § 1343(a), p. 158.

(800) Obtain and maintain information necessary to determine family shares, including the information set forth in § 1343(d). § 1343(d), p. 160.

(801) If plan payment reductions are made under § 6021, provide premium credits to each family enrolled in plans of that alliance. § 6105(a), p. 1042.

(802) If the alliance is owed a § 6124 payment adjustment for a given year, then the alliance must provide an opt-in credit for each family enrolled in plans of that alliance. § 6106(a), p. 1044.

(803) Determine specific families' wage-adjusted income and alliance credit repayment amount. § 6113(e), p. 1055.

(804) Review applications for qualification as "eligible retirees" or "qualified spouse or child" for premium liability reduction purposes. § 6114(d), p. 1057.

(805) Estimate annually the family collection shortfall add-on, i.e., the total amount of payments the alliance can reasonably identify as owed under the Act for the year and not likely to be collected. Adjust the estimate to take into account previous shortfall estimation discrepancies. § 6107(b)(2)(A), (C), p. 1046.

205. Premiums -- Federal Payments to Alliances

(See App. A, Office No. 59.)

(806) Provide information periodically as required by HHS to perform the reconciliation of amounts paid and due from the federal government to regional alliances to cover premiums for cash assistance recipients. § 9101(b)(2), p. 1297.

(807) Submit information specified by HHS to enable HHS to estimate the capped federal alliance payment amount under § 9102 for the succeeding calendar year. § 9102(c)(1), p. 1302.

206. Providers -- Provider Advisory Board

(See App. A, Office No. 55.)

(808) Establish a Provider Advisory Board, consisting of representatives of health care providers and professionals who provide covered services through health plans offered by the alliance. § 1303, p. 120.

207. Providers -- Underserved Areas/Community & Migrant Health Centers

(See App. A, Office No. 55.)

(809) Organize providers in underserved areas to create new plans for such areas. § 1329(b), p. 151.

208. Quality Management & Improvement

(See App. A, Office No. 57.)

(810) Publish annually, and make available to the public, health plan reports outlining in standard format the performance of each health plan offered in the alliance on a set of national measures of quality performance. § 5005(c)(1), p. 844.

(811) Disseminate to consumers information related to quality and access to aid in their selection of plans pursuant to § 1325. § 5012(1), p. 858.

(812) Disseminate information on the quality of health plans and providers contained in reports of the National Quality Management Council under § 5005(c)(2). § 5012(2), p. 858.

(813) Ensure through negotiations with health plans that performance and quality standards are continually improved. § 5012(3), p. 858.

(814) Conduct educational programs in cooperation with Regional Professional Foundations to assist consumers in using quality and other information in choosing health plans. § 5012(4), p. 858.

209. Regional Alliances -- Compliance & Oversight

(See App. A, Office No. 55.)

(815) Appeal, in the U.S. Court of Appeals, adverse determinations of the Board concerning matters affecting the alliance. § 5231(a), p. 920.

210. Regional Alliances -- Establishment

(See App. A, Office No. 55.)

(816) Enter into contracts with plans. § 1321(a), p. 131. At least one plan must be a fee-for-service plan. § 1322(b), p. 133.

(817) Establish the administrative allowance percentage for operation of the regional alliance in the year. § 1352(a), p. 178.

(818) Establish contingency fund for shortfalls due to estimation discrepancies under § 9201(e)(1). § 1361(b)(3), p. 182.

APPENDIX C:

PRICE CONTROL, EMPLOYER, ALLIANCE, AND HEALTH PLAN MANDATES UNDER THE HEALTH SECURITY ACT

Appendix C: Price Control, Employer, Alliance, and Health Plan Mandates Under the Health Security Act

MBS arranged the duties set forth in Appendix B into the following five categories in order to arrive at an estimate of the proportion of governmental activity that would be associated with such categories under the HSA:

	Category	No. of Duties	% of Duties
(1)	Price Controls, Global Budgets, and Premium Caps	135[17]	16.5
(2)	Employer and Individual Mandates	56[18]	6.8
(3)	Alliance Mandates	71[19]	8.7
(4)	Health Plan Mandates	156[20]	19.1
(5)	Other	400	48.9

[17] Corresponding to the following items set forth in Appendix B: 45-91, 118-119, 292-294, 304-329, 432-435, 439-442, 458, 490-497, 607, 674-675, 679-680, 681-687, 735-738, 774-782, 793-807.

[18] Corresponding to the following items set forth in Appendix B: 22, 32-37, 44, 182, 288-291, 397-404, 407-410, 425-431, 539, 546-547, 672-673, 754-764, 766-773.

[19] Corresponding to the following items set forth in Appendix B: 19, 38-39, 100, 196-199, 265, 295-303, 367, 371-380, 405-406, 411, 436-438, 585, 676-678, 692-694, 739-753, 783-792, 815-818.

[20] Corresponding to the following items set forth in Appendix B: 2-18, 20-21, 23-25, 27-31, 40-43, 95, 101-106, 117, 121, 183-185, 195, 270-287, 359, 368, 381-386, 414-424, 444, 455-457, 459-489, 508-513, 515-518, 611-613, 625-629, 664-671, 695, 717-728, 765.

APPENDIX D:

NEW REGULATIONS UNDER THE HEALTH SECURITY ACT

Appendix D -- New Regulations Under the Health Security Act

Total Pages:	**4,348**
Total CFR Pages:	**1,865**
Total Non-CFR Pages:	**2,483**

As described in Chapter 2, section (4) above, we have estimated the pages of new regulations that would have to be promulgated to put the HSA into operation by analogy to existing Medicare, Medicaid, and insurance industry regulations. Our findings are presented in the chart below. All federal regulations (both CFR and non-CFR) were obtained from CCH Medicare and Medicaid Guide. New York regulations were obtained from The Official Compilation of Codes, Rules & Regulations of the State of New York.

Alliances -- Compliance & Oversight
CFR: 10.0 pp.

