

that prohibit payment for health care-acquired conditions and shall incorporate the practices identified, or elements of such practices, which the Secretary determines appropriate for application to the Medicaid program in regulations. Such regulations shall be effective as of July 1, 2011, and shall prohibit payments to States under section 1903 of the Social Security Act [42 U.S.C. 1396b] for any amounts expended for providing medical assistance for health care-acquired conditions specified in the regulations. The regulations shall ensure that the prohibition on payment for health care-acquired conditions shall not result in a loss of access to care or services for Medicaid beneficiaries.

(b) Health care-acquired condition

In this section,¹ the term “health care-acquired condition” means a medical condition for which an individual was diagnosed that could be identified by a secondary diagnostic code described in section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv)).

(c) Medicare provisions

In carrying out this section, the Secretary shall apply to State plans (or waivers) under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] the regulations promulgated pursuant to section 1886(d)(4)(D) of such Act (42 U.S.C. 1395ww(d)(4)(D)) relating to the prohibition of payments based on the presence of a secondary diagnosis code specified by the Secretary in such regulations, as appropriate for the Medicaid program. The Secretary may exclude certain conditions identified under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] for non-payment under title XIX of such Act when the Secretary finds the inclusion of such conditions to be inapplicable to beneficiaries under title XIX. (Pub. L. 111–148, title II, §2702, Mar. 23, 2010, 124 Stat. 318.)

REFERENCES IN TEXT

The Social Security Act, referred to in subsec. (c), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Title XIX of the Act is classified generally to this subchapter. Title XVIII of the Act is classified generally to subchapter XVIII (§1395 et seq.) of this chapter. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

CODIFICATION

Section was enacted as part of the Patient Protection and Affordable Care Act, and not as part of the Social Security Act which comprises this chapter.

§ 1396c. Operation of State plans

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

- (1) that the plan has been so changed that it no longer complies with the provisions of section 1396a of this title; or
- (2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that further payments will not be made to the

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

(Aug. 14, 1935, ch. 531, title XIX, §1904, as added Pub. L. 89–97, title I, §121(a), July 30, 1965, 79 Stat. 351.)

§ 1396d. Definitions

For purposes of this subchapter—

(a) Medical assistance

The term “medical assistance” means payment of part or all of the cost of the following care and services or the care and services themselves, or both (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of medicare cost-sharing with respect to a qualified medicare beneficiary described in subsection (p)(1) of this section, if provided after the month in which the individual becomes such a beneficiary) for individuals, and, with respect to physicians’ or dentists’ services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title) not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, who are—

- (i) under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose,
- (ii) relatives specified in section 606(b)(1)¹ of this title with whom a child is living if such child is (or would, if needy, be) a dependent child under part A of subchapter IV of this chapter,
- (iii) 65 years of age or older,
- (iv) blind, with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter,
- (v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter,
- (vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under subchapter I, X, XIV, or XVI of this chapter,
- (vii) blind or disabled as defined in section 1382c of this title, with respect to States not

¹ So in original. The period probably should be a comma.

¹ See References in Text note below.

eligible to participate in the State plan program established under subchapter XVI of this chapter,

- (viii) pregnant women,
- (ix) individuals provided extended benefits under section 1396r-6 of this title,
- (x) individuals described in section 1396a(u)(1) of this title,
- (xi) individuals described in section 1396a(z)(1) of this title,
- (xii) employed individuals with a medically improved disability (as defined in subsection (v) of this section),
- (xiii) individuals described in section 1396a(aa) of this title,
- (xiv) individuals described in section 1396a(a)(10)(A)(i)(VIII) or 1396a(a)(10)(A)(i)(IX) of this title,
- (xv) individuals described in section 1396a(a)(10)(A)(ii)(XX) of this title,
- (xvi) individuals described in section 1396a(ii) of this title, or
- (xvii) individuals who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1396n(i) of this title, or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection,

but whose income and resources are insufficient to meet all of such cost—

- (1) inpatient hospital services (other than services in an institution for mental diseases);
- (2)(A) outpatient hospital services, (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (l)(1) of this section) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (l)(1) of this section) and which are otherwise included in the plan, and (C) Federally-qualified health center services (as defined in subsection (l)(2) of this section) and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan;
- (3) other laboratory and X-ray services;
- (4)(A) nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older; (B) early and periodic screening, diagnostic, and treatment services (as defined in subsection (r) of this section) for individuals who are eligible under the plan and are under the age of 21; (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies; and (D) counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in subsection (bb));
- (5)(A) physicians' services furnished by a physician (as defined in section 1395x(r)(1) of this title), whether furnished in the office, the patient's home, a hospital, or a nursing facility, or elsewhere, and (B) medical and surgical

services furnished by a dentist (described in section 1395x(r)(2) of this title) to the extent such services may be performed under State law either by a doctor of medicine or by a doctor of dental surgery or dental medicine and would be described in clause (A) if furnished by a physician (as defined in section 1395x(r)(1) of this title);

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

(7) home health care services;

(8) private duty nursing services;

(9) clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician, including such services furnished outside the clinic by clinic personnel to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address;

(10) dental services;

(11) physical therapy and related services;

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

(13) other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;

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

(15) services in an intermediate care facility for the mentally retarded (other than in an institution for mental diseases) for individuals who are determined, in accordance with section 1396a(a)(31) of this title, to be in need of such care;

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

(17) services furnished by a nurse-midwife (as defined in section 1395x(gg) of this title) which the nurse-midwife is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider, and without regard to whether or not the services are performed in the area of management of the care of mothers and babies throughout the maternity cycle;

(18) hospice care (as defined in subsection (o) of this section);

(19) case management services (as defined in section 1396n(g)(2) of this title) and TB-related services described in section 1396a(z)(2)(F) of this title;

(20) respiratory care services (as defined in section 1396a(e)(9)(C) of this title);

(21) services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner (as defined by the Secretary) which the certified pediatric nurse practitioner or certified family nurse practitioner is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the certified pediatric nurse practitioner or certified family nurse practitioner is under the supervision of, or associated with, a physician or other health care provider;

(22) home and community care (to the extent allowed and as defined in section 1396t of this title) for functionally disabled elderly individuals;

(23) community supported living arrangements services (to the extent allowed and as defined in section 1396u of this title);

(24) personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home or other location;

(25) primary care case management services (as defined in subsection (t) of this section);

(26) services furnished under a PACE program under section 1396u-4 of this title to PACE program eligible individuals enrolled under the program under such section;

(27) subject to subsection (x) of this section, primary and secondary medical strategies and treatment and services for individuals who have Sickle Cell Disease;

(28) freestanding birth center services (as defined in subsection (l)(3)(A)) and other ambulatory services that are offered by a freestanding birth center (as defined in subsection (l)(3)(B)) and that are otherwise included in the plan; and

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

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

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

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

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

this chapter), and such person is determined, under such a State plan, to be essential to the well-being of such individual. The payment described in the first sentence may include expenditures for medicare cost-sharing and for premiums under part B of subchapter XVIII of this chapter for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title, and, except in the case of individuals 65 years of age or older and disabled individuals entitled to health insurance benefits under subchapter XVIII of this chapter who are not enrolled under part B of subchapter XVIII of this chapter, other insurance premiums for medical or any other type of remedial care or the cost thereof. No service (including counseling) shall be excluded from the definition of "medical assistance" solely because it is provided as a treatment service for alcoholism or drug dependency.

(b) Federal medical assistance percentage; State percentage; Indian health care percentage

Subject to subsections (y), (z), and (aa) and section 1396u-3(d) of this title, the term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 50 per centum, (3) for purposes of this subchapter and subchapter XXI of this chapter, the Federal medical assistance percentage for the District of Columbia shall be 70 percent, and (4) the Federal medical assistance percentage shall be equal to the enhanced FMAP described in section 1397ee(b) of this title with respect to medical assistance provided to individuals who are eligible for such assistance only on the basis of section 1396a(a)(10)(A)(ii)(XVIII) of this title. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of section 1301(a)(8)(B) of this title. Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 1603 of title 25). Not-

withstanding the first sentence of this subsection, in the case of a State plan that meets the condition described in subsection (u)(1) of this section, with respect to expenditures (other than expenditures under section 1396r-4 of this title) described in subsection (u)(2)(A) of this section or subsection (u)(3) of this section for the State for a fiscal year, and that do not exceed the amount of the State's available allotment under section 1397dd of this title, the Federal medical assistance percentage is equal to the enhanced FMAP described in section 1397ee(b) of this title.

(c) Nursing facility

For definition of the term "nursing facility", see section 1396r(a) of this title.

(d) Intermediate care facility for mentally retarded

The term "intermediate care facility for the mentally retarded" means an institution (or distinct part thereof) for the mentally retarded or persons with related conditions if—

(1) the primary purpose of such institution (or distinct part thereof) is to provide health or rehabilitative services for mentally retarded individuals and the institution meets such standards as may be prescribed by the Secretary;

(2) the mentally retarded individual with respect to whom a request for payment is made under a plan approved under this subchapter is receiving active treatment under such a program; and

(3) in the case of a public institution, the State or political subdivision responsible for the operation of such institution has agreed that the non-Federal expenditures in any calendar quarter prior to January 1, 1975, with respect to services furnished to patients in such institution (or distinct part thereof) in the State will not, because of payments made under this subchapter, be reduced below the average amount expended for such services in such institution in the four quarters immediately preceding the quarter in which the State in which such institution is located elected to make such services available under its plan approved under this subchapter.

(e) Physicians' services

In the case of any State the State plan of which (as approved under this subchapter)—

(1) does not provide for the payment of services (other than services covered under section 1396a(a)(12) of this title) provided by an optometrist; but

(2) at a prior period did provide for the payment of services referred to in paragraph (1);

the term "physicians' services" (as used in subsection (a)(5) of this section) shall include services of the type which an optometrist is legally authorized to perform where the State plan specifically provides that the term "physicians' services", as employed in such plan, includes services of the type which an optometrist is legally authorized to perform, and shall be reimbursed whether furnished by a physician or an optometrist.

(f) Nursing facility services

For purposes of this subchapter, the term "nursing facility services" means services which

are or were required to be given an individual who needs or needed on a daily basis nursing care (provided directly by or requiring the supervision of nursing personnel) or other rehabilitation services which as a practical matter can only be provided in a nursing facility on an inpatient basis.

(g) Chiropractors' services

If the State plan includes provision of chiropractors' services, such services include only—

(1) services provided by a chiropractor (A) who is licensed as such by the State and (B) who meets uniform minimum standards promulgated by the Secretary under section 1395x(r)(5) of this title; and

(2) services which consist of treatment by means of manual manipulation of the spine which the chiropractor is legally authorized to perform by the State.

(h) Inpatient psychiatric hospital services for individuals under age 21

(1) For purposes of paragraph (16) of subsection (a) of this section, the term "inpatient psychiatric hospital services for individuals under age 21" includes only—

(A) inpatient services which are provided in an institution (or distinct part thereof) which is a psychiatric hospital as defined in section 1395x(f) of this title or in another inpatient setting that the Secretary has specified in regulations;

(B) inpatient services which, in the case of any individual (i) involve active treatment which meets such standards as may be prescribed in regulations by the Secretary, and (ii) a team, consisting of physicians and other personnel qualified to make determinations with respect to mental health conditions and the treatment thereof, has determined are necessary on an inpatient basis and can reasonably be expected to improve the condition, by reason of which such services are necessary, to the extent that eventually such services will no longer be necessary; and

(C) inpatient services which, in the case of any individual, are provided prior to (i) the date such individual attains age 21, or (ii) in the case of an individual who was receiving such services in the period immediately preceding the date on which he attained age 21, (I) the date such individual no longer requires such services, or (II) if earlier, the date such individual attains age 22;

(2) Such term does not include services provided during any calendar quarter under the State plan of any State if the total amount of the funds expended, during such quarter, by the State (and the political subdivisions thereof) from non-Federal funds for inpatient services included under paragraph (1), and for active psychiatric care and treatment provided on an outpatient basis for eligible mentally ill children, is less than the average quarterly amount of the funds expended, during the 4-quarter period ending December 31, 1971, by the State (and the political subdivisions thereof) from non-Federal funds for such services.

(i) Institution for mental diseases

The term "institution for mental diseases" means a hospital, nursing facility, or other in-

stitution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

(j) State supplementary payment

The term “State supplementary payment” means any cash payment made by a State on a regular basis to an individual who is receiving supplemental security income benefits under subchapter XVI of this chapter or who would but for his income be eligible to receive such benefits, as assistance based on need in supplementation of such benefits (as determined by the Commissioner of Social Security), but only to the extent that such payments are made with respect to an individual with respect to whom supplemental security income benefits are payable under subchapter XVI of this chapter, or would but for his income be payable under that subchapter.

(k) Supplemental security income benefits

Increased supplemental security income benefits payable pursuant to section 211 of Public Law 93-66 shall not be considered supplemental security income benefits payable under subchapter XVI of this chapter.

(l) Rural health clinics

(1) The terms “rural health clinic services” and “rural health clinic” have the meanings given such terms in section 1395x(aa) of this title, except that (A) clause (ii) of section 1395x(aa)(2) of this title shall not apply to such terms, and (B) the physician arrangement required under section 1395x(aa)(2)(B) of this title shall only apply with respect to rural health clinic services and, with respect to other ambulatory care services, the physician arrangement required shall be only such as may be required under the State plan for those services.

(2)(A) The term “Federally-qualified health center services” means services of the type described in subparagraphs (A) through (C) of section 1395x(aa)(1) of this title when furnished to an individual as an² patient of a Federally-qualified health center and, for this purpose, any reference to a rural health clinic or a physician described in section 1395x(aa)(2)(B) of this title is deemed a reference to a Federally-qualified health center or a physician at the center, respectively.

(B) The term “Federally-qualified health center” means an entity which—

(i) is receiving a grant under section 254b of this title,

(ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and

(II) meets the requirements to receive a grant under section 254b of this title,

(iii) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant, including requirements of the Secretary that an entity may not be owned, controlled, or operated by another entity, or

(iv) was treated by the Secretary, for purposes of part B of subchapter XVIII of this chapter, as a comprehensive Federally funded health center as of January 1, 1990;

and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638) [25 U.S.C. 450f et seq.] or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act [25 U.S.C. 1651 et seq.] for the provision of primary health services. In applying clause (ii),³ the Secretary may waive any requirement referred to in such clause for up to 2 years for good cause shown.

(3)(A) The term “freestanding birth center services” means services furnished to an individual at a freestanding birth center (as defined in subparagraph (B)) at such center.

(B) The term “freestanding birth center” means a health facility—

(i) that is not a hospital;

(ii) where childbirth is planned to occur away from the pregnant woman’s residence;

(iii) that is licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan; and

(iv) that complies with such other requirements relating to the health and safety of individuals furnished services by the facility as the State shall establish.

(C) A State shall provide separate payments to providers administering prenatal labor and delivery or postpartum care in a freestanding birth center (as defined in subparagraph (B)), such as nurse midwives and other providers of services such as birth attendants recognized under State law, as determined appropriate by the Secretary. For purposes of the preceding sentence, the term “birth attendant” means an individual who is recognized or registered by the State involved to provide health care at childbirth and who provides such care within the scope of practice under which the individual is legally authorized to perform such care under State law (or the State regulatory mechanism provided by State law), regardless of whether the individual is under the supervision of, or associated with, a physician or other health care provider. Nothing in this subparagraph shall be construed as changing State law requirements applicable to a birth attendant.

(m) Qualified family member

(1) Subject to paragraph (2), the term “qualified family member” means an individual (other than a qualified pregnant woman or child, as defined in subsection (n) of this section) who is a member of a family that would be receiving aid under the State plan under part A of subchapter IV of this chapter pursuant to section 607¹ of this title if the State had not exercised the option under section 607(b)(2)(B)(i)¹ of this title.

(2) No individual shall be a qualified family member for any period after September 30, 1998.

(n) “Qualified pregnant woman or child” defined

The term “qualified pregnant woman or child” means—

³So in original. Probably should be clause “(iii)”. See References in Text note below.

²So in original. Probably should be “a”.

(1) a pregnant woman who—

(A) would be eligible for aid to families with dependent children under part A of subchapter IV of this chapter (or would be eligible for such aid if coverage under the State plan under part A of subchapter IV of this chapter included aid to families with dependent children of unemployed parents pursuant to section 607 of this title) if her child had been born and was living with her in the month such aid would be paid, and such pregnancy has been medically verified;

(B) is a member of a family which would be eligible for aid under the State plan under part A of subchapter IV of this chapter pursuant to section 607 of this title if the plan required the payment of aid pursuant to such section; or

(C) otherwise meets the income and resources requirements of a State plan under part A of subchapter IV of this chapter; and

(2) a child who has not attained the age of 19, who was born after September 30, 1983 (or such earlier date as the State may designate), and who meets the income and resources requirements of the State plan under part A of subchapter IV of this chapter.

(o) Optional hospice benefits

(1)(A) Subject to subparagraphs (B) and (C), the term “hospice care” means the care described in section 1395x(dd)(1) of this title furnished by a hospice program (as defined in section 1395x(dd)(2) of this title) to a terminally ill individual who has voluntarily elected (in accordance with paragraph (2)) to have payment made for hospice care instead of having payment made for certain benefits described in section 1395d(d)(2)(A) of this title and for which payment may otherwise be made under subchapter XVIII of this chapter and intermediate care facility services under the plan. For purposes of such election, hospice care may be provided to an individual while such individual is a resident of a skilled nursing facility or intermediate care facility, but the only payment made under the State plan shall be for the hospice care.

(B) For purposes of this subchapter, with respect to the definition of hospice program under section 1395x(dd)(2) of this title, the Secretary may allow an agency or organization to make the assurance under subparagraph (A)(iii) of such section without taking into account any individual who is afflicted with acquired immune deficiency syndrome (AIDS).

(C) A voluntary election to have payment made for hospice care for a child (as defined by the State) shall not constitute a waiver of any rights of the child to be provided with, or to have payment made under this subchapter for, services that are related to the treatment of the child’s condition for which a diagnosis of terminal illness has been made.

(2) An individual’s voluntary election under this subsection—

(A) shall be made in accordance with procedures that are established by the State and that are consistent with the procedures established under section 1395d(d)(2) of this title;

(B) shall be for such a period or periods (which need not be the same periods described

in section 1395d(d)(1) of this title) as the State may establish; and

(C) may be revoked at any time without a showing of cause and may be modified so as to change the hospice program with respect to which a previous election was made.

(3) In the case of an individual—

(A) who is residing in a nursing facility or intermediate care facility for the mentally retarded and is receiving medical assistance for services in such facility under the plan,

(B) who is entitled to benefits under part A of subchapter XVIII of this chapter and has elected, under section 1395d(d) of this title, to receive hospice care under such part, and

(C) with respect to whom the hospice program under such subchapter and the nursing facility or intermediate care facility for the mentally retarded have entered into a written agreement under which the program takes full responsibility for the professional management of the individual’s hospice care and the facility agrees to provide room and board to the individual,

instead of any payment otherwise made under the plan with respect to the facility’s services, the State shall provide for payment to the hospice program of an amount equal to the additional amount determined in section 1396a(a)(13)(B) of this title and, if the individual is an individual described in section 1396a(a)(10)(A) of this title, shall provide for payment of any coinsurance amounts imposed under section 1395e(a)(4) of this title.

(p) Qualified medicare beneficiary; medicare cost-sharing

(1) The term “qualified medicare beneficiary” means an individual—

(A) who is entitled to hospital insurance benefits under part A of subchapter XVIII of this chapter (including an individual entitled to such benefits pursuant to an enrollment under section 1395i-2 of this title, but not including an individual entitled to such benefits only pursuant to an enrollment under section 1395i-2a of this title),

(B) whose income (as determined under section 1382a of this title for purposes of the supplemental security income program, except as provided in paragraph (2)(D)) does not exceed an income level established by the State consistent with paragraph (2), and

(C) whose resources (as determined under section 1382b of this title for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program or, effective beginning with January 1, 2010, whose resources (as so determined) do not exceed the maximum resource level applied for the year under subparagraph (D) of section 1395w-114(a)(3) of this title (determined without regard to the life insurance policy exclusion provided under subparagraph (G) of such section) applicable to an individual or to the individual and the individual’s spouse (as the case may be).

(2)(A) The income level established under paragraph (1)(B) shall be at least the percent

provided under subparagraph (B) (but not more than 100 percent) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved.

(B) Except as provided in subparagraph (C), the percent provided under this clause, with respect to eligibility for medical assistance on or after—

- (i) January 1, 1989, is 85 percent,
- (ii) January 1, 1990, is 90 percent, and
- (iii) January 1, 1991, is 100 percent.

(C) In the case of a State which has elected treatment under section 1396a(f) of this title and which, as of January 1, 1987, used an income standard for individuals age 65 or older which was more restrictive than the income standard established under the supplemental security income program under subchapter XVI of this chapter, the percent provided under subparagraph (B), with respect to eligibility for medical assistance on or after—

- (i) January 1, 1989, is 80 percent,
- (ii) January 1, 1990, is 85 percent,
- (iii) January 1, 1991, is 95 percent, and
- (iv) January 1, 1992, is 100 percent.

(D)(i) In determining under this subsection the income of an individual who is entitled to monthly insurance benefits under subchapter II of this chapter for a transition month (as defined in clause (ii)) in a year, such income shall not include any amounts attributable to an increase in the level of monthly insurance benefits payable under such subchapter which have occurred pursuant to section 415(i) of this title for benefits payable for months beginning with December of the previous year.

(ii) For purposes of clause (i), the term “transition month” means each month in a year through the month following the month in which the annual revision of the official poverty line, referred to in subparagraph (A), is published.

(3) The term “medicare cost-sharing” means (subject to section 1396a(n)(2) of this title) the following costs incurred with respect to a qualified medicare beneficiary, without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan:

- (A)(i) premiums under section 1395i-2 or 1395i-2a of this title, and
- (ii) premiums under section 1395r of this title,⁴

(B) Coinsurance under subchapter XVIII of this chapter (including coinsurance described in section 1395e of this title).

(C) Deductibles established under subchapter XVIII of this chapter (including those described in section 1395e of this title and section 1395l(b) of this title).

(D) The difference between the amount that is paid under section 1395l(a) of this title and the amount that would be paid under such section if any reference to “80 percent” therein were deemed a reference to “100 percent”.

Such term also may include, at the option of a State, premiums for enrollment of a qualified

medicare beneficiary with an eligible organization under section 1395mm of this title.

(4) Notwithstanding any other provision of this subchapter, in the case of a State (other than the 50 States and the District of Columbia)—

(A) the requirement stated in section 1396a(a)(10)(E) of this title shall be optional, and

(B) for purposes of paragraph (2), the State may substitute for the percent provided under subparagraph (B)⁵ or⁶ 1396a(a)(10)(E)(iii) of this title of such paragraph⁵ any percent.

In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1315 of this title, the Secretary shall require the State to meet the requirement of section 1396a(a)(10)(E) of this title in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this subchapter.

(5)(A) The Secretary shall develop and distribute to States a simplified application form for use by individuals (including both qualified medicare beneficiaries and specified low-income medicare beneficiaries) in applying for medical assistance for medicare cost-sharing under this subchapter in the States which elect to use such form. Such form shall be easily readable by applicants and uniform nationally. The Secretary shall provide for the translation of such application form into at least the 10 languages (other than English) that are most often used by individuals applying for hospital insurance benefits under section 426 or 426-1 of this title and shall make the translated forms available to the States and to the Commissioner of Social Security.

(B) In developing such form, the Secretary shall consult with beneficiary groups and the States.

(6) For provisions relating to outreach efforts to increase awareness of the availability of medicare cost-sharing, see section 1320b-14 of this title.

(q) Qualified severely impaired individual

The term “qualified severely impaired individual” means an individual under age 65—

(1) who for the month preceding the first month to which this subsection applies to such individual—

- (A) received (i) a payment of supplemental security income benefits under section 1382(b) of this title on the basis of blindness or disability, (ii) a supplementary payment under section 1382e of this title or under section 212 of Public Law 93-66 on such basis, (iii) a payment of monthly benefits under section 1382h(a) of this title, or (iv) a supplementary payment under section 1382e(c)(3), and

(B) was eligible for medical assistance under the State plan approved under this subchapter; and

(2) with respect to whom the Commissioner of Social Security determines that—

⁵So in original. The words “of such paragraph” probably should follow “subparagraph (B)”.

⁶So in original. Probably should be “or section”.

⁴So in original. The comma probably should be a period.

(A) the individual continues to be blind or continues to have the disabling physical or mental impairment on the basis of which he was found to be under a disability and, except for his earnings, continues to meet all non-disability-related requirements for eligibility for benefits under subchapter XVI of this chapter,

(B) the income of such individual would not, except for his earnings, be equal to or in excess of the amount which would cause him to be ineligible for payments under section 1382(b) of this title (if he were otherwise eligible for such payments),

(C) the lack of eligibility for benefits under this subchapter would seriously inhibit his ability to continue or obtain employment, and

(D) the individual's earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the benefits under subchapter XVI of this chapter (including any federally administered State supplementary payments), this subchapter, and publicly funded attendant care services (including personal care assistance) that would be available to him in the absence of such earnings.

In the case of an individual who is eligible for medical assistance pursuant to section 1382h(b) of this title in June, 1987, the individual shall be a qualified severely impaired individual for so long as such individual meets the requirements of paragraph (2).

(r) Early and periodic screening, diagnostic, and treatment services

The term "early and periodic screening, diagnostic, and treatment services" means the following items and services:

(1) Screening services—

(A) which are provided—

(i) at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care and, with respect to immunizations under subparagraph (B)(iii), in accordance with the schedule referred to in section 1396s(c)(2)(B)(i) of this title for pediatric vaccines, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions; and

(B) which shall at a minimum include—

(i) a comprehensive health and developmental history (including assessment of both physical and mental health development),

(ii) a comprehensive unclothed physical exam,

(iii) appropriate immunizations (according to the schedule referred to in section 1396s(c)(2)(B)(i) of this title for pediatric vaccines) according to age and health history,

(iv) laboratory tests (including lead blood level assessment appropriate for age and risk factors), and

(v) health education (including anticipatory guidance).

(2) Vision services—

(A) which are provided—

(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include diagnosis and treatment for defects in vision, including eyeglasses.

(3) Dental services—

(A) which are provided—

(i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.

(4) Hearing services—

(A) which are provided—

(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.

(5) Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

Nothing in this subchapter shall be construed as limiting providers of early and periodic screening, diagnostic, and treatment services to providers who are qualified to provide all of the items and services described in the previous sentence or as preventing a provider that is qualified under the plan to furnish one or more (but not all) of such items or services from being qualified to provide such items and services as part of early and periodic screening, diagnostic, and treatment services. The Secretary shall, not later than July 1, 1990, and every 12 months thereafter, develop and set annual participation goals for each State for participation of individuals who are covered under the State plan under this subchapter in early and periodic screening, diagnostic, and treatment services.

(s) Qualified disabled and working individual

The term “qualified disabled and working individual” means an individual—

(1) who is entitled to enroll for hospital insurance benefits under part A of subchapter XVIII of this chapter under section 1395i-2a of this title;

(2) whose income (as determined under section 1382a of this title for purposes of the supplemental security income program) does not exceed 200 percent of the official poverty line (as defined by the Office of Management and Budget and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved;

(3) whose resources (as determined under section 1382b of this title for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual or a couple (in the case of an individual with a spouse) may have and obtain benefits for supplemental security income benefits under subchapter XVI of this chapter; and

(4) who is not otherwise eligible for medical assistance under this subchapter.

(t) Primary care case management services; primary care case manager; primary care case management contract; and primary care

(1) The term “primary care case management services” means case-management related services (including locating, coordinating, and monitoring of health care services) provided by a primary care case manager under a primary care case management contract.

(2) The term “primary care case manager” means any of the following that provides services of the type described in paragraph (1) under a contract referred to in such paragraph:

(A) A physician, a physician group practice, or an entity employing or having other arrangements with physicians to provide such services.

(B) At State option—

(i) a nurse practitioner (as described in subsection (a)(21) of this section);

(ii) a certified nurse-midwife (as defined in section 1395x(gg) of this title); or

(iii) a physician assistant (as defined in section 1395x(aa)(5) of this title).

(3) The term “primary care case management contract” means a contract between a primary care case manager and a State under which the manager undertakes to locate, coordinate, and monitor covered primary care (and such other covered services as may be specified under the contract) to all individuals enrolled with the manager, and which—

(A) provides for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment with respect to medical emergencies;

(B) restricts enrollment to individuals residing sufficiently near a service delivery site of the manager to be able to reach that site within a reasonable time using available and affordable modes of transportation;

(C) provides for arrangements with, or referrals to, sufficient numbers of physicians and other appropriate health care professionals to

ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care;

(D) prohibits discrimination on the basis of health status or requirements for health care services in enrollment, disenrollment, or reenrollment of individuals eligible for medical assistance under this subchapter;

(E) provides for a right for an enrollee to terminate enrollment in accordance with section 1396u-2(a)(4) of this title; and

(F) complies with the other applicable provisions of section 1396u-2 of this title.

(4) For purposes of this subsection, the term “primary care” includes all health care services customarily provided in accordance with State licensure and certification laws and regulations, and all laboratory services customarily provided by or through, a general practitioner, family medicine physician, internal medicine physician, obstetrician/gynecologist, or pediatrician.

(u) Conditions for State plans

(1) The conditions described in this paragraph for a State plan are as follows:

(A) The State is complying with the requirement of section 1397ee(d)(1) of this title.

(B) The plan provides for such reporting of information about expenditures and payments attributable to the operation of this subsection as the Secretary deems necessary in order to carry out the fourth sentence of subsection (b) of this section.

(2)(A) For purposes of subsection (b) of this section, the expenditures described in this subparagraph are expenditures for medical assistance for optional targeted low-income children described in subparagraph (B).

(B) For purposes of this paragraph, the term “optional targeted low-income child” means a targeted low-income child as defined in section 1397jj(b)(1) of this title (determined without regard to that portion of subparagraph (C) of such section concerning eligibility for medical assistance under this subchapter) who would not qualify for medical assistance under the State plan under this subchapter as in effect on March 31, 1997 (but taking into account the expansion of age of eligibility effected through the operation of section 1396a(l)(1)(D) of this title). Such term excludes any child eligible for medical assistance only by reason of section 1396a(a)(10)(A)(ii)(XIX) of this title.

(3) For purposes of subsection (b) of this section, the expenditures described in this paragraph are expenditures for medical assistance for children who are born before October 1, 1983, and who would be described in section 1396a(l)(1)(D) of this title if they had been born on or after such date, and who are not eligible for such assistance under the State plan under this subchapter based on such State plan as in effect as of March 31, 1997.

(4) The limitations on payment under subsections (f) and (g) of section 1308 of this title shall not apply to Federal payments made under section 1396b(a)(1) of this title based on an enhanced FMAP described in section 1397ee(b) of this title.

(v) Employed individual with a medically improved disability

(1) The term “employed individual with a medically improved disability” means an individual who—

(A) is at least 16, but less than 65, years of age;

(B) is employed (as defined in paragraph (2));

(C) ceases to be eligible for medical assistance under section 1396a(a)(10)(A)(ii)(XV) of this title because the individual, by reason of medical improvement, is determined at the time of a regularly scheduled continuing disability review to no longer be eligible for benefits under section 423(d) or 1382c(a)(3) of this title; and

(D) continues to have a severe medically determinable impairment, as determined under regulations of the Secretary.

(2) For purposes of paragraph (1), an individual is considered to be “employed” if the individual—

(A) is earning at least the applicable minimum wage requirement under section 206 of title 29 and working at least 40 hours per month; or

(B) is engaged in a work effort that meets substantial and reasonable threshold criteria for hours of work, wages, or other measures, as defined by the State and approved by the Secretary.

(w) Independent foster care adolescent

(1) For purposes of this subchapter, the term “independent foster care adolescent” means an individual—

(A) who is under 21 years of age;

(B) who, on the individual’s 18th birthday, was in foster care under the responsibility of a State; and

(C) whose assets, resources, and income do not exceed such levels (if any) as the State may establish consistent with paragraph (2).

(2) The levels established by a State under paragraph (1)(C) may not be less than the corresponding levels applied by the State under section 1396u-1(b) of this title.

(3) A State may limit the eligibility of independent foster care adolescents under section 1396a(a)(10)(A)(ii)(XVII) of this title to those individuals with respect to whom foster care maintenance payments or independent living services were furnished under a program funded under part E of subchapter IV of this chapter before the date the individuals attained 18 years of age.

(x) Strategies, treatment, and services

For purposes of subsection (a)(27) of this section, the strategies, treatment, and services described in that subsection include the following:

(1) Chronic blood transfusion (with deferoxamine chelation) to prevent stroke in individuals with Sickle Cell Disease who have been identified as being at high risk for stroke.

(2) Genetic counseling and testing for individuals with Sickle Cell Disease or the sickle cell trait to allow health care professionals to treat such individuals and to prevent symptoms of Sickle Cell Disease.

(3) Other treatment and services to prevent individuals who have Sickle Cell Disease and who have had a stroke from having another stroke.

(y) Increased FMAP for medical assistance for newly eligible mandatory individuals**(1) Amount of increase**

Notwithstanding subsection (b), the Federal medical assistance percentage for a State that is one of the 50 States or the District of Columbia, with respect to amounts expended by such State for medical assistance for newly eligible individuals described in subclause (VIII) of section 1396a(a)(10)(A)(i) of this title, shall be equal to—

(A) 100 percent for calendar quarters in 2014, 2015, and 2016;

(B) 95 percent for calendar quarters in 2017;

(C) 94 percent for calendar quarters in 2018;

(D) 93 percent for calendar quarters in 2019; and

(E) 90 percent for calendar quarters in 2020 and each year thereafter.

(2) Definitions

In this subsection:

(A) Newly eligible

The term “newly eligible” means, with respect to an individual described in subclause (VIII) of section 1396a(a)(10)(A)(i) of this title, an individual who is not under 19 years of age (or such higher age as the State may have elected) and who, as of December 1, 2009, is not eligible under the State plan or under a waiver of the plan for full benefits or for benchmark coverage described in subparagraph (A), (B), or (C) of section 1396u-7(b)(1) of this title or benchmark equivalent coverage described in section 1396u-7(b)(2) of this title that has an aggregate actuarial value that is at least actuarially equivalent to benchmark coverage described in subparagraph (A), (B), or (C) of section 1396u-7(b)(1) of this title, or is eligible but not enrolled (or is on a waiting list) for such benefits or coverage through a waiver under the plan that has a capped or limited enrollment that is full.

(B) Full benefits

The term “full benefits” means, with respect to an individual, medical assistance for all services covered under the State plan under this subchapter that is not less in amount, duration, or scope, or is determined by the Secretary to be substantially equivalent, to the medical assistance available for an individual described in section 1396a(a)(10)(A)(i) of this title.

(z) Equitable support for certain States

(1)(A) During the period that begins on January 1, 2014, and ends on December 31, 2015, notwithstanding subsection (b), the Federal medical assistance percentage otherwise determined under subsection (b) with respect to a fiscal year occurring during that period shall be increased by 2.2 percentage points for any State described in subparagraph (B) for amounts expended for medical assistance for individuals who are not

newly eligible (as defined in subsection (y)(2)) individuals described in subclause (VIII) of section 1396a(a)(10)(A)(i) of this title.

(B) For purposes of subparagraph (A), a State described in this subparagraph is a State that—

(i) is an expansion State described in paragraph (3);

(ii) the Secretary determines will not receive any payments under this subchapter on the basis of an increased Federal medical assistance percentage under subsection (y) for expenditures for medical assistance for newly eligible individuals (as so defined); and

(iii) has not been approved by the Secretary to divert a portion of the DSH allotment for a State to the costs of providing medical assistance or other health benefits coverage under a waiver that is in effect on July 2009.⁷

(2)(A) For calendar quarters in 2014 and each year thereafter, the Federal medical assistance percentage otherwise determined under subsection (b) for an expansion State described in paragraph (3) with respect to medical assistance for individuals described in section 1396a(a)(10)(A)(i)(VIII) of this title who are non-pregnant childless adults with respect to whom the State may require enrollment in benchmark coverage under section 1396u-7 of this title shall be equal to the percent specified in subparagraph (B)(i) for such year.

(B)(i) The percent specified in this subparagraph for a State for a year is equal to the Federal medical assistance percentage (as defined in the first sentence of subsection (b)) for the State increased by a number of percentage points equal to the transition percentage (specified in clause (ii) for the year) of the number of percentage points by which—

(I) such Federal medical assistance percentage for the State, is less than

(II) the percent specified in subsection (y)(1) for the year.

(ii) The transition percentage specified in this clause for—

(I) 2014 is 50 percent;

(II) 2015 is 60 percent;

(III) 2016 is 70 percent;

(IV) 2017 is 80 percent;

(V) 2018 is 90 percent; and

(VI) 2019 and each subsequent year is 100 percent.

(3) A State is an expansion State if, on March 23, 2010, the State offers health benefits coverage statewide to parents and nonpregnant, childless adults whose income is at least 100 percent of the poverty line, that includes inpatient hospital services, is not dependent on access to employer coverage, employer contribution, or employment and is not limited to premium assistance, hospital-only benefits, a high deductible health plan, or alternative benefits under a demonstration program authorized under section 1396u-8 of this title. A State that offers health benefits coverage to only parents or only non-pregnant childless adults described in the preceding sentence shall not be considered to be an expansion State.

⁷ So in original.

(aa) Special adjustment to FMAP determination for certain States recovering from a major disaster

(1) Notwithstanding subsection (b), beginning January 1, 2011, the Federal medical assistance percentage for a fiscal year for a disaster-recovery FMAP adjustment State shall be equal to the following:

(A) In the case of the first fiscal year (or part of a fiscal year) for which this subsection applies to the State, the Federal medical assistance percentage determined for the fiscal year without regard to this subsection, subsection (y), subsection (z), and section 10202 of the Patient Protection and Affordable Care Act, increased by 50 percent of the number of percentage points by which the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection, subsection (y), subsection (z), and section 10202 of the Patient Protection and Affordable Care Act, is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year after the application of only subsection (a) of section 5001 of Public Law 111-5 (if applicable to the preceding fiscal year) and without regard to this subsection, subsection (y), and subsections (b) and (c) of section 5001 of Public Law 111-5.

(B) In the case of the second or any succeeding fiscal year for which this subsection applies to the State, the Federal medical assistance percentage determined for the preceding fiscal year under this subsection for the State, increased by 25 percent of the number of percentage points by which the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection, subsection (y), subsection (z), and section 10202 of the Patient Protection and Affordable Care Act, is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year under this subsection.