2.0 pp.	42 CFR Part 434, Subpart A: General Provisions.
0.5 p.	42 CFR Part 434, Subpart B: Contracts with Fiscal Agents and Private Nonmedical Institutions.
4.5 pp.	42 CFR Part 434, Subpart C: Contracts with HMOs and PHPs: Contract Requirements.
1.0 p.	42 CFR Part 434, Subpart D: Contracts with Health Insuring Organizations.
1.0 p.	42 CFR Part 434, Subpart E: Contracts with HMOs and PHPs: Medicaid Agency Responsibilities.
1.0 p.	42 CFR Part 434, Subpart F: Federal Financial Participation.

Benefit Package -- Fee For Service Schedule
Non-CFR: 35.5 pp.

35.5 pp.	CCH (¶ 3400) Part B Payments - Physician Fee Schedule.

Benefits -- Scope of Coverage
CFR: 133.0 pp.

1.0 p.	42 CFR Part 409, Subpart A: Hospital Insurance Benefits: General Provisions.
2.5 pp.	42 CFR Part 409, Subpart B: Inpatient Hospital Services and Inpatient Rural Primary Care Hospital Services.
1.5 pp.	42 CFR Part 409, Subpart C: Post Hospital SNF Care.
1.5 pp.	42 CFR Part 409, Subpart E: Home Health Services Under Hospital Insurance.

5.0 pp.	42 CFR Part 409, Subpart F: Scope of Hospital Insurance Benefits.
1.5 pp.	42 CFR Part 410, Subpart A: General Provisions.
11.5 pp.	42 CFR Part 410, Subpart B: Medical and Other Health Services.
2.0 pp.	42 CFR Part 410, Subpart D: Comprehensive Rehabilitation Facility (CORF) Services.
6.5 pp.	42 CFR Part 410, Subpart E: Payment of SMI Benefits.
0.5 p.	42 CFR Part 409, Subpart H: Payment of Hospital Insurance Benefits.
4.5 pp.	42 CFR Part 411, Subpart A: General Exclusions and Exclusion of Particular Services.
6.5 pp.	42 CFR Part 411, Subpart B: Insurance Coverage That Limits Medicare Payment: General Provisions.
2.0 pp.	42 CFR Part 411, Subpart D: Limitations on Medicare Payment for Services Covered Under Liability or No-Fault Insurance.
3.5 pp.	42 CFR Part 411, Subpart E: Limitations on Payment for Services Furnished to End-Stage Renal Disease Beneficiaries Who Are Also Covered Under an Employer Group Health Plan.
2.0 pp.	42 CFR Part 411, Subpart F: Limitations on Payment for Services Furnished to Employed Aged and Aged Spouses of Employed Individuals Who Are Also Covered Under an Employer Group Health Plan.
1.0 p.	42 CFR Part 411, Subpart J: Physician Ownership of, and Referral of Patients or Laboratory Specimens to, Entities Furnishing Clinical Laboratory or Other Health Services.
3.0 pp.	42 CFR Part 411, Subpart K: Payment for Certain Excluded Services.
1.0 p.	42 CFR Part 416, Subpart A: General Provisions and Definitions.
2.0 pp.	42 CFR Part 416, Subpart B: General Conditions and Requirements.
2.5 pp.	42 CFR Part 416, Subpart C: Specific Conditions for Coverage.
1.0 p.	42 CFR Part 416, Subpart D: Scope of Benefits.
1.0 p.	42 CFR Part 418, Subpart A: General Provisions and Definitions.
2.0 pp.	42 CFR Part 418, Subpart B: Eligibility, Election and Duration of Benefits.
1.5 pp.	42 CFR Part 418, Subpart F: Covered Services.
9.5 pp.	42 CFR Part 440, Subpart A: Definitions.
3.5 pp.	42 CFR Part 440, Subpart B: Requirements and Limits Applicable to All Services.
3.0 pp.	42 CFR Part 441, Subpart A: General Provisions.
3.0 pp.	42 CFR Part 441, Subpart B: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under Age 21.
1.0 p.	42 CFR Part 441, Subpart C: Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases.
2.5 pp.	42 CFR Part 441, Subpart D: Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs.
1.0 p.	42 CFR Part 441, Subpart E: Abortions.

4.5 pp.	42 CFR Part 441, Subpart F: Sterilizations.
4.5 pp.	42 CFR Part 441, Subpart G: Home and Community Based Services: Waiver Requirements.
8.0 pp	42 CFR Part 441, Subpart H: Home and Community-Based Services Waivers for Individuals Age 65 or Older: Waiver Requirements.
1.0 p.	42 CFR Part 441, Subpart I: Community Supported Living Arrangements.
5.0 pp.	42 CFR Part 494, Subpart B: Conditions for Coverage Screening Mammography.
2.5 pp.	45 CFR Part 95, Subpart A: Time Limits for States to File Claims.
3.5 pp.	45 CFR Part 95, Subpart E: Cost Allocation Plans.
11.0 pp.	45 CFR Part 95, Subpart F: Automatic Data Processing Equipment and Services-Conditions for Federal Financial Participation.
1.5 pp.	45 CFR Part 95, Subpart G: Equipment Acquired Under Public Assistance Programs.
1.0 p.	45 CFR Part 400, Subpart G: Refugee Medical Assistance.

Non-CFR: 204.0 pp.

27.5 pp.	CCH (¶ 1200) Inpatient Hospital Services.
10.5 pp.	CCH (¶ 1300) Extended Care Services.
17.0 pp.	CCH (¶ 1400) Home Health Services.
11.5 pp.	CCH (¶ 1500) Hospice Services.
50.0 pp.	CCH (¶ 3100) Benefits Under the Part B Program.
33.0 pp.	CCH (¶ 4000) Medicare Exclusion - Exclusions From Coverage.
16.0 pp.	CCH (¶ 14,211) Coverage Groups.
11.5 pp.	CCH (¶ 14,303) Conditions of Eligibility.
27.0 pp.	CCH (¶ 14,511) Medical Care and Services Provided.

Consumer Protection

CFR: 13.5 pp.

0.5 p.	42 CFR Part 420, Subpart A: General Provisions.
3.5 pp.	42 CFR Part 420, Subpart C: Disclosure of Ownership and Control Information.
2.5 pp.	42 CFR Part 420, Subpart D: Access to Books, Documents, and Records of Subcontractors.
1.0 p.	42 CFR Part 455: Program Integrity: Medicaid.
2.5 pp.	42 CFR Part 455, Subpart A: Medicaid Agency Fraud Detection and Investigation Program.
3.5 pp.	42 CFR Part 455, Subpart B: Disclosure of Information by Providers and Fiscal Agents.