(2) In this subsection, the term “disaster-recovery FMAP adjustment State” means a State that is one of the 50 States or the District of Columbia, for which, at any time during the preceding 7 fiscal years, the President has declared a major disaster under section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act [42 U.S.C. 5170] and determined as a result of such disaster that every county or parish in the State warrant individual and public assistance or public assistance from the Federal Government under such Act [42 U.S.C. 5121 et seq.] and for which—

(A) in the case of the first fiscal year (or part of a fiscal year) for which this subsection applies to the State, the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection, subsection (y), subsection (z), and section 10202 of the Patient Protection and Affordable Care Act, is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year after the application of only subsection (a) of section 5001 of Public Law 111-5 (if applicable to

the preceding fiscal year) and without regard to this subsection, subsection (y), and subsections (b) and (c) of section 5001 of Public Law 111-5, by at least 3 percentage points; and

(B) in the case of the second or any succeeding fiscal year for which this subsection applies to the State, the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection, subsection (y), subsection (z), and section 10202 of the Patient Protection and Affordable Care Act, is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year under this subsection by at least 3 percentage points.

(3) The Federal medical assistance percentage determined for a disaster-recovery FMAP adjustment State under paragraph (1) shall apply for purposes of this subchapter (other than with respect to disproportionate share hospital payments described in section 1396r-4 of this title and payments under this subchapter that are based on the enhanced FMAP described in 1397ee(b)⁸ of this title) and shall not apply with respect to payments under subchapter IV (other than under part E of subchapter IV) or payments under subchapter XXI.

(bb) Counseling and pharmacotherapy for cessation of tobacco use by pregnant women

(1) For purposes of this subchapter, the term “counseling and pharmacotherapy for cessation of tobacco use by pregnant women” means diagnostic, therapy, and counseling services and pharmacotherapy (including the coverage of prescription and nonprescription tobacco cessation agents approved by the Food and Drug Administration) for cessation of tobacco use by pregnant women who use tobacco products or who are being treated for tobacco use that is furnished—

(A) by or under the supervision of a physician; or

(B) by any other health care professional who—

(i) is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished; and

(ii) is authorized to receive payment for other services under this subchapter or is designated by the Secretary for this purpose.

(2) Subject to paragraph (3), such term is limited to—

(A) services recommended with respect to pregnant women in “Treating Tobacco Use and Dependence: 2008 Update: A Clinical Practice Guideline”, published by the Public Health Service in May 2008, or any subsequent modification of such Guideline; and

(B) such other services that the Secretary recognizes to be effective for cessation of tobacco use by pregnant women.

(3) Such term shall not include coverage for drugs or biologicals that are not otherwise covered under this subchapter.

(cc) Requirement for certain States

Notwithstanding subsections (y), (z), and (aa), in the case of a State that requires politi-

cal subdivisions within the State to contribute toward the non-Federal share of expenditures required under the State plan under section 1396a(a)(2) of this title, the State shall not be eligible for an increase in its Federal medical assistance percentage under such subsections if it requires that political subdivisions pay a greater percentage of the non-Federal share of such expenditures, or a greater percentage of the non-Federal share of payments under section 1396r-4 of this title, than the respective percentages that would have been required by the State under the State plan under this subchapter, State law, or both, as in effect on December 31, 2009, and without regard to any such increase. Voluntary contributions by a political subdivision to the non-Federal share of expenditures under the State plan under this subchapter or to the non-Federal share of payments under section 1396r-4 of this title, shall not be considered to be required contributions for purposes of this subsection. The treatment of voluntary contributions, and the treatment of contributions required by a State under the State plan under this subchapter, or State law, as provided by this subsection, shall also apply to the increases in the Federal medical assistance percentage under section 5001 of the American Recovery and Reinvestment Act of 2009.

(dd) Increased FMAP for additional expenditures for primary care services

Notwithstanding subsection (b), with respect to the portion of the amounts expended for medical assistance for services described in section 1396a(a)(13)(C) of this title furnished on or after January 1, 2013, and before January 1, 2015, that is attributable to the amount by which the minimum payment rate required under such section (or, by application, section 1396u-2(f) of this title) exceeds the payment rate applicable to such services under the State plan as of July 1, 2009, the Federal medical assistance percentage for a State that is one of the 50 States or the District of Columbia shall be equal to 100 percent. The preceding sentence does not prohibit the payment of Federal financial participation based on the Federal medical assistance percentage for amounts in excess of those specified in such sentence.

(Aug. 14, 1935, ch. 531, title XIX, §1905, as added Pub. L. 89-97, title I, §121(a), July 30, 1965, 79 Stat. 351; amended Pub. L. 90-248, title II, §§230, 233, 241(f)(6), 248(e), title III, §302(a), Jan. 2, 1968, 81 Stat. 905, 917, 919, 929; Pub. L. 92-223, §4(a), Dec. 28, 1971, 85 Stat. 809; Pub. L. 92-603, title II, §§212(a), 247(b), 275(a), 278(a)(21)-(23), 280, 297(a), 299, 299B, 299E(b), 299L, Oct. 30, 1972, 86 Stat. 1384, 1425, 1452-1454, 1459-1462, 1464; Pub. L. 93-233, §§13(a)(13)-(88), 18(w), (x)(7)-(10), (y)(2), Dec. 31, 1973, 87 Stat. 963, 964, 972, 973; Pub. L. 94-437, title IV, §402(e), Sept. 30, 1976, 90 Stat. 1410; Pub. L. 95-210, §2(a), (b), Dec. 13, 1977, 91 Stat. 1488; Pub. L. 95-292, §8(a), (b), June 13, 1978, 92 Stat. 316; Pub. L. 96-473, §6(k), Oct. 19, 1980, 94 Stat. 2266; Pub. L. 96-499, title IX, §965(a), Dec. 5, 1980, 94 Stat. 2651; Pub. L. 97-35, title XXI, §§2162(a)(2), 2172(b), Aug. 13, 1981, 95 Stat. 806, 808; Pub. L. 97-248, title I, §§136(c), 137(b)(17), (18), (f), Sept. 3, 1982, 96 Stat. 376, 379, 381; Pub. L. 98-369, div. B,

⁸ So in original. Probably should be preceded by “section”.

title III, §§ 2335(f), 2340(b), 2361(b), 2371(a), 2373(b)(15)–(20), July 18, 1984, 98 Stat. 1091, 1093, 1104, 1110, 1112; Pub. L. 99–272, title IX, §§ 9501(a), 9505(a), 9511(a), Apr. 7, 1986, 100 Stat. 201, 208, 212; Pub. L. 99–509, title IX, §§ 9403(b), (d), (g)(3), 9404(b), 9408(c)(1), 9435(b)(2), Oct. 21, 1986, 100 Stat. 2053, 2054, 2056, 2061, 2070; Pub. L. 99–514, title XVIII, § 1895(c)(3)(A), Oct. 22, 1986, 100 Stat. 2935; Pub. L. 100–203, title IV, §§ 4073(d), 4101(c)(1), 4103(a), 4105(a), 4114, 4118(p)(8), 4211(e), (f), (h)(6), Dec. 22, 1987, 101 Stat. 1330–119, 1330–141, 1330–146, 1330–147, 1330–152, 1330–159, 1330–204 to 1330–206; Pub. L. 100–360, title III, § 301(a)(2)–(d), (g)(2), title IV, § 411(h)(4)(E), (k)(4), (8), (14)(A), July 1, 1988, 102 Stat. 748–750, 787, 791, 794, 798; Pub. L. 100–485, title III, § 303(b)(2), title IV, § 401(d)(2), title VI, § 608(d)(14)(A)–(G), (J), (f)(3), Oct. 13, 1988, 102 Stat. 2392, 2396, 2415, 2416, 2424; Pub. L. 100–647, title VIII, § 8434(a), (b)(3), (4), Nov. 10, 1988, 102 Stat. 3805; Pub. L. 101–234, title II, § 201(b), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–239, title VI, §§ 6402(c)(1), 6403(a), (c), (d)(2), 6404(a), (b), 6405(a), 6408(d)(2), (4)(A), (B), Dec. 19, 1989, 103 Stat. 2261–2265, 2268, 2269; Pub. L. 101–508, title IV, §§ 4402(d)(2), 4501(a), (c), (e)(1), 4601(a)(2), 4704(c), (d), (e)(1), 4705(a), 4711(a), 4712(a), 4713(b), 4717, 4719(a), 4721(a), 4722, 4755(a)(1)(A), Nov. 5, 1990, 104 Stat. 1388–163 to 1388–166, 1388–172, 1388–174, 1388–187, 1388–191, 1388–193, 1388–194, 1388–209; Pub. L. 103–66, title XIII, §§ 13601(a), 13603(e), 13605(a), 13606(a), 13631(f)(2), (g)(1), Aug. 10, 1993, 107 Stat. 612, 620, 621, 644, 645; Pub. L. 103–296, title I, § 108(d)(2), (3), Aug. 15, 1994, 108 Stat. 1486; Pub. L. 104–299, § 4(b)(2), Oct. 11, 1996, 110 Stat. 3645; Pub. L. 105–33, title IV, §§ 4702(a), 4711(c)(1), 4712(d)(1), 4714(a)(2), 4725(b)(1), 4732(b), 4802(a)(1), 4911(a), Aug. 5, 1997, 111 Stat. 494, 508–510, 518, 520, 538, 570; Pub. L. 105–100, title I, § 162(1), (2), Nov. 19, 1997, 111 Stat. 2188; Pub. L. 106–113, div. B, § 1000(a)(6) [title VI, §§ 605(a), 608(l), (m), (aa)(3)], Nov. 29, 1999, 113 Stat. 1536, 1501A–396 to 1501A–398; Pub. L. 106–169, title I, § 121(a)(2), (c)(5), Dec. 14, 1999, 113 Stat. 1829, 1830; Pub. L. 106–170, title II, § 201(a)(2)(B), (C), Dec. 17, 1999, 113 Stat. 1892; Pub. L. 106–354, § 2(a)(4), (c), Oct. 24, 2000, 114 Stat. 1382, 1384; Pub. L. 106–554, § 1(a)(6) [title VII, § 709(a), title VIII, § 802(d)(1), (2), title IX, § 911(a)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–578, 2763A–581, 2763A–584; Pub. L. 108–357, title VII, § 712(a)(1), Oct. 22, 2004, 118 Stat. 1558; Pub. L. 109–171, title VI, § 6062(c)(2), Feb. 8, 2006, 120 Stat. 98; Pub. L. 110–275, title I, §§ 112, 118(a), July 15, 2008, 122 Stat. 2503, 2507; Pub. L. 111–148, title II, §§ 2001(a)(3), (5)(C), (e)(2)(A), 2005(c)(1), 2006, 2301(a), 2302(a), 2303(a)(4)(A), 2304, 2402(d)(2)(B), title IV, §§ 4106(a), (b), 4107(a), title X, § 10201(c), Mar. 23, 2010, 124 Stat. 272, 275, 279, 284, 292–294, 296, 304, 559, 560, 918; Pub. L. 111–152, title I, §§ 1201, 1202(b), Mar. 30, 2010, 124 Stat. 1051, 1053.)

AMENDMENT OF SUBSECTION (a)(13)

Pub. L. 111–148, title IV, § 4106(a), (c), Mar. 23, 2010, 124 Stat. 559, 560, provided that, effective Jan. 1, 2013, subsection (a)(13) of this section is amended to read as follows:

(13) other diagnostic, screening, preventive, and rehabilitative services, including—

(A) any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force;

(B) with respect to an adult individual, approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) and their administration; and

(C) any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;

AMENDMENT OF SUBSECTION (b)

Pub. L. 111–148, title II, § 2005(c), Mar. 23, 2010, 124 Stat. 284, as amended by Pub. L. 111–152, title I, § 1204(b)(2)(B), Mar. 30, 2010, 124 Stat. 1056, provided that, effective July 1, 2011, subsection (b) of this section is amended by striking “shall be 50 per centum” and inserting “shall be 55 percent”.

Pub. L. 111–148, title IV, § 4106(b), (c), Mar. 23, 2010, 124 Stat. 559, 560, provided that, effective Jan. 1, 2013, subsection (b) of this section is amended in the first sentence—

(1) by striking “, and (4)” and inserting “, (4)”; and

(2) by inserting before the period the following: “, and (5) in the case of a State that provides medical assistance for services and vaccines described in subparagraphs (A) and (B) of subsection (a)(13), and prohibits cost-sharing for such services and vaccines, the Federal medical assistance percentage, as determined under this subsection and subsection (y) (without regard to paragraph (1)(C) of such subsection), shall be increased by 1 percentage point with respect to medical assistance for such services and vaccines and for items and services described in subsection (a)(4)(D)”.

REFERENCES IN TEXT

Part A of subchapter IV of this chapter, referred to in subssecs. (a), (m)(1), and (n), is classified to section 601 et seq. of this title.

Parts A and B of subchapter XVIII of this chapter, referred to in subssecs. (a), (l)(2)(B)(iv), (o)(3)(B), (p)(1)(A), and (s)(1), are classified to sections 1395c et seq. and 1395j et seq., respectively, of this title.

Section 606 of this title, referred to in subsec. (a)(ii), was repealed and a new section 606 enacted by Pub. L. 104–193, title I, § 103(a)(1), Aug. 22, 1996, 110 Stat. 2112, and, as so enacted, no longer contains a subsec. (b)(1).

Section 211 of Pub. L. 93–66, referred to in subsec. (k), is section 211 of Pub. L. 93–66, July 9, 1973, 87 Stat. 152, which is set out as a note under section 1382 of this title.

The Indian Self-Determination Act, referred to in subsec. (l)(2)(B), is title I of Pub. L. 93–638, Jan. 4, 1975, 88 Stat. 2206, which is classified principally to part A (§ 450f et seq.) of subchapter II of chapter 14 of Title 25, Indians. For complete classification of this Act to the Code, see Short Title note set out under section 450 of Title 25 and Tables.

The Indian Health Care Improvement Act, referred to in subsec. (l)(2)(B), is Pub. L. 94–437, Sept. 30, 1976, 90 Stat. 1400. Title V of the Act is classified generally to subchapter IV (§ 1651 et seq.) of chapter 18 of Title 25. For complete classification of this Act to the Code, see Short Title note set out under section 1601 of Title 25 and Tables.

Clause (ii), referred to in subsec. (l)(2)(B), was redesignated as cl. (iii) by Pub. L. 101-508, title IV, §4704(c)(3), Nov. 5, 1990, 104 Stat. 1388-172.

Section 607 of this title, referred to in subsec. (m)(1), was repealed and a new section 607 enacted by Pub. L. 104-193, title I, §103(a)(1), Aug. 22, 1996, 110 Stat. 2112, and, as so enacted, no longer contains a subsec. (b)(2)(B)(i).

Section 212 of Public Law 93-66, referred to in subsec. (q)(1)(A), is section 212 of Pub. L. 93-66, title II, July 9, 1973, 87 Stat. 155, which is set out as a note under section 1382 of this title.

Section 5001 of Public Law 111-5, referred to in subsec. (aa)(1)(A), (2)(A), is set out as a note under this section.

Section 10202 of the Patient Protection and Affordable Care Act, referred to in subsec. (aa)(1), (2), is section 10202 of Pub. L. 111-148, which is set out as a note under this section.

The Robert T. Stafford Disaster Relief and Emergency Assistance Act, referred to in subsec. (aa)(2), is Pub. L. 93-288, May 22, 1974, 88 Stat. 143, which is classified principally to chapter 68 (§5121 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 5121 of this title and Tables.

Section 5001 of the American Recovery and Reinvestment Act of 2009, referred to in subsec. (cc), is section 5001 of Pub. L. 111-5, which is set out as a note under this section.

AMENDMENTS

2010—Subsec. (a). Pub. L. 111-148, §2304, inserted “or the care and services themselves, or both” before “(if provided in or after)” in introductory provisions.

Subsec. (a)(xiv). Pub. L. 111-148, §10201(c)(1), inserted “or 1396a(a)(10)(A)(i)(IX)” after “section 1396a(a)(10)(A)(i)(VIII)”.

Pub. L. 111-148, §2001(a)(5)(C), added cl. (xiv).

Subsec. (a)(xv). Pub. L. 111-148, §2001(e)(2)(A), added cl. (xv).

Subsec. (a)(xvi). Pub. L. 111-148, §2303(a)(4)(A), added cl. (xvi).

Subsec. (a)(xvii). Pub. L. 111-148, §2402(d)(2)(B), added cl. (xvii).

Subsec. (a)(4). Pub. L. 111-148, §4107(a)(1), added subpar. (D).

Subsec. (a)(28), (29). Pub. L. 111-148, §2301(a)(1), added par. (28) and redesignated former par. (28) as (29).

Subsec. (b). Pub. L. 111-148, §10201(c)(2), inserted “, (z),” before “and (aa)” in first sentence.

Pub. L. 111-148, §2006(1), substituted “subsections (y) and (aa)” for “subsection (y)” in first sentence.

Pub. L. 111-148, §2001(a)(3)(A), inserted “subsection (y) and” before “section 1396u-3(d) of this title” in first sentence.

Subsec. (l)(3). Pub. L. 111-148, §2301(a)(2), added par. (3).

Subsec. (o)(1)(A). Pub. L. 111-148, §2302(a)(1), substituted “subparagraphs (B) and (C)” for “subparagraph (B)”.

Subsec. (o)(1)(C). Pub. L. 111-148, §2302(a)(2), added subpar. (C).

Subsec. (y). Pub. L. 111-148, §2001(a)(3)(B), added subsec. (y).

Subsec. (y)(1). Pub. L. 111-152, §1201(1)(B), added par. (1) and struck out former par. (1). Prior to amendment, par. (1) related to the amount of increase for the Federal medical assistance percentage.

Subsec. (y)(1)(B)(ii)(II). Pub. L. 111-152, §1201(1)(A), redesignated subcl. (II) as par. (5) of subsec. (z).

Pub. L. 111-148, §10201(c)(3)(A), inserted “includes inpatient hospital services,” after “100 percent of the poverty line, that”.

Subsec. (y)(2)(A). Pub. L. 111-148, §10201(c)(3)(B), substituted “as of December 1, 2009” for “on March 23, 2010”.

Subsec. (z). Pub. L. 111-148, §10201(c)(4), added subsec. (z).

Subsec. (z)(1)(A). Pub. L. 111-152, §1201(2)(A), substituted “December 31, 2015” for “September 30, 2019”.

Subsec. (z)(1)(B)(i). Pub. L. 111-152, §1201(2)(A), substituted “paragraph (3)” for “subsection (y)(1)(B)(ii)(II)”.

Subsec. (z)(2). Pub. L. 111-152, §1201(2)(B), added par. (2) and struck out former par. (2), which read as follows:

“(A) During the period that begins on January 1, 2014, and ends on December 31, 2016, notwithstanding subsection (b), the Federal medical assistance percentage otherwise determined under subsection (b) with respect to all or any portion of a fiscal year occurring during that period shall be increased by .5 percentage point for a State described in subparagraph (B) for amounts expended for medical assistance under the State plan under this subchapter or under a waiver of that plan during that period.

“(B) For purposes of subparagraph (A), a State described in this subparagraph is a State that—

“(i) is described in clauses (i) and (ii) of paragraph (1)(B); and

“(ii) is the State with the highest percentage of its population insured during 2008, based on the Current Population Survey.”