Non-CFR: 38.0 pp.

38.0 pp.	Title 11, Chapter IX: Unfair Trade Practices.

Core Functions

CFR: 9.0 pp.

1.0 p. 20 CFR Part 422, Subpart A: Employees' Benefits; 422.1, 422.5.
1.5 pp. 20 CFR Part 422, Subpart B: General Procedures; 422.101, 422.130, 422.140.
4.0 pp. 20 CFR Part 422, Subpart C: Procedures of the Office of Hearings and Appeals; 422.201, 422.203, 422.205, 422.210.
2.5 pp. 20 CFR Part 422, Subpart F: Applications and Related Forms; 422.501, 422.510, 422.515, 422.525, 422.527.

Demonstration Projects
Non-CFR: 4.0 pp.
4.0 pp. CCH (¶ 13,650) Miscellaneous - Demonstration Projects - State Cost Control System Experiments.

Dispute Resolution
CFR: 103.5 pp.
31.5 pp. 20 CFR Part 404, Subpart J: Determinations, Administrative Review Process, and Reopening of Determinations, and Decisions.
8.0 pp. 42 CFR Part 405, Subpart G: Reconsiderations and Appeals Under the Hospital Insurance Program.
7.5 pp. 42 CFR Part 405, Subpart H: Review and Hearing Under the Supplementary Medical Insurance Program.
16.0 pp. 42 CFR Part 405, Subpart R: Provider Reimbursement Determinations and Appeals.
3.5 pp. 42 CFR Part 417, Subpart Q: Beneficiary Appeals.
4.0 pp. 42 CFR Part 417, Subpart R: Medicare Contract Appeals.
1.0 p. 42 CFR Part 431, Subpart D: Appeals Process for SNFs and ICFs.
4.0 pp. 42 CFR Part 431, Subpart E: Fair Hearings for Applicants and Recipients.
5.5 pp. 42 CFR Part 473, Subpart B: Utilization and Quality Control Peer Review Organization: Reconsiderations and Appeals.
4.0 pp. 42 CFR Part 498, Subpart A: General Provisions.
2.0 pp. 42 CFR part 498, Subpart B: Initial, Reconsidered, and Revised Determinations.
0.5 p. 42 CFR Part 498, Subpart C: Reopening of Initial or Reconsidered Determinations.
5.0 pp. 42 CFR Part 498, Subpart D: Hearings.
2.0 pp. 42 CFR Part 498, Subpart E: Appeals Council Review.
1.0 p. 42 CFR Part 498, Subpart F: Reopening of Decisions Made by Administrative Law Judges of the Appeals Council.
8.0 pp. 42 CFR Part 1005: Appeals of Exclusions, Civil Money Penalties and Assessments.
Non-CFR: 72.5 pp.
58.0 pp. CCH (¶ 7660) Provider Reimbursement - Provider Appeals Procedures-Audits.

14.5 pp. CCH (¶ 13,470) Notices, Determinations, and Appeals.

Education & Training
CFR: 3.0 pp.

1.0 p. 42 CFR Part 432, Subpart B: Training Programs; Subprofessional and Volunteer Programs.
2.0 pp. 42 CFR Part 432, Subpart C: Staffing and Training Expenditures.

Enforcement
CFR: 48.0 pp.

2.0 pp. 42 CFR Part 1000, Subpart B: Definitions.
1.0 p. 42 CFR Part 1001, Subpart A: General Provisions.
1.0 p. 42 CFR Part 1001, Subpart B: Mandatory Exclusions.
16.5 pp. 42 CFR Part 1001, Subpart C: Permissive Exclusions.
1.5 pp. 42 CFR Part 1001, Subpart D: Waivers and Effect of Exclusion.
2.0 pp. 42 CFR Part 1001, Subpart E: Notice and Appeals.
2.0 pp. 42 CFR Part 1001, Subpart F: Reinstatement into the Program.
0.5 p. 42 CFR Part 1002, Subpart A: General Provisions.
0.5 p. 42 CFR Part 1002, Subpart B: Mandatory Exclusion.
1.0 p. 42 CFR Part 1002, Subpart C: Permissive Exclusions.
9.0 pp. 42 CFR part 1003, Civil Money Penalties, Assessments and Exclusions.
0.5 p. 42 CFR Part 1004, Subpart A: General Provisions.
0.5 p. 42 CFR Part 1004, Subpart B: Sanctions Under the PRO Program; General Provisions.
2.0 pp. 42 CFR Part 1004, Subpart C: PRO Responsibilities.
1.5 pp. 42 CFR Part 1004, Subpart D: OIG Responsibilities.
0.5 p. 42 CFR Part 1004, Subpart E: Effects and Duration of Exclusion.
1.5 pp. 42 CFR Part 1006: Investigational Inquiries.
4.5 pp. 42 CFR Part 1007: State Medicaid Fraud Control Units.

Non-CFR: 14.0 pp.

14.0 pp. Medicare-Medicaid - Fraud and Abuse.

Financial Management -- of Alliances
Non-CFR: 133.0 pp.

133.0 pp. Title 11, Chapter IV, Subchapters A & B: Financial Condition of Insurer and Reports to Superintendent - Rules of General Application - Life Insurers.

Financial Management -- of Health Plans
Non-CFR: 285.0 pp.

269.0 pp. Title 11, Chapter III, Subchapter A: Policy and Certificate Provisions - Life, Accident and Health Insurance.
8.0 pp. Title 11, Chapter VI: Authorized Investments.

8.0 pp. Title 11, Chapter X: Records.

General Provisions
CFR: 4.5 pp.
3.0 pp. 42 CFR Part 400, Subpart B: Definitions.
1.5 pp. 42 CFR Part 432, Subpart A: General Provisions.
Non-CFR: 80.0 pp.
80.0 pp. Title 11, Chapter I: General Provisions

Long Term Care
CFR: 6.5 pp.
6.5 pp. 42 CFR Part 403, Subpart B: Medicare Supplemental Policies.

Mental Health & Substance Abuse Care
CFR: 7.0 pp.
0.5 p. 42 CFR Part 442, Subpart A: General Provisions.
4.0 pp. 42 CFR Part 442, Subpart B: Provider Agreements.
2.5 pp. 42 CFR Part 442, Subpart C: Certification of SNFs, and ICFs/MR.

National Health Information System
CFR: 276.5 pp.
9.5 pp. 42 CFR Part 401, Subpart B: Confidentiality and Disclosure.
2.0 pp. 42 CFR Part 431, Subpart F: Safeguarding Information on Applicants and Recipients.
5.5 pp. 42 CFR Part 433, Subpart C: Mechanized Claims Processing and Information Retrieval Systems.
10.0 pp. 42 CFR Part 476, Subpart B: Utilization and Quality Control Peer Review Organizations.
3.5 pp. 42 CFR Part 482, Subpart B: Administration.
8.0 pp. 42 CFR Part 476, Subpart C: Basic Hospital Functions.
238.0 pp. 42 CFR Part 4888, Subpart C: Survey Forms and Procedures.
Non-CFR: 615.5 pp.
8.0 pp. CCH (¶ 9100) Medicare Forms - Cost Reporting Forms.
382.0 pp. CCH (¶ 10,188) HCFA-1450 - Uniform (Institutional Provider) Bill (UB-82) (For Inpatient and/or Outpatient Services).
98.0 pp. CCH (¶ 10,261) HCFA-1500 - Health Insurance Claim Form (for Physicians and Suppliers).
117.5 pp. CCH (¶ 10,351) Medicare: Billing Instructions - Miscellaneous Forms.
10.0 pp. CCH (¶ 13,850) Miscellaneous - Disclosure of Information.

Plans -- Certification
CFR: 16 pp.
3.5 pp. 42 CFR Part 417, Subpart D: Application for Federal Qualification.
8.5 pp. 42 CFR Part 417, Subpart J: Qualifying Conditions for Medicare

Contracts.

4.0 pp. 42 CFR Part 417, Subpart L: Medicare Contract Requirements.

Plans -- Compliance & Oversight

CFR: 64.0 pp.

3.0 pp. 42 CFR Part 417, Subpart A: General Provisions.

11.5 pp. 42 CFR Part 417, Subpart B: Qualified Health Maintenance Organizations (HMO): Services.

9.5 pp. 42 CFR Part 417, Subpart E: Inclusion of Qualified Health Maintenance Organizations in Employee Health Benefits Plans.

2.5 pp. 42 CFR Part 417, Subpart F: Continued Regulation of Qualified HMO's.

1.5 pp. 42 CFR Part 417, Subpart N: Medicare Payment to HMOs and CMPs: General Rules.

12.0 pp. 42 CFR Part 417, Subpart O: Medicare Payment: Cost Basis.

6.5 pp. 42 CFR Part 417, Subpart P: Medicare Payment: Risk Basis.

4.0 pp. 42 CFR Part 417, Subpart U: Health Care Prepayment Plans.

13.5 pp. 42 CFR Part 417, Subpart V: Administration of Outstanding Loans and Loan Guarantees.

Non-CFR: 12.0 pp.

7.0 pp. CCH (¶ 13,150) Administration.

5.0 pp. CCH (¶ 13,860) Miscellaneous - Health Prepayment Plans - Prohibition Against Any Federal Interference - Free Choice by Patient Guaranteed -Option to Obtain Other Insurance - "Medigap" Insurance.

Plans -- Eligibility

CFR: 98.0 pp.

0.5 p. 20 CFR Part 416, Subpart K: Income; 416.1161a

3.0 pp. 20 CFR Part 416, Subpart L: Resources and Exclusions; 416.1204a, 416.1242, 416.1245, 416.1246.

1.0 p. 20 CFR Part 416, Subpart T: State Supplementation Provisions; Agreements; Payments; 416.2001, 416.2070.

3.0 pp. 20 CFR Part 416, Subpart U: Medicaid Eligibility Determinations.

2.0 pp. 42 CFR Part 406, Subpart A: General Provisions.

6.0 pp. 42 CFR Part 406, Subpart B: Hospital Insurance Without Premiums.

5.0 pp. 42 CFR Part 406, Subpart C: Premium Hospital Insurance.

2.0 pp. 42 CFR Part 406, Subpart D: Special Circumstances That Affect Entitlement to Hospital Insurance.

5.0 pp. 42 CFR Part 435, Subpart A: General Provisions and Definitions.

8.0 pp. 42 CFR Part 435, Subpart B: Mandatory Coverage of the Categorically Needy.

3.5 pp. 42 CFR Part 435, Subpart C: Options for Coverage as Categorically Needy.

2.5 pp. 42 CFR Part 435, Subpart D: Optional Coverage of the Medically Needy.
5.0 pp. 42 CFR Part 435, Subpart E: General Eligibility Requirements.
3.0 pp. 42 CFR Part 435, Subpart F: Categorical Requirements for Eligibility.
1.0 p. 42 CFR Part 435, Subpart G: General Financial Eligibility Requirements for the Categorically Needy.
8.0 pp. 42 CFR Part 435, Subpart H: Post-Eligibility Financial Requirements for the Categorically Needy.
5.5 pp. 42 CFR Part 435, Subpart I: Specific Eligibility and Post-Eligibility Financial Requirements for the Medically Needy.
7.5 pp. 42 CFR Part 435, Subpart J: Eligibility in the States and District of Columbia.
4.5 pp. 42 CFR Part 435, Subpart K: Federal Financial Participation.
1.0 p. 42 CFR Part 436, Subpart A: General Provisions and Definitions.
2.5 pp. 42 CFR Part 436, Subpart B: Mandatory Coverage of the Categorically Needy.
3.0 pp. 42 CFR Part 436, Subpart C: Options for Coverage as Categorically Needy.
2.0 pp. 42 CFR Part 436, Subpart D: Optional Coverage of the Medically Needy.
4.5 pp. 42 CFR Part 436, Subpart E: General Eligibility Requirements.
1.5 pp. 42 CFR Part 436, Subpart F: Categorical Requirements for Medicaid Eligibility.
1.0 p. 42 CFR Part 436, Subpart G: General Financial Eligibility Requirements and Options.
4.5 pp. 42 CFR Part 436, Subpart I: Financial Requirements for the Medically Needy.
0.5 p. 42 CFR Part 436, Subpart J: Eligibility in Guam, Puerto Rico, and the Virgin Islands.
1.0 p. 42 CFR Part 436, Subpart K: Federal Financial Participation.
1.5 pp. 45 CFR Part 233: Coverage and Conditions of Eligibility in Financial Assistance Programs.