Subsec. (z)(3). Pub. L. 111-152, §1201(2)(C), redesignated par. (5) as (3), struck out heading, and substituted “A State is” for “For purposes of the table in subclause (I), a State is”.

Pub. L. 111-152, §1201(2)(B), struck out par. (3), which read as follows: “Notwithstanding subsection (b) and paragraphs (1) and (2) of this subsection, the Federal medical assistance percentage otherwise determined under subsection (b) with respect to all or any portion of a fiscal year that begins on or after January 1, 2017, for the State of Nebraska, with respect to amounts expended for newly eligible individuals described in subclause (VIII) of section 1396a(a)(10)(A)(i) of this title, shall be determined as provided for under subsection (y)(1)(A) (notwithstanding the period provided for in such paragraph).”

Subsec. (z)(4). Pub. L. 111-152, §1201(2)(B), struck out par. (4) which read as follows: “The increase in the Federal medical assistance percentage for a State under paragraphs (1), (2), or (3) shall apply only for purposes of this subchapter and shall not apply with respect to—

“(A) disproportionate share hospital payments described in section 1396r-4 of this title;

“(B) payments under subchapter IV;

“(C) payments under subchapter XXI; and

“(D) payments under this subchapter that are based on the enhanced FMAP described in section 1397ee(b) of this title.”

Subsec. (z)(5). Pub. L. 111-152, §1201(2)(C), redesignated par. (5) as (3).

Pub. L. 111-152, §1201(1)(A), redesignated subsec. (y)(1)(B)(ii)(II) as subsec. (z)(5) and realigned margins.

Subsec. (aa). Pub. L. 111-148, §2006(2), added subsec. (aa).

Subsec. (aa)(1), (2). Pub. L. 111-148, §10201(c)(5), substituted “without regard to this subsection, subsection (y), subsection (z), and section 10202 of the Patient Protection and Affordable Care Act” for “without regard to this subsection and subsection (y)” wherever appearing.

Subsec. (bb). Pub. L. 111-148, §4107(a)(2), added subsec. (bb).

Subsec. (cc). Pub. L. 111-148, §10201(c)(6), added subsec. (cc).

Subsec. (dd). Pub. L. 111-152, §1202(b), added subsec. (dd).

2008—Subsec. (p)(1)(C). Pub. L. 110-275, §112, inserted “or, effective beginning with January 1, 2010, whose resources (as so determined) do not exceed the maximum resource level applied for the year under subparagraph (D) of section 1395w-114(a)(3) of this title (determined without regard to the life insurance policy exclusion provided under subparagraph (G) of such section) applicable to an individual or to the individual and the individual’s spouse (as the case may be)” before period at end.

Subsec. (p)(5)(A). Pub. L. 110-275, §118(a), inserted at end “The Secretary shall provide for the translation of

such application form into at least the 10 languages (other than English) that are most often used by individuals applying for hospital insurance benefits under section 426 or 426-1 of this title and shall make the translated forms available to the States and to the Commissioner of Social Security.”

2006—Subsec. (u)(2)(B). Pub. L. 109-171 inserted at end “Such term excludes any child eligible for medical assistance only by reason of section 1396a(a)(10)(A)(ii)(XIX) of this title.”

2004—Subsec. (a)(27), (28). Pub. L. 108-357, § 712(a)(1)(A), added par. (27) and redesignated former par. (27) as (28).

Subsec. (x). Pub. L. 108-357, § 712(a)(1)(B), added subsec. (x).

2000—Subsec. (a)(xiii). Pub. L. 106-354, § 2(a)(4), added cl. (xiii).

Subsec. (b). Pub. L. 106-554, § 1(a)(6) [title VIII, § 802(d)(1)], in last sentence, substituted “the State’s available allotment under section 1397dd of this title” for “the State’s allotment under section 1397dd of this title (not taking into account reductions under section 1397dd(d)(2) of this title) for the fiscal year reduced by the amount of any payments made under section 1397ee of this title to the State from such allotment for such fiscal year”.

Pub. L. 106-354, § 2(c), in first sentence, struck out “and” before “(3)” and inserted before period at end “, and (4) the Federal medical assistance percentage shall be equal to the enhanced FMAP described in section 1397ee(b) of this title with respect to medical assistance provided to individuals who are eligible for such assistance only on the basis of section 1396a(a)(10)(A)(ii)(XVIII) of this title”.

Subsec. (p)(5). Pub. L. 106-554, § 1(a)(6) [title VII, § 709(a)], added par. (5).

Subsec. (p)(6). Pub. L. 106-554, § 1(a)(6) [title IX, § 911(a)(2)], added par. (6).

Subsec. (u)(1)(B). Pub. L. 106-554, § 1(a)(6) [title VIII, § 802(d)(2)], struck out “and section 1397dd(d) of this title” before period at end.

1999—Subsec. (a)(xii). Pub. L. 106-170, § 201(a)(2)(C), added cl. (xii).

Subsec. (a)(15). Pub. L. 106-113, § 1000(a)(6) [title VI, § 608(aa)(3)], substituted “1396a(a)(31) of this title” for “1396a(a)(31)(A) of this title”.

Subsec. (b). Pub. L. 106-113, § 1000(a)(6) [title VI, § 605(a)], inserted “(other than expenditures under section 1396r-4 of this title)” after “with respect to expenditures” in last sentence.

Subsec. (b)(1). Pub. L. 106-113, § 1000(a)(6) [title VI, § 608(l)], substituted “83 per centum,” for “83 per centum,.”

Subsec. (l)(2)(B). Pub. L. 106-113, § 1000(a)(6) [title VI, § 608(m)], substituted “an entity” for “a entity” in introductory provisions.

Subsec. (v). Pub. L. 106-169, § 121(c)(5)(A), redesignated subsec. (v), related to independent foster care adolescent, as (w).

Pub. L. 106-169, § 121(a)(2), added subsec. (v), related to independent foster care adolescent.

Pub. L. 106-170, § 201(a)(2)(B), added subsec. (v).

Subsec. (w). Pub. L. 106-169, § 121(c)(5), redesignated subsec. (v) as (w) and substituted “1396a(a)(10)(A)(ii)(XVII)” for “1396a(a)(10)(A)(ii)(XV)”.

1997—Subsec. (a)(25). Pub. L. 105-33, § 4702(a)(1), added par. (25). Former par. (25) redesignated (26).

Subsec. (a)(26). Pub. L. 105-33, § 4802(a)(1), added par. (26). Former par. (26) redesignated (27).

Pub. L. 105-33, § 4702(a)(1)(B), redesignated par. (25) as (26) and substituted comma for period at end.

Subsec. (a)(27). Pub. L. 105-33, § 4802(a)(1)(B), redesignated par. (26) as (27).

Subsec. (b). Pub. L. 105-100, § 162(1), inserted “for the State for a fiscal year, and that do not exceed the amount of the State’s allotment under section 1397dd of this title (not taking into account reductions under section 1397dd(d)(2) of this title) for the fiscal year reduced by the amount of any payments made under section 1397ee of this title to the State from such allot-

ment for such fiscal year,” after “subsection (u)(3) of this section”.

Pub. L. 105-33, § 4911(a)(1), inserted at end “Notwithstanding the first sentence of this subsection, in the case of a State plan that meets the condition described in subsection (u)(1) of this section, with respect to expenditures described in subsection (u)(2)(A) of this section or subsection (u)(3) of this section the Federal medical assistance percentage is equal to the enhanced FMAP described in section 1397ee(b) of this title.”

Pub. L. 105-33, § 4732(b), substituted “Subject to section 1396u-3(d) of this title, the term” for “The term”.

Pub. L. 105-33, § 4725(b)(1), in first sentence, substituted “, (2)” for “and (2)” and inserted before period “, and (3) for purposes of this subchapter and subchapter XXI of this chapter, the Federal medical assistance percentage for the District of Columbia shall be 70 percent”.

Subsec. (l)(2)(B)(iii). Pub. L. 105-33, § 4712(d)(1), inserted “including requirements of the Secretary that an entity may not be owned, controlled, or operated by another entity,” after “such a grant,.”

Subsec. (o)(3). Pub. L. 105-33, § 4711(c)(1), substituted “amount determined in section 1396a(a)(13)(B) of this title” for “amount described in section 1396a(a)(13)(D) of this title” in concluding provisions.

Subsec. (p)(3). Pub. L. 105-33, § 4714(a)(2), inserted “(subject to section 1396a(n)(2) of this title)” after “means” in introductory provisions.

Subsec. (t). Pub. L. 105-33, § 4702(a)(2), added subsec. (t).

Subsec. (u). Pub. L. 105-33, § 4911(a)(2), added subsec. (u).

Subsec. (u)(1)(B). Pub. L. 105-100, § 162(2)(A), substituted “the fourth sentence of subsection (b) of this section” for “paragraph (2)”.

Subsec. (u)(2)(A). Pub. L. 105-100, § 162(2)(B), substituted “subparagraph (B)” for “subparagraph (C), but not in excess, for a State for a fiscal year, of the amount described in subparagraph (B) for the State and fiscal year”.

Subsec. (u)(2)(B), (C). Pub. L. 105-100, § 162(2)(C), added subpar. (B) and struck out former subpars. (B) and (C) which read as follows:

“(B) The amount described in this subparagraph, for a State for a fiscal year, is the amount of the State’s allotment under section 1397dd of this title (not taking into account reductions under section 1397dd(d)(2) of this title) for the fiscal year reduced by the amount of any payments made under section 1397ee of this title to the State from such allotment for such fiscal year.

“(C) For purposes of this paragraph, the term ‘optional targeted low-income child’ means a targeted low-income child as defined in section 1397jj(b)(1) of this title who would not qualify for medical assistance under the State plan under this subchapter based on such plan as in effect on April 15, 1997 (but taking into account the expansion of age of eligibility effected through the operation of section 1396a(l)(2)(D) of this title).”

Subsec. (u)(3). Pub. L. 105-100, § 162(2)(D), substituted “described in this paragraph” for “described in this subparagraph” and “March 31, 1997” for “April 15, 1997”.

Subsec. (u)(4). Pub. L. 105-100, § 162(2)(E), added par. (4).

1996—Subsec. (l)(2)(B)(i), (ii)(II). Pub. L. 104-299 substituted “section 254b of this title” for “section 254b, 254c, 256, or 256a of this title”.

1994—Subsecs. (j), (q)(2). Pub. L. 103-296 substituted “Commissioner of Social Security” for “Secretary”.

1993—Subsec. (a)(xi). Pub. L. 103-66, § 13603(e)(1)–(3), added cl. (xi).

Subsec. (a)(7). Pub. L. 103-66, § 13601(a)(1), struck out “including personal care services (A) prescribed by a physician for an individual in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual’s family, (C) supervised by a registered nurse, and (D) furnished in a home or other lo-

cation; but not including such services furnished to an inpatient or resident of a nursing facility” after “services”.

Subsec. (a)(17). Pub. L. 103-66, §13605(a), inserted before semicolon at end “, and without regard to whether or not the services are performed in the area of management of the care of mothers and babies throughout the maternity cycle”.

Subsec. (a)(19). Pub. L. 103-66, §13603(e)(4), amended par. (19) generally, inserting reference to TB-related services described in section 1396a(z)(2)(F) of this title.

Subsec. (a)(21). Pub. L. 103-66, §13601(a)(2), struck out “and” at end.

Subsec. (a)(22). Pub. L. 103-66, §13601(a)(4), redesignated par. (23) as (22). Former par. (22) redesignated (25).

Subsec. (a)(23). Pub. L. 103-66, §13601(a)(4), redesignated par. (24) as (23). Former par. (23) redesignated (22).

Subsec. (a)(24). Pub. L. 103-66, §13601(a)(5), added par. (24). Former par. (24) redesignated (23).

Pub. L. 103-66, §13601(a)(3), which directed amendment of par. (24) by substituting semicolon for comma at end, was executed by substituting semicolon for period at end to reflect the probable intent of Congress.

Subsec. (a)(25). Pub. L. 103-66, §13601(a)(4), redesignated par. (22) as (25), transferred such par. to appear after par. (23), and substituted period for semicolon at end.

Subsec. (l)(2)(B). Pub. L. 103-66, §13631(f)(2)(B), in concluding provisions, inserted “or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act for the provision of primary health services” before “. In applying clause”.

Subsec. (l)(2)(B)(i). Pub. L. 103-66, §13631(f)(2)(A), substituted “256, or 256a” for “or 256”.

Pub. L. 103-66, §13606(a)(1), struck out “or” at end.

Subsec. (l)(2)(B)(ii). Pub. L. 103-66, §13631(f)(2)(A), substituted “256, or 256a” for “or 256” in subcl. (II).

Pub. L. 103-66, §13606(a)(2), (3), realigned margin and substituted a comma for semicolon at end.

Subsec. (l)(2)(B)(iv). Pub. L. 103-66, §13606(a)(4), (5), added cl. (iv).

Subsec. (r)(1)(A)(i). Pub. L. 103-66, §13631(g)(1)(A), inserted “and, with respect to immunizations under subparagraph (B)(iii), in accordance with the schedule referred to in section 1396s(c)(2)(B)(i) of this title for pediatric vaccines” after “child health care”.

Subsec. (r)(1)(B)(iii). Pub. L. 103-66, §13631(g)(1)(B), inserted “(according to the schedule referred to in section 1396s(c)(2)(B)(i) of this title for pediatric vaccines)” after “appropriate immunizations”.

1990—Subsec. (a). Pub. L. 101-508, §4722, inserted at end “No service (including counseling) shall be excluded under the definition of ‘medical assistance’ solely because it is provided as a treatment service for alcoholism or drug dependency.”

Pub. L. 101-508, §4402(d)(2), inserted at end “The payment described in the first sentence may include expenditures for medicare cost-sharing and for premiums under part B of subchapter XVIII of this chapter for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title, and, except in the case of individuals 65 years of age or older and disabled individuals entitled to health insurance benefits under subchapter XVIII of this chapter who are not enrolled under part B of subchapter XVIII of this chapter, other insurance premiums for medical or any other type of remedial care or the cost thereof.”

Subsec. (a)(x). Pub. L. 101-508, §4713(b), added cl. (x).

Subsec. (a)(2)(C). Pub. L. 101-508, §4704(e)(1), repealed Pub. L. 101-239, §6402(c)(1). See 1989 Amendment note below.

Subsec. (a)(7). Pub. L. 101-508, §4721(a), substituted “services including personal care services” for “services” and added subpars. (A) to (D).

Subsec. (a)(13). Pub. L. 101-508, §4719(a), inserted before semicolon at end “, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level”.

Subsec. (a)(22). Pub. L. 101-508, §4711(a)(1), which directed amendment of par. (22) by striking “and” at end, could not be executed because the word did not appear.

Subsec. (a)(23). Pub. L. 101-508, §4712(a)(1), inserted “and” after semicolon at end.

Pub. L. 101-508, §4711(a)(2), (3), which directed amendment of subsec. (a) by redesignating par. (23) as (24) and adding a new par. (23), was executed by adding the new par. (23), there being no former par. (23).

Subsec. (a)(24). Pub. L. 101-508, §4712(a)(2), (3), which directed amendment of subsec. (a) by redesignating par. (24) as (25) and adding a new par. (24), was executed by adding the new par. (24), there being no former par. (24).

Subsec. (h)(1)(A). Pub. L. 101-508, §4755(a)(1)(A), inserted “or in another inpatient setting that the Secretary has specified in regulations” after “section 1395x(f) of this title”.

Subsec. (l)(2)(A). Pub. L. 101-508, §4704(c)(1), substituted “patient” for “outpatient”.

Subsec. (l)(2)(B). Pub. L. 101-508, §4704(d)(2), which directed amendment of subpar. (B) by inserting “and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638).” after and below cl. (ii), was executed by inserting the new language after cl. (iii) to reflect the probable intent of Congress and the intervening redesignation of former cl. (ii) as (iii) by Pub. L. 101-508, §4704(c)(3). See below.

Pub. L. 101-508, §4704(c)(2), substituted “entity” for “facility” in introductory provisions.

Subsec. (l)(2)(B)(ii), (iii). Pub. L. 101-508, §4704(c)(3), (d)(1), added cl. (ii), redesignated former cl. (ii) as (iii), and substituted comma for period at end of cl. (iii).

Subsec. (n)(2). Pub. L. 101-508, §4601(a)(2), substituted “age of 19” for “age of 7 (or any age designated by the State that exceeds 7 but does not exceed 8)”.

Subsec. (o)(1)(A). Pub. L. 101-508, §4717, inserted “and for which payment may otherwise be made under subchapter XVIII of this chapter” after “section 1395d(d)(2)(A) of this title”.

Subsec. (o)(3). Pub. L. 101-508, §4705(a)(1), struck out “a State which elects not to provide medical assistance for hospice care, but provides medical assistance for skilled nursing or intermediate care facility services with respect to” after “In the case of” in introductory provisions.

Pub. L. 101-508, §4705(a)(3), (4), in concluding provisions, substituted “the additional amount described in section 1396a(a)(13)(D) of this title” for “the amounts allocated under the plan for room and board in the facility, in accordance with the rates established under section 1396a(a)(13) of this title,” and struck out at end “For purposes of this paragraph and section 1396a(a)(13)(D) of this title, the term ‘room and board’ includes performance of personal care services, including assistance in activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident’s room, and supervising and assisting in the use of durable medical equipment and prescribed therapies.”

Subsec. (o)(3)(A), (C). Pub. L. 101-508, §4705(a)(2), substituted “nursing facility or intermediate care facility for the mentally retarded” for “skilled nursing or intermediate care facility”.

Subsec. (p)(1)(B). Pub. L. 101-508, §4501(e)(1)(A), which directed amendment of subpar. (B) by inserting

“, except as provided in paragraph (2)(D)” after “supplementary social security income program”, was executed by inserting the new language after “supplemental security income program” to reflect the probable intent of Congress.

Subsec. (p)(2)(B). Pub. L. 101-508, § 4501(a)(1), inserted “and” at end of cl. (ii), substituted “100 percent.” for “95 percent, and” in cl. (iii), and struck out cl. (iv) which read as follows: “January 1, 1992, is 100 percent.”

Subsec. (p)(2)(C). Pub. L. 101-508, § 4501(a)(2), substituted “95 percent, and” for “90 percent,” in cl. (iii) and “100 percent.” for “95 percent, and” in cl. (iv) and struck out cl. (v) which read as follows: “January 1, 1993, is 100 percent.”

Subsec. (p)(2)(D). Pub. L. 101-508, § 4501(e)(1)(B), added subpar. (D).

Subsec. (p)(4). Pub. L. 101-508, § 4501(c)(2), inserted at end “In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1315 of this title, the Secretary shall require the State to meet the requirement of section 1396a(a)(10)(E) of this title in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this subchapter.”

Subsec. (p)(4)(B). Pub. L. 101-508, § 4501(c)(1), inserted “or 1396a(a)(10)(E)(iii) of this title” after “subparagraph (B)”.

1989—Subsec. (a)(2)(B). Pub. L. 101-239, § 6404(a)(2), substituted “subsection (l)(1)” for “subsection (l)” in two places.

Subsec. (a)(2)(C). Pub. L. 101-239, § 6404(a)(3), added cl. (C) relating to Federally-qualified health center services.

Pub. L. 101-239, § 6402(c)(1), which directed addition of cl. (C) relating to ambulatory services, was repealed by Pub. L. 101-508, § 4704(e)(1).