Non-CFR: 18.5 pp.

14.0 pp. CCH (¶ 1000) Entitlement to Part A Benefits.
4.5 pp. CCH (¶ 3000) Eligibility, Enrollment and Period of Coverage.

Plans -- Enrollment

CFR: 29.5 pp.

6.5 pp. 20 CFR Part 404, Subpart G: Part 404-Federal Old-age, Survivors and Disability Insurance; Subpart G-Filing of Applications and Other Forms.
1.0 p. 42 CFR Part 407, Subpart A: General Provisions
5.5 pp. 42 CFR Part 407, Subpart B: Individual Enrollment and Entitlement for SMI.

4.5 pp. 42 CFR Part 407, Subpart C: State Buy-In Agreements.
12.0 pp. 42 CFR Part 417, Subpart K: Enrollment, Entitlement, and Disenrollment Under Medicare Contract.

Non-CFR: 2.5 pp.

2.5 pp. CCH (¶ 13,955) Enrollment.

Plans -- Federal Employee Health Programs

CFR: 45.5 pp.

6.0 pp. 5 CFR Part 890, Subpart A: Administration and General Provisions.
4.5 pp. 5 CFR Part 890, Subpart B: Health Benefits Plans.
13.0 pp. 5 CFR Part 890, Subpart C: Registration and Enrollment.
1.5 pp. 5 CFR Part 890, Subpart D: Temporary Extension of Coverage and Conversion.
4.0 pp. 5 CFR Part 890, Subpart E: Contributions and Withholdings.
0.5 p. 5 CFR Part 890, Subpart F: Transfers from Retired Federal Employees Health Benefits Program.
0.5 p. 5 CFR Part 890, Subpart G: Benefits in Medically Underserved Areas.
5.5 pp. 5 CFR Part 890, Subpart H: Benefits for Former Spouses.
1.0 p. 5 CFR Part 890, Subpart I: Limit on Inpatient Hospital Charges and FEHB Benefit Payments.
2.0 pp. 5 CFR Part 890, Subpart J: Debarments, Civil Monetary Penalties and Assessments Imposed Against Providers.
5.0 pp. 5 CFR Part 890, Subpart K: Temporary Continuation of Coverage.
2.0 pp. 5 CFR Part 890, Subpart L: Benefits for United States Hostages in Iraq and Kuwait and United States Hostages Captured in Lebanon.

Plans -- Insolvency -- Guaranty Funds for Insolvent Regional Alliance Plans

Non-CFR: 3.0 pp.

3.0 pp. Title 11, Chapter IV, Subchapter E: Property and Liability Insurance Security Fund.

Plans -- Uniformed Services Health Plans

CFR: 284.0 pp.

206.0 pp. 32 CFR Part 199: Civilian Health and Medical Program of the Uniformed Services.
25.0 pp. 32 CFR Part 728, Subpart A: General.
2.0 pp. 32 CFR Part 728, Subpart B: Members of the Uniformed Services on Active Duty.
3.0 pp. 32 CFR Part 728, Subpart C: Members of Reserve Components, Reserve Officers' Training Corps, Navy and Marine Corps Officer Candidate Programs, and National Guard Personnel.
7.0 pp. 32 CFR Part 728, Subpart D: Retired Members and Dependents of the Uniformed Services.

6.0 pp	32 CFR Part 728, Subpart E: Members of Foreign Military Services and Their Dependents.
10.0 pp.	32 CFR Part 728, Subpart F: Beneficiaries of Other Federal Agencies.
8.0 pp.	32 CFR Part 728, Subpart G: Other Persons.
1.5 pp.	32 CFR Part 728, Subpart H: Adjuncts to Medical Care.
0.5 p.	32 CFR Part 728, Subpart I: Reservists-Continued Treatment, Return to Limited Duty, Separation, or Retirement for Physical Disability.
1.0 p.	32 CFR Part 728, Subpart J: Initiating Collection Action on Pay Patients.
0.5 p.	32 CFR Part 732, Subpart A: General.
13.0 pp.	32 CFR Part 732, Subpart B: Medical and Dental Care from Nonnaval Sources.
0.5 p.	32 CFR Part 732, Subpart C: Accounting Classifications for Nonnaval Medical and Dental Care Expenses and Standard Document Numbers.

Plans -- Veterans Administration Health Plans & Facilities
CFR: 23.0 pp.

1.0 p.	38 CFR Part 17: Medical - Hospital or Nursing Home Care and Medical Services in Foreign Countries.
0.5 p.	38 CFR Part 17: Medical - Examinations and Observation and Examination.
8.0 pp.	38 CFR Part 17: Medical - Hospital, Domiciliary and Nursing Home Care.
0.5 p.	38 CFR Part 17: Medical - Use of Department of Defense, Public Health Service or Other Federal Hospitals.
4.0 pp.	38 CFR Part 17: Medical - Use of Public or Private Hospitals.
1.5 pp.	38 CFR Part 17: Medical - Use of Community Nursing Home Care Facilities.
2.0 pp.	38 CFR Part 17: Medical - Adult Day Health Care.
5.5 pp.	38 CFR Part 17: Medical - Community Residential Care.

Premiums -- Collection and Transfer Among Plans & Alliances
CFR: 4.0 pp.

4.0 pp.	42 CFR Part 401, Subpart F: Claims, Collection and Compromise.

Premiums -- Determination of Amount
CFR: 17.0 pp.