Subsec. (a)(4)(B). Pub. L. 101-239, § 6403(d)(2), amended cl. (B) generally. Prior to amendment, cl. (B) read as follows: “effective July 1, 1969, such early and periodic screening and diagnosis of individuals who are eligible under the plan and are under the age of 21 to ascertain their physical or mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in regulations of the Secretary; and”.

Subsec. (a)(21), (22). Pub. L. 101-239, § 6405(a), added par. (21) and redesignated former par. (21) as (22).

Subsec. (l). Pub. L. 101-239, § 6404(b), designated existing provisions as par. (1), redesignated former cls. (1) and (2) as (A) and (B), respectively, and added par. (2).

Subsec. (p)(1)(A). Pub. L. 101-239, § 6408(d)(4)(B), inserted “, but not including an individual entitled to such benefits only pursuant to an enrollment under section 1395i-2a of this title” after “section 1395i-2 of this title”.

Subsec. (p)(3)(A). Pub. L. 101-239, § 6408(d)(4)(A)(i), amended subpar. (A) generally. Prior to amendment, subpar. (A) read as follows: “Premiums under subchapter XVIII of this chapter (including under part B and, if applicable, under section 1395i-2 of this title).”

Subsec. (p)(3)(A)(i). Pub. L. 101-239, § 6408(d)(4)(A)(ii), substituted “section 1395i-2 or 1395i-2a” for “section 1395i-2”.

Subsec. (p)(3)(C). Pub. L. 101-234, § 201(b)(1), substituted “Deductibles” for “Subject to paragraph (4), deductibles” and “section 1395e of this title and section 1395l(b) of this title” for “section 1395e of this title, section 1395l(b) of this title, and section 1395m(c)(1) of this title”.

Subsec. (p)(4), (5). Pub. L. 101-234, § 201(b)(2), redesignated par. (5) as (4) and struck out former par. (4) which read as follows: “In a State which provides medical assistance for prescribed drugs under subsection (a)(12) of this section, instead of providing to qualified medicare beneficiaries, under paragraph (3)(C), medicare cost-sharing with respect to the annual deductible for covered outpatient drugs under section 1395m(c)(1) of this title, the State may provide to such beneficiaries, before charges for covered outpatient drugs for a year

reach such deductible amount, benefits for prescribed drugs in the same amount, duration, and scope as the benefits made available under the State plan for individuals described in section 1396a(a)(10)(A)(i) of this title.”

Subsec. (r). Pub. L. 101-239, § 6403(c), inserted at end “The Secretary shall, not later than July 1, 1990, and every 12 months thereafter, develop and set annual participation goals for each State for participation of individuals who are covered under the State plan under this subchapter in early and periodic screening, diagnostic, and treatment services.”

Pub. L. 101-239, § 6403(a), added subsec. (r).

Subsec. (s). Pub. L. 101-239, § 6408(d)(2), added subsec. (s).

1988—Subsec. (a). Pub. L. 100-647, § 8434(b)(3), substituted “in the case of medicare cost-sharing with respect to a qualified medicare beneficiary” for “in the case of a qualified medicare beneficiary” in introductory provisions.

Subsec. (a)(ix). Pub. L. 100-485, § 303(b)(2), added cl. (ix).

Subsec. (a)(5)(B). Pub. L. 100-360, § 411(k)(4), substituted “described in clause (A) if” for “described in subparagraph (A) if”.

Subsec. (a)(17). Pub. L. 100-360, § 411(h)(4)(E), amended Pub. L. 100-203, § 4073(d)(1), see 1987 Amendment note below.

Subsec. (i). Pub. L. 100-360, § 411(k)(14)(A), added subsec. (i).

Subsec. (m). Pub. L. 100-485, § 401(d)(2), added subsec. (m).

Subsec. (o)(1). Pub. L. 100-360, § 411(k)(8)(A), made clarifying amendment to directory language of Pub. L. 100-203, § 4114, see 1987 Amendment note below.

Subsec. (o)(1)(B). Pub. L. 100-360, § 411(k)(8)(B), struck out “only” after “For purposes of this subchapter” and substituted “immune deficiency syndrome (AIDS)” for “immunodeficiency syndrome”.

Subsec. (o)(3). Pub. L. 100-485, § 608(f)(3), realigned the margin of par. (3).

Subsec. (p)(1). Pub. L. 100-647, § 8434(a), redesignated subpars. (C) and (D) as (B) and (C), respectively, and struck out former subpar. (B) which read: “who, but for section 1396a(a)(10)(E) of this title, is not eligible for medical assistance under the plan.”

Subsec. (p)(1)(B). Pub. L. 100-360, § 301(a)(2), struck out “and the election of the State” after “1396a(a)(10)(E) of this title”.

Subsec. (p)(1)(C). Pub. L. 100-360, § 301(c)(1), as amended by Pub. L. 100-485, § 608(d)(14)(E)(i), substituted “paragraph (2)” for “paragraph (2)(A)”.

Subsec. (p)(1)(D). Pub. L. 100-360, § 301(c)(2), as amended by Pub. L. 100-485, § 608(d)(14)(E)(ii), substituted “twice” for “(except as provided in paragraph (2)(B))”.

Subsec. (p)(2)(A). Pub. L. 100-647, § 8434(b)(4), substituted “paragraph (1)(B)” for “paragraph (1)(C)”.

Pub. L. 100-360, § 301(b)(1), as amended by Pub. L. 100-485, § 608(d)(14)(A), substituted “shall be at least the percent provided under subparagraph (B) (but not more than 100 percent)” for “may not exceed a percentage (not more than 100 percent)”.

Pub. L. 100-360, § 301(c)(3)(A), which directed amendment of subpar. (A) by striking “(2)(A)” and inserting “(2)”, was repealed by Pub. L. 100-485, § 608(d)(14)(E)(iii).

Pub. L. 100-360, § 301(b)(2), which directed amendment of subpar. (A) by inserting “(i)” after “(2)(A)”, was repealed by Pub. L. 100-485, § 608(d)(14)(B).

Subsec. (p)(2)(B). Pub. L. 100-360, § 301(b)(2), formerly § 301(b)(3), as renumbered and amended by Pub. L. 100-485, § 608(d)(14)(B)-(D)(ii), added subpar. (B) and struck out former subpar. (B) which read as follows: “In the case of a State that provides medical assistance to individuals not described in section 1396a(a)(10)(A) of this title and at the State’s option, the State may use under paragraph (1)(D) such resource level (which is higher than the level described in that paragraph) as may be applicable with respect to individuals described in paragraph (1)(A) who are not described in section 1396a(a)(10)(A) of this title.”

Pub. L. 100-360, §301(c)(3)(B), which directed amendment of par. (2) by striking subpar. (B), was repealed by Pub. L. 100-485, §608(d)(14)(E)(iii).

Subsec. (p)(2)(C). Pub. L. 100-360, §301(b)(2), formerly §301(b)(3), as renumbered and amended by Pub. L. 100-485, §608(d)(14)(B), (C), (D)(i), (iii), added subpar. (C).

Subsec. (p)(3). Pub. L. 100-360, §301(d)(1), as added by Pub. L. 100-485, §608(d)(14)(G)(ii), inserted “without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan” after “qualified medicare beneficiary” in introductory provisions.

Subsec. (p)(3)(A). Pub. L. 100-360, §301(d)(2), formerly §301(d)(1), as renumbered by Pub. L. 100-485, §608(d)(14)(G)(i), substituted “under subchapter XVIII of this chapter (including under part B and, if applicable, under section 1395i-2 of this title)” for “under part B and (if applicable) under section 1395i-2 of this title”.

Subsec. (p)(3)(B). Pub. L. 100-360, §301(d)(3), formerly §301(d)(2), as renumbered by Pub. L. 100-485, §608(d)(14)(G)(i), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: “Deductibles and coinsurance described in section 1395e of this title.”

Subsec. (p)(3)(C). Pub. L. 100-360, §301(d)(3), formerly §301(d)(2), as renumbered and amended by Pub. L. 100-485, §608(d)(14)(F), (G)(i), amended subpar. (C) generally. Prior to amendment, subpar. (C) read as follows: “The annual deductible described in section 1395l(b) of this title.”

Subsec. (p)(4). Pub. L. 100-360, §301(d)(4), formerly §301(d)(3), as renumbered by Pub. L. 100-485, §618(d)(14)(G)(i), added par. (4).

Subsec. (p)(5). Pub. L. 100-360, §301(g)(2), as amended by Pub. L. 100-485, §608(d)(14)(J), added par. (5).

1987—Subsec. (a)(4)(A). Pub. L. 100-203, §4211(f), struck out “skilled” before “nursing”.

Subsec. (a)(5). Pub. L. 100-203, §4211(h)(6)(A), struck out “skilled” before “nursing” in cl. (A).

Pub. L. 100-203, §4103(a), designated existing provisions as cl. (A) and added cl. (B).

Subsec. (a)(9). Pub. L. 100-203, §4105(a), inserted provision including services furnished to an eligible individual who does not reside in a permanent dwelling or have a fixed home or mailing address.

Subsec. (a)(14). Pub. L. 100-203, §4211(h)(6)(B), substituted “and nursing facility services” for “, skilled nursing facility services, and intermediate care facility services”.

Subsec. (a)(15). Pub. L. 100-203, §4211(h)(6)(C), substituted “services in an intermediate care facility for the mentally retarded (other than” for “intermediate care facility services (other than such services”.

Subsec. (a)(17). Pub. L. 100-203, §4073(d)(1), as amended by Pub. L. 100-360, §411(h)(4)(E), substituted “(as defined in section 1395x(gg) of this title)” for “(as defined in subsection (m) of this section)”.

Subsec. (c). Pub. L. 100-203, §4211(e)(1), amended subsec. (c) generally. Prior to amendment, subsec. (c) defined “intermediate care facility”.

Subsec. (d). Pub. L. 100-203, §4211(e)(2), substituted “intermediate care facility for the mentally retarded” for “intermediate care facility” and “means an” for “may include services in a public”, and in par. (3) inserted “in the case of a public institution” after “(3)”.

Subsec. (f). Pub. L. 100-203, §4211(e)(3), struck out “skilled” before “nursing” in four places and before “rehabilitation”.

Subsec. (i). Pub. L. 100-203, §4211(e)(4), struck out subsec. (i) which provided that for purposes of this subchapter “skilled nursing facility” also includes any institution which is located in a State on an Indian reservation and is certified by the Secretary as being a qualified skilled nursing facility by meeting the requirements of section 1395x(j) of this title.

Subsec. (m). Pub. L. 100-203, §4073(d)(2), struck out subsec. (m) which defined “nurse-midwife”. See section 1395x(gg) of this title.

Subsec. (n)(2). Pub. L. 100-203, §4101(c)(1), substituted “has not attained the age of 7 (or any age designated by

the State that exceeds 7 but does not exceed 8)” for “is under 5 years of age”.

Subsec. (o)(1). Pub. L. 100-203, §4114, as amended by Pub. L. 100-360, §411(k)(8)(A), designated existing provisions as subpar. (A), substituted “Subject to subparagraph (B), the” for “The”, and added subpar. (B).

Subsec. (p)(2)(A). Pub. L. 100-203, §4118(p)(8), struck out “nonfarm” before “official”.

1986—Subsec. (a). Pub. L. 99-509, §9403(g)(3), inserted “or, in the case of a qualified medicare beneficiary described in subsection (p)(1) of this section, if provided after the month in which the individual becomes such a beneficiary” after “makes application for assistance”.

Subsec. (a)(18). Pub. L. 99-272, §9505(a)(1), added par. (18). Former par. (18) redesignated (19).

Subsec. (a)(19). Pub. L. 99-514, §1895(c)(3)(A), added par. (19). Former par. (19) redesignated (20).

Pub. L. 99-272, §9505(a)(1)(B), redesignated former par. (18) as (19).

Subsec. (a)(20). Pub. L. 99-509, §9408(c)(1), added par. (20). Former par. (20) redesignated (21).

Pub. L. 99-514, §1895(c)(3)(A)(ii), redesignated former par. (19) as (20).

Subsec. (a)(21). Pub. L. 99-509, §9408(c)(1)(B), redesignated former par. (20) as (21).

Subsec. (n)(1)(C). Pub. L. 99-272, §9501(a), added subpar. (C).

Subsec. (n)(2). Pub. L. 99-272, §9511(a), inserted “(or such earlier date as the State may designate)” after “September 30, 1983”.

Subsec. (o). Pub. L. 99-272, §9505(a)(2), added subsec. (o).

Subsec. (o)(3). Pub. L. 99-509, §9435(b)(2), added par. (3).

Subsec. (p). Pub. L. 99-509, §9403(b), (d), added subsec. (p).

Subsec. (q). Pub. L. 99-509, §9404(b), added subsec. (q). 1984—Subsec. (a). Pub. L. 98-369, §2335(f), substituted “mental diseases” for “tuberculosis or mental diseases” in subd. (B) following par. (18).

Pub. L. 98-369, §2373(b)(17), substituted “clause (vi)” for “clauses (vi)” and “well-being” for “well being” in last sentence.

Subsec. (a)(1). Pub. L. 98-369, §2335(f), substituted “mental diseases” for “tuberculosis or mental diseases”.

Subsec. (a)(4). Pub. L. 98-369, §2335(f), substituted “mental diseases” for “tuberculosis or mental diseases”.

Pub. L. 98-369, §2373(b)(15), inserted a semicolon before “(B)”.

Subsec. (a)(9). Pub. L. 98-369, §2371(a), amended par. (9) generally, inserting “furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician”.

Subsec. (a)(14), (15). Pub. L. 98-369, §2335(f), substituted “mental diseases” for “tuberculosis or mental diseases”.

Subsec. (a)(17). Pub. L. 98-369, §2373(b)(16), substituted “the nurse-midwife” for “he” in two places.

Subsec. (b). Pub. L. 98-369, §2373(b)(18), substituted “section 1301(a)(8)(B) of this title” for “subparagraph (B) of section 1301(a)(8) of this title”.

Subsec. (d)(1). Pub. L. 98-369, §2373(b)(19), substituted “the institution meets” for “which meet”.

Subsec. (h)(1)(A). Pub. L. 98-369, §2340(b), amended subpar. (A) generally. Prior to amendment, subpar. (A) read as follows: “inpatient services which are provided in an institution which is accredited as a psychiatric hospital by the Joint Commission on Accreditation of Hospitals;”.

Subsec. (m). Pub. L. 98-369, §2373(b)(20), substituted “the nurse” for “he” in two places.

Subsec. (n). Pub. L. 98-369, §2361(b), added subsec. (n). 1982—Subsec. (a)(i). Pub. L. 97-248, §137(b)(17), struck out “or any reasonable category of such individuals,” after “as the State may choose,”.

Subsec. (a)(viii). Pub. L. 97-248, §137(b)(18), added cl. (viii).

Subsec. (b)(2). Pub. L. 97-248, §136(c), substituted “the Northern Mariana Islands, and American Samoa” for “and the Northern Mariana Islands”.

Subsec. (h)(1)(C). Pub. L. 97-248, §137(f), redesignated cls. (i) and (ii) as subcls. (I) and (II), respectively, and redesignated cls. (A) and (B) as cls. (i) and (ii), respectively.

1981—Subsec. (a). Pub. L. 97-35, §2172(b), in cl. (i), inserted “or, at the option of the State, under the age of 20, 19, or 18 as the State may choose, or any reasonable category of such individuals,” and in cl. (ii), struck out reference to section 606(a)(2) of this title.

Subsec. (b). Pub. L. 97-35, §2162(a)(2), inserted reference to Northern Mariana Islands.

1980—Subsec. (a)(17), (18). Pub. L. 96-499, §965(a)(1)(B), (C), added par. (17) and redesignated former par. (17) as (18).

Subsec. (c). Pub. L. 96-473 substituted “clause (1)” for “clauses (1)”.

Subsec. (m). Pub. L. 96-499, §965(a)(2), added subsec. (m).

1978—Subsec. (c). Pub. L. 95-292 added cl. (4) to first sentence relating to a requirement that intermediate care facilities meet section 1395x(j)(14) of this title with respect to protection of patients’ personal funds, and inserted reference to that cl. (4) in provisions covering intermediate care facilities on Indian reservations.

1977—Subsec. (a)(2). Pub. L. 95-210, §2(a), designated existing provisions as cl. (A) and added cl. (B).

Subsec. (l). Pub. L. 95-210, §2(b), added subsec. (l).

1976—Subsec. (b). Pub. L. 94-437 inserted provision requiring that the Federal medical assistance percentage be 100 per centum for services received through an Indian Health Service facility.

1973—Subsec. (a). Pub. L. 93-233, §13(a)(13), substituted in introductory text “individuals (other than individuals with respect to whom there is being paid, or who are eligible or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title) not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter” for “individuals not receiving aid or assistance under the State’s plan approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter”.

Subsec. (a)(iv). Pub. L. 93-233, §13(a)(14), inserted “with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter,” after “blind.”

Subsec. (a)(v). Pub. L. 93-233, §13(a)(15), substituted “with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter,” for “or”.

Subsec. (a)(vi). Pub. L. 93-233, §13(a)(16), inserted “or” at end of text.

Subsec. (a)(vii). Pub. L. 93-233, §13(a)(17), added cl. (vii).

Subsec. (a)(16). Pub. L. 93-233, §18(x)(7), substituted “under age 21, as defined in subsection (h) of this section; and” for “under 21, as defined in subsection (e) of this section;”.

Subsec. (b). Pub. L. 93-233, §18(y)(2), struck out “; except that the Secretary shall promulgate such percentage as soon as possible after July 30, 1965, which promulgation shall be conclusive for each of the six quarters in the period beginning January 1, 1966, and ending with the close of June 30, 1966” after “section 1301(a)(8) of this title”.

Subsec. (c). Pub. L. 93-233, §18(x)(8), substituted “skilled nursing facility” for “skilled nursing home” wherever appearing.

Subsec. (h)(1)(B). Pub. L. 93-233, §18(w), substituted “(i) involve active treatment” for “, involves active

treatment (i)”;

struck out “pursuant to subchapter XVIII of this chapter” after “may be prescribed”; and substituted “(i)” for “(ii) which”, respectively.

Subsec. (h)(2). Pub. L. 93-233, §18(x)(10), substituted “paragraph (1)” for “paragraph (e)(1)”.

Subsec. (i). Pub. L. 93-233, §18(x)(9), redesignated subsec. (h) as added by Pub. L. 92-603, §299L(b), as subsec. (i).

Subsecs. (j), (k). Pub. L. 93-233, §13(a)(18), added subsecs. (j) and (k).

1972—Subsec. (a). Pub. L. 92-603, §299B(c), in text following redesignated subsec. (a)(17) substituted “as otherwise provided in paragraph (16),” for “that”.

Subsec. (a)(4). Pub. L. 92-603, §§278(a)(21), 299E(b), substituted “skilled nursing facility” for “skilled nursing home” and added cl. (C).

Subsec. (a)(5). Pub. L. 92-603, §§278(a)(22), 280, substituted “skilled nursing facility” for “skilled nursing home” and inserted “furnished by a physician (as defined in section 1395x(r)(1) of this title) after ‘physicians’ services”.

Subsec. (a)(14). Pub. L. 92-603, §§278(a)(23), 297(a), substituted “skilled nursing facility” for “skilled nursing home” and inserted reference to intermediate care facility services.

Subsec. (a)(15) to (17). Pub. L. 92-603, §299B(a), added par. (16) and redesignated existing pars. (15) and (16) as (17) and (15), respectively.