2.5 pp.	42 CFR Part 408, Subpart A: General Provisions.
3.5 pp.	42 CFR Part 408, Subpart B: Amount of Monthly Premium.
2.5 pp.	42 CFR Part 408, Subpart C: Deduction from Monthly Benefits.
1.5 pp.	42 CFR Part 408, Subpart D: Direct Remittance: Individual Payment.
2.0 pp.	42 CFR Part 408, Subpart E: Direct Remittance: Group Payment.
1.0 p.	42 CFR Part 408, Subpart F: Termination and Reinstatement of

Coverage.

1.5 pp. 42 CFR Part 408, Subpart G: Collection of Unpaid Premiums; Refund of Excess Premiums After the Death of the Enrollee.

2.5 pp. 42 CFR Part 409, Subpart G: Hospital Insurance Deductibles and Coinsurance.

Non-CFR: 119.0 pp.

9.0 pp. CCH (¶ 13,000) Financing Medicare Benefits.

110.0 pp. Title 11, Chapter V: Rates and Rating Organizations.

Providers -- Certification

CFR: 125.0 pp.

1.0 p. 42 CFR Part 482, Subpart A: General Provisions.

2.0 pp. 42 CFR Part 482, Subpart B: Administration.

7.5 pp. 42 CFR Part 482, Subpart C: Basic Hospital Functions.

3.0 pp. 42 CFR Part 482, Subpart D: Optional Hospital Services.

3.0 pp. 42 CFR Part 482, Subpart E: Requirements for Specialty Hospitals.

21.5 pp. 42 CFR Part 483, Subpart B: Requirements for Long-Term Care Facilities.

6.5 pp. 42 CFR Part 483, Subpart D: Requirements That Must Be Met by States and State Agencies; Nurse Aide Training and Competency Evaluation.

14.5 pp. 42 CFR Part 483, Subpart I: Conditions of Participation for Intermediate Care Facilities for the Mentally Retarded.

3.0 pp. 42 CFR Part 484, Subpart A: General Provisions.

4.5 pp. 42 CFR Part 484, Subpart B: Administration.

4.5 pp. 42 CFR Part 484, Subpart C: Furnishing of Services.

7.0 pp. 42 CFR Part 484, Subpart B: Conditions of Participation: Comprehensive Outpatient Rehabilitation Facilities.

3.0 pp. 42 CFR Part 484, Subpart D: Conditions for Coverage: Organ Procurement Organizations.

5.5 pp. 42 CFR Part 488, Subpart A: General Provisions.

5.0 pp. 42 CFR Part 488, Subpart B: Special Requirements.

1.5 pp. 42 CFR Part 488, Subpart D: Reconsideration of Adverse Determinations - Deeming Authority for Accreditation Organizations and CLIA Exemption of Laboratories Under State Programs.

9.0 pp. 42 CFR Part 493, Subpart A: General Provisions.

1.5 pp. 42 CFR Part 493, Subpart B: Certificate of Waiver

2.5 pp. 42 CFR Part 493, Subpart C: Registration Certificate, Certificate for Physician-Performed Microscopy Procedures, and Certificate.

3.0 pp. 42 CFR Part 493, Subpart D: Certificate of Accreditation.

11.5 pp. 42 CFR Part 493, Subpart E: Accreditation by a Private, Nonprofit Accreditation Organization or Exemption Under an Approved State Laboratory Program.

4.5 pp. 42 CFR Part 493, Subpart F: General Administration.

Non-CFR: 3.0 pp.

3.0 pp.	CCH (¶ 13,950) Qualifying Conditions for Eligible Organizations.

Providers -- Compliance & Oversight
CFR: 445 pp.

8.0 pp.	42 CFR Part 405, Subpart C: Exclusions, Recovery of Overpayment, Liability of a Certifying Officer, and Suspension of Payment.
8.5 pp.	42 CFR Part 405, Subpart D: Principles of Reimbursement for Providers, Outpatient Maintenance Dialysis, and Services by Hospital-Based Physicians.
19.5 pp.	42 CFR Part 405, Subpart E: Criteria for Determination of Reasonable Charges; Payment for Services of Hospital Interns, Residents, and Supervising Physicians.
3.0 pp.	42 CFR Part 405, Subpart F: Notice, Election and Agreements.
3.0 pp.	42 CFR Part 405, Subpart N: Conditions for Coverage of Portable X-Ray Services.
11.5 pp.	42 CFR Part 405, Subpart Q: Conditions of Participation: Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and/or Speech Pathology Services; and Conditions for Coverage: Outpatient Physical Therapy Services Furnished by Physical Therapists in Independent Practice.
20.5 pp.	42 CFR Part 405, Subpart U: Conditions for Coverage of Suppliers of End-Stage Renal Disease Services.
4.0 pp.	42 CFR Part 409, Subpart D: Requirements for Coverage of Post hospital SNF Care.
4.0 pp.	42 CFR Part 412, Subpart A: General Provisions.
7.0 pp.	42 CFR Part 411, Subpart B: Hospital Services Subject to and Excluded from the Prospective Payment System.
4.0 pp.	42 CFR Part 412, Subpart C: Conditions for Payment Under the Prospective Payment System.
5.0 pp.	42 CFR Part 412, Subpart D: Basic Methodology for Determining Federal Prospective Payment Rates.
4.0 pp.	42 CFR Part 412, Subpart E: Determination of Transition Period Payment Rate.
2.5 pp.	42 CFR Part 412, Subpart E: Payment to outlier Cases.
14.0 pp.	42 CFR Part 412, Subpart G: Special Treatment of Certain Facilities.
6.0 pp.	42 CFR Part 412, Subpart H: Payments to Hospitals Under the Prospective Payment System.
3.0 pp.	42 CFR Part 412, Subpart K: Prospective Payment system for Hospitals Located in Puerto Rico.
9.0 pp.	42 CFR Part 412, Subpart L: The Medicare Geographic Classification Review Board.
14.0 pp.	42 CFR Part 412, Subpart M: Prospective Payment System for Inpatient Hospital Capital Costs.

9.0 pp.	42 CFR Part 413, Subpart A: Introduction and General Rule.
4.0 pp.	42 CFR Part 413, Subpart B: Accounting Records and Reports.
12.0 pp.	42 CFR Part 413, Subpart C: Limits on Cost Reimbursement.
12.0 pp.	42 CFR Part 413, Subpart D: Apportionment.
17.0 pp.	42 CFR Part 413, Subpart F: Specific Categories of Costs.
24.5 pp.	42 CFR part 413, Subpart G: Capital-Related Costs.
7.0 pp.	42 CFR Part 413, Subpart H: Payment for End-Stage Renal Disease Services.
9.0 pp.	42 CFR Part 414, Subpart A: General Provisions.
7.0 pp.	42 CFR Part 414, Subpart D: Payment for Durable Medical Equipment and Prosthetic and Orthotic Devices.
4.0 pp.	42 CFR Part 414, Subpart E: Determination of Reasonable Charges Under the ESRD Program.
2.0 pp.	42 CFR Part 414, Subpart H: Payment for the Services of Anesthetists.
1.0 p.	42 CFR Part 416, Subpart E: Payment for Facility Services.
3.0 pp.	42 CFR Part 418, Subpart C: Conditions of Participation, General Provisions and Administration.
1.5 pp.	42 CFR Part 418, Subpart D: Conditions of Participation: Core Services.
4.0 pp.	42 CFR Part 418, Subpart E: Conditions of Participation: Other Services.
3.5 pp.	42 CFR Part 418, Subpart G: Payment for Hospice Care.
1.5 pp.	42 CFR Part 424, Subpart A: General Provisions.
6.5 pp.	42 CFR Part 424, Subpart B: Physician Certification Requirements.
3.0 pp.	42 CFR Part 424, Subpart C: Claims for Payment.
2.5 pp.	42 CFR Part 424, Subpart D: To Whom Payment is Ordinarily Made.
2.5 pp.	42 CFR Part 424, Subpart E: To Whom Payment is Made in Special Situations.
3.5 pp.	42 CFR Part 424, Subpart F: Limitations on Assignment and Reassignment of Claims.
2.5 pp.	42 CFR Part 424, Subpart G: Special Conditions: Emergency Services Furnished by a Nonparticipating Hospital.
1.5 pp.	42 CFR Part 424, Subpart H: Special Conditions: Services Furnished in a Foreign Country.
1.0 p.	42 CFR Part 424, Subpart M: Replacement and Reclamation of Medicare Payments.
9.5 pp.	42 CFR Part 447, Subpart A: Payments: General Provisions.
1.0 p.	42 CFR Part 447, Subpart B: Payment Methods: General Provisions.
4.0 pp.	42 CFR Part 447, Subpart C: Payment for Inpatient Hospital and Long-Term Care Facility Services.
6.5 pp.	42 CFR Part 447, Subpart F: Payment Methods for Other Institutional and Noninstitutional Services.
2.5 pp.	42 CFR Part 456, Subpart A: General Provisions.

0.5 p.	42 CFR Part 456, Subpart B: Utilization Control: All Medicaid Services.
6.0 pp.	42 CFR Part 456, Subpart C: Utilization Control: Hospitals.
5.0 pp.	42 CFR Part 456, Subpart D: Utilization Control: Mental Hospitals.
6.0 pp.	42 CFR Part 456, Subpart E: Utilization Control: Skilled Nursing Facilities.
4.0 pp.	42 CFR Part 456, Subpart F: Utilization Control: Intermediate Care Facilities.
0.5 p.	42 CFR Part 456, Subpart G: Inpatient Psychiatric Services for Individuals Under Age 21: Admission and Plan of Care Requirements.
2.5 pp.	42 CFR Part 456, Subpart H: Utilization Review Plans: FFP, Waivers, and Variances for Hospitals, Mental Hospitals, and Skilled Nursing Facilities.
2.5 pp.	42 CFR Part 456, Subpart I: Inspections of Care in Skilled Nursing and Intermediate Care Facilities and Institutions for Mental Diseases.
3.5 pp.	42 CFR Part 456, Subpart J: Penalty for Failure to Make a Satisfactory Showing of an Effective Institutional Utilization Control Program.
3.5 pp.	42 CFR Part 489, Subpart A: General Provisions.
2.0 pp.	42 CFR Part 489, Subpart B: Essentials of Provider Agreements.
1.5 pp.	42 CFR Part 489, Subpart C: Allowable Charges.
1.0 p.	42 CFR Part 489, Subpart D: Handling of Incorrect Collections.
2.0 pp.	42 CFR Part 489, Subpart E: Termination of Agreement and Reinstatement After Termination.
1.5 pp.	42 CFR Part 489, Subpart F: Denial of Payments to SNFs for New Admissions; Withholding of Payment.
11.0 pp.	42 CFR Part 493, Subpart H: Participation in Proficiency Testing for Laboratories Performing Tests of Moderate or High Complexity, or Both.
18.0 pp.	42 CFR Part 493, Subpart I: Proficiency Testing Programs for Tests of Moderate or High Complexity, or Both.
2.0 pp.	42 CFR Part 493, Subpart J: Patient Test Management for Moderate or High Complexity, or Both.
17.0 pp.	42 CFR Part 493, Subpart K: Quality Control for Tests of Moderate or High Complexity, or Both.
20.0 pp.	42 CFR Part 493, Subpart M: Personnel for Moderate and High Complexity Testing.
1.5 pp.	42 CFR Part 493, Subpart P: Quality Assurance for Moderate or High Complexity Testing, or Both.
2.0 pp.	42 CFR Part 493, Subpart Q: Inspection.
12.0 pp.	42 CFR Part 493, Subpart R: Enforcement Procedures.
0.5 p.	42 CFR Part 493, Subpart T: Consultations.

Non-CFR: 763.0 pp.