Subsec. (c). Pub. L. 92-603, §299L(a), inserted provision defining “intermediate care facility” with respect to any institution located in a State on an Indian reservation.

Subsec. (d)(3). Pub. L. 92-603, §299, inserted provisions relating to reduction of non-Federal expenditures in any calendar quarter prior to January 1, 1975.

Subsec. (e). Pub. L. 92-603, §212(a), added subsec. (e).

Subsec. (f). Pub. L. 92-603, §247(b), added subsec. (f).

Subsec. (g). Pub. L. 92-603, §275(a), added subsec. (g).

Subsec. (h). Pub. L. 92-603, §299B(b), added subsec. (h).

Subsec. (i). Pub. L. 92-603, §299L(b), added subsec. (i).

1971—Subsec. (a)(16). Pub. L. 92-223, §4(a)(1)(C), added cl. (16).

Subsecs. (c), (d). Pub. L. 92-223, §4(a)(2), added subsecs. (c) and (d).

1968—Subsec. (a). Pub. L. 90-248, §230, inserted “, and with respect to physicians’ or dentists’ services, at the option of the State, to individuals not receiving aid or assistance under the State’s plan approved under subchapter I, X, XIV, XVI of this chapter, or part A of subchapter IV of this chapter” after “for individuals” in text preceding cl. (i).

Pub. L. 90-248, §233(b), inserted provision deeming, for purposes of cl. (vi) of the preceding sentence, a person as essential to another individual if such person is the spouse of and is living with such individual, the needs of such person are taken into account in determining the amount of aid or assistance furnished to such individual (under a State plan approved under subchapter I, X, XIV, or XV of this chapter, and such person is determined, under such a State plan, to be essential to the well being of such individual).

Subsec. (a)(ii). Pub. L. 90-248, §241(f)(6), inserted “part A of” before “subchapter IV”.

Subsec. (a)(vi). Pub. L. 90-248, §233(a), added cl. (vi).

Subsec. (a)(4). Pub. L. 90-248, §302(a), designated existing provisions as cl. (A) and added cl. (B).

Subsec. (b). Pub. L. 90-248, §248(e), substituted in cl. (2) of first sentence “50” for “55”.

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111-148, title II, §2005(c)(2), Mar. 23, 2010, 124 Stat. 284, as amended by Pub. L. 111-152, title I, §1204(b)(2)(B), Mar. 30, 2010, 124 Stat. 1056, provided that: “The amendment made by paragraph (1) [amending this section] takes effect on July 1, 2011.”

Amendment by section 2301(a) of Pub. L. 111-148 effective Mar. 23, 2010, and applicable to services furnished on or after such date, with certain exceptions, see section 2301(c) of Pub. L. 111-148, set out as an Effective and Termination Dates of 2010 Amendment note under section 1396a of this title.

Amendment by section 2303(a)(4)(A) of Pub. L. 111-148 effective Mar. 23, 2010, and applicable to items and services furnished on or after such date, see section 2303(d) of Pub. L. 111-148, set out as an Effective and Termination Dates of 2010 Amendment note under section 1396a of this title.

Amendment by section 2402(d)(2)(B) of Pub. L. 111-148 effective on the first day of the first fiscal year quarter that begins after Mar. 23, 2010, see section 2402(g) of Pub. L. 111-148, set out as an Effective and Termination Dates of 2010 Amendment note under section 1396a of this title.

Pub. L. 111-148, title IV, §4106(c), Mar. 23, 2010, 124 Stat. 560, provided that: “The amendments made under this section [amending this section] shall take effect on January 1, 2013.”

Pub. L. 111-148, title IV, §4107(d), Mar. 23, 2010, 124 Stat. 561, provided that: “The amendments made by this section [amending this section and sections 1396o, 1396o-1, and 1396r-8 of this title] shall take effect on October 1, 2010.”

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110-275, title I, §118(b), July 15, 2008, 122 Stat. 2508, provided that: “The amendment made by subsection (a) [amending this section] shall take effect on January 1, 2010.”

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by Pub. L. 109-171 applicable to medical assistance for items and services furnished on or after Jan. 1, 2007, see section 6062(d) of Pub. L. 109-171, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2004 AMENDMENT

Amendment by Pub. L. 108-357 effective Oct. 22, 2004, and applicable to medical assistance and services provided under this subchapter on or after that date, see section 712(d) of Pub. L. 108-357, set out as a note under section 1396b of this title.

EFFECTIVE DATE OF 2000 AMENDMENTS

Pub. L. 106-554, §1(a)(6) [title VII, §709(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A-578, provided that: “The amendment made by subsection (a) [amending this section] shall take effect 1 year after the date of the enactment of this Act [Dec. 21, 2000], regardless of whether regulations have been promulgated to carry out such amendment by such date. The Secretary of Health and Human Services shall develop the uniform application form under such amendment by not later than 9 months after the date of the enactment of this Act.”

Pub. L. 106-554, §1(a)(6) [title VIII, §802(f)], Dec. 21, 2000, 114 Stat. 2763, 2763A-582, provided that: “The amendments made by this section [amending this section and sections 1397dd, 1397ee, and 1397jj of this title] shall be effective as if included in the enactment of section 4901 of the BBA [Pub. L. 105-33] (111 Stat. 552).”

Amendment by section 1(a)(6) [title IX, §911(a)(2)] of Pub. L. 106-554 effective one year after Dec. 21, 2000, see section 1(a)(6) [title IX, §911(c)] of Pub. L. 106-554, set out as an Effective Date note under section 1320b-14 of this title.

Amendment by Pub. L. 106-354 applicable to medical assistance for items and services furnished on or after Oct. 1, 2000, without regard to whether final regulations to carry out such amendments have been promulgated by such date, see section 2(d) of Pub. L. 106-354, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1999 AMENDMENTS

Amendment by Pub. L. 106-170 applicable to medical assistance for items and services furnished on or after Oct. 1, 2000, see section 201(d) of Pub. L. 106-170, set out as a note under section 1396a of this title.

Amendment by section 121(a)(2) of Pub. L. 106-169 applicable to medical assistance for items and services furnished on or after Oct. 1, 1999, see section 121(b) of Pub. L. 106-169, set out as a note under section 1396a of this title.

Pub. L. 106-113, div. B, §1000(a)(6) [title VI, §605(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A-396, provided that: “The amendment made by subsection (a) [amending this section] takes effect on October 1, 1999, and applies to expenditures made on or after such date.”

Pub. L. 106-113, div. B, §1000(a)(6) [title VI, §608(aa)], Nov. 29, 1999, 113 Stat. 1536, 1501A-398, provided that the amendment made by section 1000(a)(6) [title VI, §608(aa)(3)] is effective as if included in the enactment of BBA [the Balanced Budget Act of 1997, Pub. L. 105-33].

Amendment by section 1000(a)(6) [title VI, §608(l), (m)] of Pub. L. 106-113 effective Nov. 29, 1999, see section 1000(a)(6) [title VI, §608(bb)] of Pub. L. 106-113, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1997 AMENDMENTS

Section 162 of Pub. L. 105-100 provided that the amendment made by that section is effective as if included in the enactment of subtitle J (§§4901-4923) of title IV of the Balanced Budget Act of 1997, Pub. L. 105-33.

Amendment by section 4702(a) of Pub. L. 105-33 applicable to primary care case management services furnished on or after Oct. 1, 1997, subject to provisions relating to extension of effective date for State law amendments, and to nonapplication to waivers, see section 4710(b)(1) of Pub. L. 105-33, set out as a note under section 1396b of this title.

Amendment by section 4711(c)(1) of Pub. L. 105-33 effective Aug. 5, 1997, and applicable to payment for items and services furnished on or after Oct. 1, 1997, see section 4711(d) of Pub. L. 105-33, set out as a note under section 1396a of this title.

Section 4712(d)(2) of Pub. L. 105-33 provided that: “The amendment made by paragraph (1) [amending this section] shall apply to services furnished on or after the date of the enactment of this Act [Aug. 5, 1997].”

Amendment by section 4714(a)(2) of Pub. L. 105-33 applicable to payment for (and with respect to provider agreements with respect to) items and services furnished on or after Aug. 5, 1997, and to payment by a State for items and services furnished before such date if such payment is subject of lawsuit that is based on subsection (p) of this section and section 1396a(n) of this title and that is pending as of, or is initiated after Aug. 5, 1997, see section 4714(c) of Pub. L. 105-33, set out as a note under section 1396a of this title.

Section 4725(b)(2) of Pub. L. 105-33 provided that: “The amendments made by paragraph (1) [amending this section] shall apply to—

“(A) items and services furnished on or after October 1, 1997;

“(B) payments made on a capitation or other risk-basis for coverage occurring on or after such date; and

“(C) payments attributable to DSH allotments for such States determined under section 1923(f) of such Act (42 U.S.C. 1396r-4(f)) for fiscal years beginning with fiscal year 1998.”

Amendment by section 4911(a) of Pub. L. 105-33 applicable to medical assistance for items and services furnished on or after Oct. 1, 1997, see section 4911(c) of Pub. L. 105-33, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104-299 effective Oct. 1, 1996, see section 5 of Pub. L. 104-299, as amended, set out as a note under section 233 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103-296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103-296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Amendment by section 13601(a) of Pub. L. 103-66 effective as if included in enactment of section 4721(a) of the

Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508, see section 13601(c) of Pub. L. 103-66, set out as a note under section 1396a of this title.

Amendment by section 13603(e) of Pub. L. 103-66 applicable to medical assistance furnished on or after Jan. 1, 1994, without regard to whether or not final regulations to carry out the amendments by section 13603 of Pub. L. 103-66 have been promulgated by such date, see section 13603(f) of Pub. L. 103-66, set out as a note under section 1396a of this title.

Section 13605(b) of Pub. L. 103-66 provided that: "The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after October 1, 1993."

Section 13606(b) of Pub. L. 103-66 provided that: "The amendments made by subsection (a) [amending this section] shall apply to calendar quarters beginning on or after July 1, 1993."

Amendment by section 13631(f)(2) of Pub. L. 103-66 applicable, except as otherwise provided, to calendar quarters beginning on or after Oct. 1, 1993, without regard to whether or not final regulations to carry out the amendments by section 13631(f) of Pub. L. 103-66 have been promulgated by such date, see section 13631(f)(3) of Pub. L. 103-66, set out as a note under section 1396a of this title.

Section 13631(g)(2) of Pub. L. 103-66 provided that: "The amendments made by subparagraphs (A) and (B) of paragraph (1) [amending this section] shall first apply 90 days after the date the schedule referred to in subparagraphs (A)(i) and subparagraph (B)(iii) of section 1905(r)(1) of the Social Security Act [subsec. (r)(1)(B)(iii) of this section] (as amended by such respective subparagraphs) is first established."

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 4402(d)(2) of Pub. L. 101-508 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after Jan. 1, 1991, without regard to whether or not final regulations to carry out the amendments by section 4402 of Pub. L. 101-508 have been promulgated by such date, see section 4402(e) of Pub. L. 101-508, set out as a note under section 1396a of this title.

Amendment by section 4501(a), (c), (e)(1) of Pub. L. 101-508 applicable to calendar quarters beginning on or after Jan. 1, 1991, without regard to whether or not regulations to implement the amendments by section 4501 of Pub. L. 101-508 are promulgated by such date, except that amendment by section 4501(e)(1) of Pub. L. 101-508 is applicable to determinations of income for months beginning with January 1991, see section 4501(f) of Pub. L. 101-508, set out as a note under section 1396a of this title.

Amendment by section 4601(a)(2) of Pub. L. 101-508 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out the amendments by section 4601 of Pub. L. 101-508 have been promulgated by such date, see section 4601(b) of Pub. L. 101-508, set out as a note under section 1396a of this title.

Amendment by section 4704(c), (d), (e)(1) of Pub. L. 101-508 effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989, Pub. L. 101-239, see section 4704(f) of Pub. L. 101-508, set out as a note under section 1396a of this title.

Section 4705(b) of Pub. L. 101-508 provided that: "The amendments made by subsection (a) [amending this section] shall be effective as if included in the amendments made by section 6408(c)(1) of the Omnibus Budget Reconciliation Act of 1989 [Pub. L. 101-239, amending section 1396a of this title]."

Amendment by section 4711(a) of Pub. L. 101-508 applicable to home and community care furnished on or after July 1, 1991, without regard to whether or not final regulations to carry out the amendments by section 4711 of Pub. L. 101-508 have been promulgated by such date, see section 4711(e) of Pub. L. 101-508, set out as a note under section 1396a of this title.

Amendment by section 4712(a) of Pub. L. 101-508 applicable to community supported living arrangements services furnished on or after the later of July 1, 1991, or 30 days after the publication of regulations setting forth interim requirements under section 1396u(h) of this title without regard to whether or not final regulations to carry out the amendments by section 4712 of Pub. L. 101-508 have been promulgated by such date, see section 4712(c) of Pub. L. 101-508, set out as an Effective Date note under section 1396u of this title.

Amendment by section 4713(b) of Pub. L. 101-508 applicable to medical assistance furnished on or after Jan. 1, 1991, see section 4713(c) of Pub. L. 101-508, set out as a note under section 1396a of this title.

Section 4719(b) of Pub. L. 101-508 provided that: "The amendment made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Nov. 5, 1990]."

Section 4721(b) of Pub. L. 101-508 provided that: "The amendment made by this section [amending this section] shall become effective with respect to personal care services provided on or after October 1, 1994."

Section 4755(a)(1)(B) of Pub. L. 101-508 provided that: "The amendment made by subparagraph (A) [amending this section] shall be effective as if included in the enactment of the Deficit Reduction Act of 1984 [Pub. L. 98-369]."

EFFECTIVE DATE OF 1989 AMENDMENTS

Amendment by section 6403(a), (c), (d)(2) of Pub. L. 101-239 effective Apr. 1, 1990, without regard to whether or not final regulations to carry out the amendments by section 6403 of Pub. L. 101-239 have been promulgated by such date, see section 6403(e) of Pub. L. 101-239, set out as a note under section 1396a of this title.

Amendment by section 6404(a), (b) of Pub. L. 101-239 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after Apr. 1, 1990, without regard to whether or not final regulations to carry out the amendments by section 6404 of Pub. L. 101-239 have been promulgated by such date, see section 6404(d) of Pub. L. 101-239, set out as a note under section 1396a of this title.

Amendment by section 6405(a) of Pub. L. 101-239 effective with respect to services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner on or after July 1, 1990, see section 6405(c) of Pub. L. 101-239, set out as a note under section 1396a of this title.

Amendment by section 6408(d)(2), (4)(A), (B) of Pub. L. 101-239 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after July 1, 1990, without regard to whether or not final regulations to carry out the amendments by section 6408(d) of Pub. L. 101-239 have been promulgated by such date, see section 6408(d)(5) of Pub. L. 101-239, set out as a note under section 1396a of this title.

Amendment by Pub. L. 101-234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101-234, set out as a note under section 1320a-7a of this title.

EFFECTIVE DATE OF 1988 AMENDMENTS

Amendment by Pub. L. 100-647 effective as if included in the enactment of section 301 of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100-360, see section 8434(c) of Pub. L. 100-647, set out as a note under section 1396a of this title.

Amendment by section 303(b)(2) of Pub. L. 100-485 applicable to payments under this subchapter for calendar quarters beginning on or after Apr. 1, 1990 (or, in the case of the Commonwealth of Kentucky, Oct. 1, 1990) (without regard to whether regulations to implement such amendment are promulgated by such date), with respect to families that cease to be eligible for aid under part A of subchapter IV of this chapter on or after that date, see section 303(f)(1) of Pub. L. 100-485, set out as a note under section 1396a of this title.

Amendment by section 401(d)(2) of Pub. L. 100-485 effective Oct. 1, 1990, except as provided in subsec. (m)(2) of this section and not effective for Puerto Rico, Guam, American Samoa, and the Virgin Islands, until the date of repeal of limitations contained in section 1308(a) of this title on payments to such jurisdictions for purposes of making maintenance payments under this part and part E of this subchapter, see section 401(g) of Pub. L. 100-485, as amended, set out as a note under section 1396a of this title.

Amendment by section 608(d)(14)(A)-(G), (J) of Pub. L. 100-485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100-360, see section 608(g)(1) of Pub. L. 100-485, set out as a note under section 704 of this title.

Amendment by section 608(f)(3) of Pub. L. 100-485 effective Oct. 13, 1988, see section 608(g)(2) of Pub. L. 100-485, set out as a note under section 704 of this title.

Amendment by section 301(a)(2)-(d) of Pub. L. 100-360 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after Jan. 1, 1989, without regard to whether or not final regulations to carry out such amendment have been promulgated by that date, with respect to medical assistance for monthly premiums under subchapter XVIII of this chapter for months beginning with January 1989, and items and services furnished on and after Jan. 1, 1989, see section 301(h) of Pub. L. 100-360, set out as a note under section 1396a of this title.

Except as specifically provided in section 411 of Pub. L. 100-360, amendment by section 411(h)(4)(E), (k)(4), (8) of Pub. L. 100-360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100-203, effective as if included in the enactment of that provision in Pub. L. 100-203, see section 411(a) of Pub. L. 100-360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

Section 411(k)(14)(B) of Pub. L. 100-360 provided that: "The amendment made by subparagraph (A) [amending this section] shall take effect on the date of the enactment of this Act [July 1, 1988]."

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by section 4073(d) of Pub. L. 100-203 effective with respect to services performed on or after July 1, 1988, see section 4073(e) of Pub. L. 100-203, set out as a note under section 1395k of this title.

Section 4101(c)(3) of Pub. L. 100-203 provided that:

"(A) The amendments made by this subsection [amending this section and section 1396a of this title] shall apply to medical assistance furnished on or after October 1, 1988.

"(B) For purposes of section 1905(n)(2) of the Social Security Act [section 1396d(n)(2) of this title] (as amended by subsection (a) [probably means "subsection (c)"]) for medical assistance furnished during fiscal year 1989, any reference to 'age of 7' is deemed to be a reference to 'age of 6.'"

Section 4103(b) of Pub. L. 100-203 provided that:

"(1) The amendment made by subsection (a) [amending this section] applies (except as provided under paragraph (2)) to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after January 1, 1988, without regard to whether or not final regulations to carry out such amendment have been promulgated by such date.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendment made by subsection (a), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act [Dec. 22, 1987]."

Section 4105(b) of Pub. L. 100-203 provided that: "The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after January 1, 1988, without regard to whether regulations to implement such amendment are promulgated by such date."

Amendments by section 4211(e), (f), (h)(6) of Pub. L. 100-203 applicable to nursing facility services furnished on or after Oct. 1, 1990, without regard to whether regulations implementing such amendments are promulgated by such date, except as otherwise specifically provided in section 1396f of this title, with transitional rule, see section 4214(a), (b)(2) of Pub. L. 100-203, as amended, set out as an Effective Date note under section 1396r of this title.

EFFECTIVE DATE OF 1986 AMENDMENTS

Amendment by Pub. L. 99-514 effective, except as otherwise provided, as if included in enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99-272, see section 1895(e) of Pub. L. 99-514, set out as a note under section 162 of Title 26, Internal Revenue Code.

Amendment by section 9403(b), (d), (g)(3) of Pub. L. 99-509 applicable to payments under this subchapter for calendar quarters beginning on or after July 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date, see section 9403(h) of Pub. L. 99-509, set out as a note under section 1396a of this title.

Amendment by section 9404(b) of Pub. L. 99-509 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after July 1, 1987, without regard to whether regulations to implement such amendments are promulgated by such date, see section 9404(c) of Pub. L. 99-509, set out as a note under section 1396a of this title.

Amendment by section 9408(c)(1) of Pub. L. 99-509 applicable to services furnished on or after Oct. 21, 1986, see section 9408(d) of Pub. L. 99-509, set out as a note under section 1396a of this title.

Section 9501(d)(1) of Pub. L. 99-272 provided that:

"(A) The amendments made by subsection (a) [amending this section] apply (except as provided under subparagraph (B)) to payments under title XIX of the Social Security Act [this subchapter] for calendar quarters beginning on or after the [sic] July 1, 1986, without regard to whether or not final regulations to carry out the amendments have been promulgated by that date.

"(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by subsection (a), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Apr. 7, 1986]."

Amendment by section 9505(a) of Pub. L. 99-272 applicable to medical assistance provided for hospice care furnished on or after Apr. 7, 1986, see section 9505(e) of Pub. L. 99-272, set out as a note under section 1396a of this title.

Section 9511(b) of Pub. L. 99-272, as amended by Pub. L. 99-509, title IX, §9435(d)(2), Oct. 21, 1986, 100 Stat. 2070, provided that: "The amendment made by this section [amending this section] shall apply to services furnished on or after April 1, 1986, without regard to whether or not regulations to carry out the amendment have been promulgated by that date."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by section 2335(f) of Pub. L. 98-369 effective July 18, 1984, see section 2335(g) of Pub. L. 98-369, set out as a note under section 1395f of this title.

Amendment by section 2340(b) of Pub. L. 98-369 effective July 18, 1984, see section 2340(c) of Pub. L. 98-369, set out as a note under section 1395x of this title.

Amendment by section 2361(b) of Pub. L. 98-369 applicable to calendar quarters beginning on or after Oct. 1, 1984, without regard to whether or not final regulations to carry out the amendment have been promulgated by such date, except as otherwise provided, see section 2361(d) of Pub. L. 98-369, set out as a note under section 1396a of this title.

Section 2371(b) of Pub. L. 98-369 provided that: “The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after the date of the enactment of this Act [July 18, 1984].”

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by section 136(c) of Pub. L. 97-248 effective Oct. 1, 1982, see section 136(e) of Pub. L. 97-248, set out as a note under section 1301 of this title.

Amendment by section 137(b)(17), (18) of Pub. L. 97-248 effective as if originally included as part of this section as this section was amended by the Omnibus Budget Reconciliation Act of 1981, Pub. L. 97-35, see section 137(d)(2) of Pub. L. 97-248, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by section 2172(b) of Pub. L. 97-35 effective Aug. 13, 1981, see section 2172(c) of Pub. L. 97-35, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

For effective date of amendment by Pub. L. 96-499, see section 965(c) of Pub. L. 96-499, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1978 AMENDMENT

Section 8(d)(1) of Pub. L. 95-292 provided that: “The amendments made by subsections (a) and (b) [amending this section] shall become effective on July 1, 1978.”

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by Pub. L. 95-210 applicable to medical assistance provided, under a State plan approved under subchapter XIX of this chapter, on and after the first day of the first calendar quarter that begins more than six months after Dec. 13, 1977, with exception for plans requiring State legislation, see section 2(f) of Pub. L. 95-210, set out as a note under section 1395cc of this title.

EFFECTIVE DATE OF 1973 AMENDMENT

Amendment by section 13(a)(13)–(18) of Pub. L. 93-233 effective with respect to payments under section 1396b of this title for calendar quarters commencing after Dec. 31, 1973, see section 13(d) of Pub. L. 93-233, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Section 212(b) of Pub. L. 92-603 provided that: “The provisions of subsection (e) of section 1905 of the Social Security Act [subsec. (e) of this section] (as added by subsection (a) of this section) shall be applicable in the case of services performed on or after the date of enactment of this Act [Oct. 30, 1972].”

Amendment by section 247(b) of Pub. L. 92-603 effective with respect to services furnished after Dec. 31, 1972, see section 247(c) of Pub. L. 92-603, set out as a note under section 1395f of this title.

Section 275(b) of Pub. L. 92-603 provided that: “The amendment made by this section [amending this section] shall be effective with respect to services furnished after June 30, 1973.”

Section 297(b) of Pub. L. 92-603 provided that: “The amendment made by this section [amending this section] shall apply with respect to services furnished after December 31, 1972.”

EFFECTIVE DATE OF 1971 AMENDMENT

Amendment by Pub. L. 92-223 effective Jan. 1, 1972, see section 4(d) of Pub. L. 92-223, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1968 AMENDMENT

Section 248(e) of Pub. L. 90-248 provided that the amendment made by that section is effective with respect to quarters after 1967.

CONSTRUCTION OF 2004 AMENDMENT

Pub. L. 108-357, title VII, §712(a)(2), Oct. 22, 2004, 118 Stat. 1558, provided that: “Nothing in subsections (a)(27) or (x) of section 1905 of the Social Security Act (42 U.S.C. 1396d), as added by paragraph (1), shall be construed as implying that a State medicaid program under title XIX of such Act [this subchapter] could not have treated, prior to the date of enactment of this Act [Oct. 22, 2004], any of the primary and secondary medical strategies and treatment and services described in such subsections as medical assistance under such program, including as early and periodic screening, diagnostic, and treatment services under section 1905(r) of such Act [subsec. (r) of this section].”

CONSTRUCTION OF 1999 AMENDMENT

Amendment by Pub. L. 106-170 to be executed as if Pub. L. 106-169 had been enacted after the enactment of Pub. L. 106-170, see section 121(c)(1) of Pub. L. 106-169, set out as a note under section 1396a of this title.

INCENTIVES FOR STATES TO OFFER HOME AND COMMUNITY-BASED SERVICES AS A LONG-TERM CARE ALTERNATIVE TO NURSING HOMES

Pub. L. 111-148, title X, §10202, Mar. 23, 2010, 124 Stat. 923, provided that:

“(a) STATE BALANCING INCENTIVE PAYMENTS PROGRAM.—Notwithstanding section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), in the case of a balancing incentive payment State, as defined in subsection (b), that meets the conditions described in subsection (c), during the balancing incentive period, the Federal medical assistance percentage determined for the State under section 1905(b) of such Act and, if applicable, increased under subsection (z) or (aa) shall be increased by the applicable percentage points determined under subsection (d) with respect to eligible medical assistance expenditures described in subsection (e).

“(b) BALANCING INCENTIVE PAYMENT STATE.—A balancing incentive payment State is a State—

“(1) in which less than 50 percent of the total expenditures for medical assistance under the State Medicaid program for a fiscal year for long-term services and supports (as defined by the Secretary under subsection (f)(1)) [sic] are for non-institutionally-based long-term services and supports described in subsection (f)(1)(B);

“(2) that submits an application and meets the conditions described in subsection (c); and

“(3) that is selected by the Secretary to participate in the State balancing incentive payment program established under this section.

“(c) CONDITIONS.—The conditions described in this subsection are the following:

“(1) APPLICATION.—The State submits an application to the Secretary that includes, in addition to such other information as the Secretary shall require—

“(A) a proposed budget that details the State’s plan to expand and diversify medical assistance for non-institutionally-based long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program during the balancing incentive period and achieve the target spending percentage applicable to the State under paragraph (2), including through structural changes to how the State furnishes such assistance, such as through the establishment of a ‘no wrong door—single entry

point system', optional presumptive eligibility, case management services, and the use of core standardized assessment instruments, and that includes a description of the new or expanded offerings of such services that the State will provide and the projected costs of such services; and

“(B) in the case of a State that proposes to expand the provision of home and community-based services under its State Medicaid program through a State plan amendment under section 1915(i) of the Social Security Act [42 U.S.C. 1396n(i)], at the option of the State, an election to increase the income eligibility for such services from 150 percent of the poverty line to such higher percentage as the State may establish for such purpose, not to exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1) of the Social Security Act (42 U.S.C. 1382(b)(1)).

“(2) TARGET SPENDING PERCENTAGES.—

“(A) In the case of a balancing incentive payment State in which less than 25 percent of the total expenditures for long-term services and supports under the State Medicaid program for fiscal year 2009 are for home and community-based services, the target spending percentage for the State to achieve by not later than October 1, 2015, is that 25 percent of the total expenditures for long-term services and supports under the State Medicaid program are for home and community-based services.

“(B) In the case of any other balancing incentive payment State, the target spending percentage for the State to achieve by not later than October 1, 2015, is that 50 percent of the total expenditures for long-term services and supports under the State Medicaid program are for home and community-based services.

“(3) MAINTENANCE OF ELIGIBILITY REQUIREMENTS.—The State does not apply eligibility standards, methodologies, or procedures for determining eligibility for medical assistance for non-institutionally-based long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program that are more restrictive than the eligibility standards, methodologies, or procedures in effect for such purposes on December 31, 2010.

“(4) USE OF ADDITIONAL FUNDS.—The State agrees to use the additional Federal funds paid to the State as a result of this section only for purposes of providing new or expanded offerings of non-institutionally-based long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program.

“(5) STRUCTURAL CHANGES.—The State agrees to make, not later than the end of the 6-month period that begins on the date the State submits an application under this section, the following changes:

“(A) ‘NO WRONG DOOR—SINGLE ENTRY POINT SYSTEM’.—Development of a statewide system to enable consumers to access all long-term services and supports through an agency, organization, coordinated network, or portal, in accordance with such standards as the State shall establish and that shall provide information regarding the availability of such services, how to apply for such services, referral services for services and supports otherwise available in the community, and determinations of financial and functional eligibility for such services and supports, or assistance with assessment processes for financial and functional eligibility.

“(B) CONFLICT-FREE CASE MANAGEMENT SERVICES.—Conflict-free case management services to develop a service plan, arrange for services and supports, support the beneficiary (and, if appropriate, the beneficiary’s caregivers) in directing the provision of services and supports for the beneficiary, and conduct ongoing monitoring to assure that services and supports are delivered to meet the beneficiary’s needs and achieve intended outcomes.

“(C) CORE STANDARDIZED ASSESSMENT INSTRUMENTS.—Development of core standardized assess-

ment instruments for determining eligibility for non-institutionally-based long-term services and supports described in subsection (f)(1)(B), which shall be used in a uniform manner throughout the State, to determine a beneficiary’s needs for training, support services, medical care, transportation, and other services, and develop an individual service plan to address such needs.

“(6) DATA COLLECTION.—The State agrees to collect from providers of services and through such other means as the State determines appropriate the following data:

“(A) SERVICES DATA.—Services data from providers of non-institutionally-based long-term services and supports described in subsection (f)(1)(B) on a per-beneficiary basis and in accordance with such standardized coding procedures as the State shall establish in consultation with the Secretary.

“(B) QUALITY DATA.—Quality data on a selected set of core quality measures agreed upon by the Secretary and the State that are linked to population-specific outcomes measures and accessible to providers.

“(C) OUTCOMES MEASURES.—Outcomes measures data on a selected set of core population-specific outcomes measures agreed upon by the Secretary and the State that are accessible to providers and include—

“(i) measures of beneficiary and family caregiver experience with providers;

“(ii) measures of beneficiary and family caregiver satisfaction with services; and

“(iii) measures for achieving desired outcomes appropriate to a specific beneficiary, including employment, participation in community life, health stability, and prevention of loss in function.

“(d) APPLICABLE PERCENTAGE POINTS INCREASE IN FMAP.—The applicable percentage points increase is—

“(1) in the case of a balancing incentive payment State subject to the target spending percentage described in subsection (c)(2)(A), 5 percentage points; and

“(2) in the case of any other balancing incentive payment State, 2 percentage points.

“(e) ELIGIBLE MEDICAL ASSISTANCE EXPENDITURES.—

“(1) IN GENERAL.—Subject to paragraph (2), medical assistance described in this subsection is medical assistance for non-institutionally-based long-term services and supports described in subsection (f)(1)(B) that is provided by a balancing incentive payment State under its State Medicaid program during the balancing incentive payment period.

“(2) LIMITATION ON PAYMENTS.—In no case may the aggregate amount of payments made by the Secretary to balancing incentive payment States under this section during the balancing incentive period exceed \$3,000,000,000.

“(f) DEFINITIONS.—In this section:

“(1) LONG-TERM SERVICES AND SUPPORTS DEFINED.—The term ‘long-term services and supports’ has the meaning given that term by Secretary and may include any of the following (as defined for purposes of State Medicaid programs):

“(A) Institutionally-based long-term services and supports.—Services provided in an institution, including the following:

“(i) Nursing facility services.

“(ii) Services in an intermediate care facility for the mentally retarded described in subsection (a)(15) of section 1905 of such Act [42 U.S.C. 1396d(a)(15)].

“(B) Non-institutionally-based long-term services and supports.—Services not provided in an institution, including the following:

“(i) Home and community-based services provided under subsection (c), (d), or (i) of section 1915 of such Act [42 U.S.C. 1396n(c), (d), (i)] or under a waiver under section 1115 of such Act [42 U.S.C. 1315].

“(ii) Home health care services.

“(iii) Personal care services.

“(iv) Services described in subsection (a)(26) of section 1905 of such Act [42 U.S.C. 1396d(a)(26)] (relating to PACE program services).

“(v) Self-directed personal assistance services described in section 1915(j) of such Act [42 U.S.C. 1396n(j)].

“(2) BALANCING INCENTIVE PERIOD.—The term ‘balancing incentive period’ means the period that begins on October 1, 2011, and ends on September 30, 2015.

“(3) POVERTY LINE.—The term ‘poverty line’ has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

“(4) STATE MEDICAID PROGRAM.—The term ‘State Medicaid program’ means the State program for medical assistance provided under a State plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] and under any waiver approved with respect to such State plan.”

TEMPORARY INCREASE OF MEDICAID FMAP

Pub. L. 111-5, div. B, title V, §5001, Feb. 17, 2009, 123 Stat. 496, as amended by Pub. L. 111-226, title II, §201, Aug. 10, 2010, 124 Stat. 2393, provided that:

“(a) PERMITTING MAINTENANCE OF FMAP.—Subject to subsections (e), (f), and (g), if the FMAP determined without regard to this section for a State for—

“(1) fiscal year 2009 is less than the FMAP as so determined for fiscal year 2008, the FMAP for the State for fiscal year 2008 shall be substituted for the State’s FMAP for fiscal year 2009, before the application of this section;

“(2) fiscal year 2010 is less than the FMAP as so determined for fiscal year 2008 or fiscal year 2009 (after the application of paragraph (1)), the greater of such FMAP for the State for fiscal year 2008 or fiscal year 2009 shall be substituted for the State’s FMAP for fiscal year 2010, before the application of this section; and

“(3) fiscal year 2011 is less than the FMAP as so determined for fiscal year 2008, fiscal year 2009 (after the application of paragraph (1)), or fiscal year 2010 (after the application of paragraph (2)), the greatest of such FMAP for the State for fiscal year 2008, fiscal year 2009, or fiscal year 2010 shall be substituted for the State’s FMAP for fiscal year 2011, before the application of this section, but only for the first 3 calendar quarters in fiscal year 2011.

“(b) GENERAL 6.2 PERCENTAGE POINT INCREASE.—

“(1) IN GENERAL.—Subject to subsections (e), (f), and (g) and paragraphs (2) and (3), for each State for calendar quarters during the recession adjustment period (as defined in subsection (h)(3)), the FMAP (after the application of subsection (a)) shall be increased (without regard to any limitation otherwise specified in section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b))) by 6.2 percentage points.

“(2) SPECIAL ELECTION FOR TERRITORIES.—In the case of a State that is not one of the 50 States or the District of Columbia, paragraph (1) shall only apply if the State makes a one-time election, in a form and manner specified by the Secretary and for the entire recession adjustment period, to apply the increase in FMAP under paragraph (1) and a 15 percent increase under subsection (d) instead of applying a 30 percent increase under subsection (d).

“(3) PHASE-DOWN OF GENERAL INCREASE.—

“(A) SECOND QUARTER OF FISCAL YEAR 2011.—For each State, for the second quarter of fiscal year 2011, the FMAP percentage increase for the State under paragraph (1) or (2) (as applicable) shall be 3.2 percentage points.

“(B) THIRD QUARTER OF FISCAL YEAR 2011.—For each State, for the third quarter of fiscal year 2011, the FMAP percentage increase for the State under paragraph (1) or (2) (as applicable) shall be 1.2 percentage points.

“(c) ADDITIONAL RELIEF BASED ON INCREASE IN UNEMPLOYMENT.—

“(1) IN GENERAL.—Subject to subsections (e), (f), and (g), if a State is a qualifying State under paragraph (2) for a calendar quarter occurring during the recession adjustment period, the FMAP for the State shall be further increased by the number of percentage points equal to the product of—

“(A) the State percentage applicable for the State under section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) after the application of subsection (a) and after the application of ½ of the increase under subsection (b); and

“(B) the applicable percent determined in paragraph (3) for the calendar quarter (or, if greater, for a previous such calendar quarter).

“(2) QUALIFYING CRITERIA.—

“(A) IN GENERAL.—For purposes of paragraph (1), a State qualifies for additional relief under this subsection for a calendar quarter occurring during the recession adjustment period if the State is 1 of the 50 States or the District of Columbia and the State satisfies any of the following criteria for the quarter:

“(i) The State unemployment increase percentage (as defined in paragraph (4)) for the quarter is at least 1.5 percentage points but less than 2.5 percentage points.

“(ii) The State unemployment increase percentage for the quarter is at least 2.5 percentage points but less than 3.5 percentage points.

“(iii) The State unemployment increase percentage for the quarter is at least 3.5 percentage points.

“(B) MAINTENANCE OF STATUS.—If a State qualifies for additional relief under this subsection for a calendar quarter, it shall be deemed to have qualified for such relief for each subsequent calendar quarter ending before January 1, 2011.

“(3) APPLICABLE PERCENT.—

“(A) IN GENERAL.—For purposes of paragraph (1), subject to subparagraph (B), the applicable percent is—

“(i) 5.5 percent, if the State satisfies the criteria described in paragraph (2)(A)(i) for the calendar quarter;

“(ii) 8.5 percent if the State satisfies the criteria described in paragraph (2)(A)(ii) for the calendar quarter; and

“(iii) 11.5 percent if the State satisfies the criteria described in paragraph (2)(A)(iii) for the calendar quarter.

“(B) MAINTENANCE OF HIGHER APPLICABLE PERCENT.—

“(i) HOLD HARMLESS PERIOD.—If the percent applied to a State under subparagraph (A) for any calendar quarter in the recession adjustment period beginning on or after January 1, 2009, and ending before January 1, 2011, [sic] (determined without regard to this subparagraph) is less than the percent applied for the preceding quarter (as so determined), the higher applicable percent shall continue in effect for each subsequent calendar quarter ending before January 1, 2011.

“(ii) NOTICE OF LOWER APPLICABLE PERCENT.—The Secretary shall notify a State at least 60 days prior to applying any lower applicable percent to the State under this paragraph.

“(4) COMPUTATION OF STATE UNEMPLOYMENT INCREASE PERCENTAGE.—

“(A) IN GENERAL.—In this subsection, the ‘State unemployment increase percentage’ for a State for a calendar quarter is equal to the number of percentage points (if any) by which—

“(i) the average monthly unemployment rate for the State for months in the most recent previous 3-consecutive-month period for which data are available, subject to subparagraph (C); exceeds

“(ii) the lowest average monthly unemployment rate for the State for any 3-consecutive-month period preceding the period described in clause (i) and beginning on or after January 1, 2006.