21.0 pp.	CCH (¶ 3185) Part B Payments - General
101.5 pp.	CCH (¶ 4500) Prospective Payments Systems for Inpatient Hospital Services.
56.0 pp.	CCH (¶ 4611) Depreciation.
15.5 pp.	CCH (¶ 4906) Interest Expense.
7.5 pp.	CCH (¶ 5206) Bad Debts, Charity, and Courtesy Allowances.
8.0 pp.	CCH (¶ 5305) Cost of Educational Activities.
3.5 pp.	CCH (¶ 5403) Research Costs.
5.0 pp.	CCH (¶ 5431) Grants, Gifts, and Income from Endowments.
5.5 pp.	CCH (¶ 5481) Value of Services of Nonpaid Workers.
3.5 pp.	CCH (¶ 5529) Purchase Discounts and Allowances, and Refunds of Expenses.
7.5 pp.	CCH (¶ 5579) Compensation of Owners.
6.0 pp.	CCH (¶ 5679) Cost to Related Organizations.
10.0 pp.	CCH (¶ 5758) Return on Equity Capital of Proprietary Providers.
2.5 pp.	CCH (¶ 5842) Inpatient Routine Nursing Salary Cost Differential.
30.5 pp.	CCH (¶ 5849D-2) Reasonable Cost of Physical and Other Therapy Services Furnished Under Arrangements.
99.0 pp.	CCH (¶ 5854) Cost Related to Patient Care.
53.5 pp.	CCH (¶ 6038) Determination of Cost of Services to Beneficiaries.
28.5 pp.	CCH (¶ 6329) Adequate Cost Data and Cost Finding.
55.0 pp.	CCH (¶ 7229) Provider Reimbursement - Payments to Providers.
22.5 pp.	CCH (¶ 7521) Limitations on Reimbursable Costs Under Medicare and Notice of Schedule of Limits on Provider Costs.
17.0 pp.	CCH (¶ 7575) Lower of Cost or Charges.
54.0 pp.	CCH (¶ 7598B) Provider Reimbursement - End-Stage Renal Disease Services.
2.5 pp.	CCH (¶ 7975) Provider Audits.
31.5 pp.	CCH (¶ 8100) Provider Reimbursement - Provider-Based Physicians.
9.5 pp.	CCH (¶ 11,125) Claims.
10.5 pp.	CCH (¶ 11,225) Refunds, Underpayments, and Overpayments.
6.0 pp.	CCH (¶ 11,260) Waiver of Liability.
0.5 p.	CCH (¶ 11,315) Guarantee of Payment.
6.5 pp.	CCH (¶ 11,405) Certification and Recertification.
16.0 pp.	CCH (¶ 12,101) Provider Agreements.
57.0 pp.	CCH (¶ 12,305) Conditions of Participation.
10.0 pp.	CCH (¶ 13,960) Health Maintenance Organizations - Benefits - Marketing - Charges to Beneficiaries - Risk Reimbursement - Cost Reimbursement - Contract Requirements - Appeals - Arrangements for Health Services.

Providers -- Underserved Populations

CFR: 22.5 pp.

14.0 pp.	42 CFR Part 405, Subpart X: Rural Health Clinic and Federally

Qualified Health Center Services.

3.5 pp. 42 CFR Part 447, Subpart E: Payment Adjustments for Hospitals That Serve a Disproportionate Number of Low-Income Patients.

5.0 pp. 42 CFR Part 491, Subpart A: Rural Health Clinics: Conditions for Certification; and Federally Qualified Health Centers: Conditions for Coverage.

Quality Management & Improvement

CFR: 14.5 pp.

1.0 p. 42 CFR Part 462, Subpart A: General Provisions.

2.0 pp. 42 CFR Part 462, Subpart C: Utilization and Quality Control Peer Review Organizations.

2.5 pp. 42 CFR Part 466, Subpart A: General Provisions.

9.0 pp. 42 CFR Part 466, Subpart C: Review Responsibilities of Utilization and Quality Control Peer Review Organizations (PROs).

Non-CFR: 32.5 pp.

3.5 pp. CCH (¶ 12,720) Utilization and Medical Review.

29.0 pp. CCH (¶ 12,855) Utilization and Quality Control Peer Review.

Risk Adjustment and Reinsurance

CFR: 1.0 p.

1.0 p. 42 CFR Part 418, Subpart H: Coinsurance.

Non-CFR: 25.0 pp.

25.0 pp. Title 11, Chapter IV, Subchapter D: Reinsurance.

State Systems -- Compliance & Oversight

CFR: 76.0 pp.

7.5 pp. 42 CFR Part 403, Subpart C: Recognition of State Reimbursement Control Systems.

1.0 p. 42 CFR Part 430, Subpart A: Introduction; General Provisions.

3.5 pp. 42 CFR Part 430, Subpart B: State Plans.

5.0 pp. 42 CFR Part 430, Subpart C: Grants; Reviews and Audits; Withholding for Failure to Comply; Deferral and Disallowance of Claims; Reduction of Federal Medicaid Payments.

5.0 pp. 42 CFR Part 430, Subpart D: Hearings on Conformity of State Medicaid Plans and Practice to Federal Requirements.

3.0 pp. 42 CFR Part 431, Subpart A: Single State Agency.

5.0 pp. 42 CFR Part 431, Subpart B: General Administrative Requirements.

2.5 pp. 42 CFR Part 431, Subpart C: Administrative Requirements: Provider Relations.

5.0 pp. 42 CFR Part 431, Subpart M: Relations with Other Agencies.

2.0 pp. 42 CFR Part 431, Subpart N: State Programs for Licensing Nursing Home Administrators.

11.5 pp. 42 CFR Part 431, Subpart P: Quality Control. (excludes 431.861,

431.862, 431.863, and 431.864).

1.5 pp. 42 CFR Part 433, Subpart A: Federal Matching and General Administration Provisions.

5.0 pp. 42 CFR Part 433, Subpart B: General Administrative Requirements: State Financial Participation.

9.0 pp. 42 CFR Part 433, Subpart D: Third Party Liability.

5.0 pp. 42 CFR Part 433, Subpart F: Refunding of Federal Share of Medicaid Overpayment to Providers.

4.5 pp. 45 CFR Part 234: Financial Assistance to Individuals.

Non-CFR: 59.0 pp.

45.5 pp. CCH (¶ 14,701) Requirements for State Plans, Including Reimbursement.

13.5 pp. CCH (¶ 14,901) Federal-State Financial Arrangements.

Workers Compensation & Automobile Insurance

CFR: 2.0 pp.

2.0 pp. 42 CFR Part 411, Subpart C: Limitations on Medicare Payment for Services Covered Under Worker's Compensation.