“(B) AVERAGE MONTHLY UNEMPLOYMENT RATE DEFINED.—In this paragraph, the term ‘average monthly unemployment rate’ means the average of the monthly number unemployed, divided by the average of the monthly civilian labor force, seasonally adjusted, as determined based on the most recent monthly publications of the Bureau of Labor Statistics of the Department of Labor.

“(C) SPECIAL RULE.—With respect to—

“(i) the first 2 calendar quarters of the recession adjustment period, the most recent previous 3-consecutive-month period described in subparagraph (A)(i) shall be the 3-consecutive-month period beginning with October 2008; and

“(ii) the last 2 calendar quarters of the recession adjustment period, the most recent previous 3-consecutive-month period described in such subparagraph shall be the 3-consecutive-month period beginning with December 2009, or, if it results in a higher applicable percent under paragraph (3), any 3-consecutive-month period that begins after December 2009 and ends before January 2011.

“(d) INCREASE IN CAP ON MEDICAID PAYMENTS TO TERRITORIES.—Subject to subsections (f) and (g), with respect to entire fiscal years occurring during the recession adjustment period and with respect to fiscal years only a portion of which occurs during such period (and in proportion to the portion of the fiscal year that occurs during such period), the amounts otherwise determined for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa under subsections (f) and (g) of section 1108 of the Social Security Act (42 U.S.C. 1308) shall each be increased by 30 percent (or, in the case of an election under subsection (b)(2), 15 percent). In the case of such an election by a territory, subsection (a)(1) of such section shall be applied without regard to any increase in payment made to the territory under part E of title IV of such Act [part E of subchapter IV of this chapter] that is attributable to the increase in FMAP effected under subsection (b) for the territory.

“(e) SCOPE OF APPLICATION.—The increases in the FMAP for a State under this section shall apply for purposes of title XIX of the Social Security Act [this subchapter] and shall not apply with respect to—

“(1) disproportionate share hospital payments described in section 1923 of such Act (42 U.S.C. 1396r-4);

“(2) payments under title IV of such Act (42 U.S.C. 601 et seq.) (except that the increases under subsections (a) and (b) shall apply to payments under part E of title IV of such Act (42 U.S.C. 670 et seq.) and, for purposes of the application of this section to the District of Columbia, payments under such part shall be deemed to be made on the basis of the FMAP applied with respect to such District for purposes of title XIX [this subchapter] and as increased under subsection (b));

“(3) payments under title XXI of such Act (42 U.S.C. 1397aa et seq.);

“(4) any payments under title XIX of such Act [this subchapter] that are based on the enhanced FMAP described in section 2105(b) of such Act (42 U.S.C. 1397ee(b)); or

“(5) any payments under title XIX of such Act [this subchapter] that are attributable to expenditures for medical assistance provided to individuals made eligible under a State plan under title XIX of the Social Security Act (including under any waiver under such title or under section 1115 of such Act (42 U.S.C. 1315)) because of income standards (expressed as a percentage of the poverty line) for eligibility for medical assistance that are higher than the income standards (as so expressed) for such eligibility as in effect on July 1, 2008, [sic] (including as such standards were proposed to be in effect under a State law enacted but not effective as of such date or a State plan amendment or waiver request under title XIX of such Act that was pending approval on such date).

Notwithstanding paragraph (5), effective for payments made on or after January 1, 2010, the increases in the

FMAP for a State under this section shall apply to payments under title XIX of such Act [42 U.S.C. 1396 et seq.] that are attributable to expenditures for medical assistance provided to nonpregnant childless adults made eligible under a State plan under such title (including under any waiver under such title or under section 1115 of such Act (42 U.S.C. 1315)) who would have been eligible for child health assistance or other health benefits under eligibility standards in effect as of December 31, 2009, of a waiver of the State child health plan under the [sic] title XXI of such Act [42 U.S.C. 1397aa et seq.].

“(f) STATE INELIGIBILITY; LIMITATION; SPECIAL RULES.—

“(1) MAINTENANCE OF ELIGIBILITY REQUIREMENTS.—

“(A) IN GENERAL.—Subject to subparagraphs (B) and (C), a State is not eligible for an increase in its FMAP under subsection (a), (b), or (c), or an increase in a cap amount under subsection (d), if eligibility standards, methodologies, or procedures under its State plan under title XIX of the Social Security Act [this subchapter] (including any waiver under such title or under section 1115 of such Act (42 U.S.C. 1315)) are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on July 1, 2008.

“(B) STATE REINSTATEMENT OF ELIGIBILITY PERMITTED.—Subject to subparagraph (C), a State that has restricted eligibility standards, methodologies, or procedures under its State plan under title XIX of the Social Security Act [this subchapter] (including any waiver under such title or under section 1115 of such Act (42 U.S.C. 1315)) after July 1, 2008, is no longer ineligible under subparagraph (A) beginning with the first calendar quarter in which the State has reinstated eligibility standards, methodologies, or procedures that are no more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on July 1, 2008.

“(C) SPECIAL RULES.—A State shall not be ineligible under subparagraph (A)—

“(i) for the calendar quarters before July 1, 2009, on the basis of a restriction that was applied after July 1, 2008, and before the date of the enactment of this Act [Feb. 17, 2009], if the State prior to July 1, 2009, has reinstated eligibility standards, methodologies, or procedures that are no more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on July 1, 2008; or

“(ii) on the basis of a restriction that was directed to be made under State law as in effect on July 1, 2008, and would have been in effect as of such date, but for a delay in the effective date of a waiver under section 1115 of such Act [42 U.S.C. 1315] with respect to such restriction.

“(2) COMPLIANCE WITH PROMPT PAY REQUIREMENTS.—

“(A) APPLICATION TO PRACTITIONERS.—

“(i) IN GENERAL.—Subject to the succeeding provisions of this subparagraph, no State shall be eligible for an increased FMAP rate as provided under this section for any claim received by a State from a practitioner subject to the terms of section 1902(a)(37)(A) of the Social Security Act (42 U.S.C. 1396a(a)(37)(A)) for such days during any period in which that State has failed to pay claims in accordance with such section as applied under title XIX of such Act [this subchapter].

“(ii) REPORTING REQUIREMENT.—Each State shall report to the Secretary, on a quarterly basis, its compliance with the requirements of clause (i) as such requirements pertain to claims made for covered services during each month of the preceding quarter.

“(iii) WAIVER AUTHORITY.—The Secretary may waive the application of clause (i) to a State, or the reporting requirement imposed under clause (ii), during any period in which there are exigent

circumstances, including natural disasters, that prevent the timely processing of claims or the submission of such a report.

“(iv) APPLICATION TO CLAIMS.—Clauses (i) and (ii) shall only apply to claims made for covered services after the date of enactment of this Act [Feb. 17, 2009].

“(B) APPLICATION TO NURSING FACILITIES AND HOSPITALS.—

“(i) IN GENERAL.—Subject to clause (ii), the provisions of subparagraph (A) shall apply with respect to a nursing facility or hospital, insofar as it is paid under title XIX of the Social Security Act [this subchapter] on the basis of submission of claims, in the same or similar manner (but within the same timeframe) as such provisions apply to practitioners described in such subparagraph.

“(ii) GRACE PERIOD.—Notwithstanding clause (i), no period of ineligibility shall be imposed against a State prior to June 1, 2009, on the basis of the State failing to pay a claim in accordance with such clause.

“(3) STATE’S APPLICATION TOWARD RAINY DAY FUND.—A State is not eligible for an increase in its FMAP under subsection (b) or (c), or an increase in a cap amount under subsection (d), if any amounts attributable (directly or indirectly) to such increase are deposited or credited into any reserve or rainy day fund of the State.

“(4) NO WAIVER AUTHORITY.—Except as provided in paragraph (2)(A)(iii), the Secretary may not waive the application of this subsection or subsection (g) under section 1115 of the Social Security Act [42 U.S.C. 1315] or otherwise.

“(5) LIMITATION OF FMAP TO 100 PERCENT.—In no case shall an increase in FMAP under this section result in an FMAP that exceeds 100 percent.

“(6) TREATMENT OF CERTAIN EXPENDITURES.—With respect to expenditures described in section 2105(a)(1)(B) of the Social Security Act (42 U.S.C. 1397ee(a)(1)(B)), as in effect before April 1, 2009, that are made during the period beginning on October 1, 2008, and ending on March 31, 2009, any additional Federal funds that are paid to a State as a result of this section that are attributable to such expenditures shall not be counted against any allotment under section 2104 of such Act (42 U.S.C. 1397dd).

“(g) REQUIREMENTS.—

“(1) STATE REPORTS.—Each State that is paid additional Federal funds as a result of this section shall, not later than March 31, 2012, submit a report to the Secretary, in such form and such manner as the Secretary shall determine, regarding how the additional Federal funds were expended.

“(2) ADDITIONAL REQUIREMENT FOR CERTAIN STATES.—In the case of a State that requires political subdivisions within the State to contribute toward the non-Federal share of expenditures under the State Medicaid plan required under section 1902(a)(2) of the Social Security Act (42 U.S.C. 1396a(a)(2)), the State is not eligible for an increase in its FMAP under subsection (b) or (c), or an increase in a cap amount under subsection (d), if it requires that such political subdivisions pay for quarters during the recession adjustment period a greater percentage of the non-Federal share of such expenditures, or a greater percentage of the non-Federal share of payments under section 1923 of such Act [42 U.S.C. 1396r-4], than the respective percentage that would have been required by the State under such plan on September 30, 2008, prior to application of this section.

“(3) CERTIFICATION BY CHIEF EXECUTIVE OFFICER.—No additional Federal funds shall be paid to a State as a result of this section with respect to a calendar quarter occurring during the period beginning on January 1, 2011, and ending on June 30, 2011, unless, not later than 45 days after the date of enactment of this paragraph, the chief executive officer of the State certifies that the State will request and use such additional Federal funds.

“(h) DEFINITIONS.—In this section, except as otherwise provided:

“(1) FMAP.—The term ‘FMAP’ means the Federal medical assistance percentage, as defined in section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), as determined without regard to this section except as otherwise specified.

“(2) POVERTY LINE.—The term ‘poverty line’ has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

“(3) RECESSION ADJUSTMENT PERIOD.—The term ‘recession adjustment period’ means the period beginning on October 1, 2008, and ending on June 30, 2011.

“(4) SECRETARY.—The term ‘Secretary’ means the Secretary of Health and Human Services.

“(5) STATE.—The term ‘State’ has the meaning given such term in section 1101(a)(1) of the Social Security Act (42 U.S.C. 1301(a)(1)) for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

“(i) SUNSET.—This section shall not apply to items and services furnished after the end of the recession adjustment period.

“(j) LIMITATION ON FMAP CHANGE.—The increase in FMAP effected under section 614 of the Children’s Health Insurance Program Reauthorization Act of 2009 [section 614 of Pub. L. 111-3, set out below] shall not apply in the computation of the enhanced FMAP under title XXI or XIX of the Social Security Act [subchapters XXI or XIX of this chapter] for any period (notwithstanding subsection (i)).”

STATE AUTHORITY UNDER MEDICAID

Pub. L. 111-3, title I, §115, Feb. 4, 2009, 123 Stat. 35, provided that: “Notwithstanding any other provision of law, including the fourth sentence of subsection (b) of section 1905 of the Social Security Act (42 U.S.C. 1396d) or subsection (u) of such section, at State option, the Secretary shall provide the State with the Federal medical assistance percentage determined for the State for Medicaid with respect to expenditures described in section 1905(u)(2)(A) of such Act or otherwise made to provide medical assistance under Medicaid to a child who could be covered by the State under CHIP.”

[For definitions of “CHIP”, “Medicaid”, and “Secretary”, see section 1(c) of Pub. L. 111-3, set out as a Definitions note under section 1396 of this title.]

ADJUSTMENT IN COMPUTATION OF FMAP TO DISREGARD AN EXTRAORDINARY EMPLOYER PENSION CONTRIBUTION

Pub. L. 111-3, title VI, §614, Feb. 4, 2009, 123 Stat. 101, provided that:

“(a) IN GENERAL.—Only for purposes of computing the FMAP (as defined in subsection (e)) for a State for a fiscal year (beginning with fiscal year 2006) and applying the FMAP under title XIX of the Social Security Act [this subchapter], any significantly disproportionate employer pension or insurance fund contribution described in subsection (b) shall be disregarded in computing the per capita income of such State, but shall not be disregarded in computing the per capita income for the continental United States (and Alaska) and Hawaii.

“(b) SIGNIFICANTLY DISPROPORTIONATE EMPLOYER PENSION AND INSURANCE FUND CONTRIBUTION.—

“(1) IN GENERAL.—For purposes of this section, a significantly disproportionate employer pension and insurance fund contribution described in this subsection with respect to a State is any identifiable employer contribution towards pension or other employee insurance funds that is estimated to accrue to residents of such State for a calendar year (beginning with calendar year 2003) if the increase in the amount so estimated exceeds 25 percent of the total increase in personal income in that State for the year involved.

“(2) DATA TO BE USED.—For estimating and adjusting a FMAP already calculated as of the date of the enactment of this Act [Feb. 4, 2009] for a State with

a significantly disproportionate employer pension and insurance fund contribution, the Secretary shall use the personal income data set originally used in calculating such FMAP.

“(3) SPECIAL ADJUSTMENT FOR NEGATIVE GROWTH.—If in any calendar year the total personal income growth in a State is negative, an employer pension and insurance fund contribution for the purposes of calculating the State’s FMAP for a calendar year shall not exceed 125 percent of the amount of such contribution for the previous calendar year for the State.

“(c) HOLD HARMLESS.—No State shall have its FMAP for a fiscal year reduced as a result of the application of this section.

“(d) REPORT.—Not later than May 15, 2009, the Secretary shall submit to the Congress a report on the problems presented by the current treatment of pension and insurance fund contributions in the use of Bureau of Economic Affairs calculations for the FMAP and for Medicaid and on possible alternative methodologies to mitigate such problems.

“(e) FMAP DEFINED.—For purposes of this section, the term ‘FMAP’ means the Federal medical assistance percentage, as defined in section 1905(b) of the Social Security Act (42 U.S.C. 1396(d) [1396d(b)]).”

[For definitions of “Medicaid” and “Secretary”, see section 1(c) of Pub. L. 111-3, set out as a Definitions note under section 1396 of this title.]

TEMPORARY STATE FISCAL RELIEF

Pub. L. 108-27, title IV, § 401(a), May 28, 2003, 117 Stat. 764, as amended by Pub. L. 108-74, § 2(a), Aug. 15, 2003, 117 Stat. 896, which authorized \$10,000,000,000 for an increase of the Medicaid Federal medical assistance percentage (FMAP) for the last 2 calendar quarters of fiscal year 2003 and the first 3 quarters of fiscal year 2004 and set forth State eligibility requirements, and was repealed effective Oct. 1, 2004, by Pub. L. 108-27, title IV, § 401(a)(9), May 28, 2003, 117 Stat. 766.

ALASKA FMAPS

Pub. L. 106-554, § 1(a)(6) [title VII, § 706], Dec. 21, 2000, 114 Stat. 2763, 2763A-577, provided that: “Notwithstanding the first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), only with respect to each of fiscal years 2001 through 2005, for purposes of titles XIX and XXI of the Social Security Act [this subchapter and subchapter XXI of this chapter], the State percentage used to determine the Federal medical assistance percentage for Alaska shall be that percentage which bears the same ratio to 45 percent as the square of the adjusted per capita income of Alaska (determined by dividing the State’s 3-year average per capita income by 1.05) bears to the square of the per capita income of the 50 States.”

Section 4725(a) of Pub. L. 105-33 provided that: “Notwithstanding the first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), the Federal medical assistance percentage determined under such sentence for Alaska shall be 59.8 percent but only with respect to—

“(1) items and services furnished under a State plan under title XIX [this subchapter] or under a State child health plan under title XXI of such Act [subchapter XXI of this chapter] during fiscal years 1998, 1999, and 2000;

“(2) payments made on a capitation or other risk-basis under such titles for coverage occurring during such period; and

“(3) payments under title XIX of such Act attributable to DSH allotments for such State determined under section 1923(f) of such Act (42 U.S.C. 1396r-4(f)) for such fiscal years.”

EPSDT BENEFIT STUDY AND REPORT

Section 4744 of Pub. L. 105-33 provided that:

“(a) STUDY.—

“(1) IN GENERAL.—The Secretary of Health and Human Services, in consultation with Governors, di-

rectors of State medicaid programs, the American Academy of Actuaries, and representatives of appropriate provider and beneficiary organizations, shall conduct a study of the provision of early and periodic screening, diagnostic, and treatment services under the medicaid program under title XIX of the Social Security Act [this subchapter] in accordance with the requirements of section 1905(r) of such Act (42 U.S.C. 1396d(r)).

“(2) REQUIRED CONTENTS.—The study conducted under paragraph (1) shall include examination of the actuarial value of the provision of such services under the medicaid program and an examination of the portions of such actuarial value that are attributable to paragraph (5) of section 1905(r) of such Act and to the second sentence of such section.

“(b) REPORT.—Not later than 12 months after the date of the enactment of this Act [Aug. 5, 1997], the Secretary of Health and Human Services shall submit a report to Congress on the results of the study conducted under subsection (a).”

REFERENCES TO PROVISIONS OF PART A OF SUBCHAPTER IV CONSIDERED REFERENCES TO SUCH PROVISIONS AS IN EFFECT JULY 16, 1996

For provisions that certain references to provisions of part A (§ 601 et seq.) of subchapter IV of this chapter be considered references to such provisions of part A as in effect July 16, 1996, see section 1396u-1(a) of this title.

LIMITATION ON DISALLOWANCES OR DEFERRAL OF FEDERAL FINANCIAL PARTICIPATION FOR CERTAIN INPATIENT PSYCHIATRIC HOSPITAL SERVICES FOR INDIVIDUALS UNDER AGE 21

Section 4706 of Pub. L. 101-508 provided that:

“(a) IN GENERAL.—(1) If the Secretary of Health and Human Services makes a determination that a psychiatric facility has failed to comply with certification of need requirements for inpatient psychiatric hospital services for individuals under age 21 pursuant to section 1905(h) of the Social Security Act [subsec. (h) of this section], and such determination has not been subject to a final judicial decision, any disallowance or deferral of Federal financial participation under such Act [this chapter] based on such determination shall only apply to the period of time beginning with the first day of noncompliance and ending with the date by which the psychiatric facility develops documentation (using plan of care or utilization review procedures) of the need for inpatient care with respect to such individuals.

“(2) Any disallowance of Federal financial participation under title XIX of the Social Security Act [this subchapter] relating to the failure of a psychiatric facility to comply with certification of need requirements—

“(A) shall not exceed 25 percent of the amount of Federal financial participation for the period described in paragraph (1); and

“(B) shall not apply to any fiscal year before the fiscal year that is 3 years before the fiscal year in which the determination of noncompliance described in paragraph (1) is made.

“(b) EFFECTIVE DATE.—Subsection (a) shall apply to disallowance actions and deferrals of Federal financial participation with respect to services provided before the date of enactment of this Act [Nov. 5, 1990].”

INTERMEDIATE CARE FACILITY; ACCESS AND VISITATION RIGHTS

Section 411(l)(3)(C)(i), formerly § 411(l)(3)(C), of Pub. L. 100-360, as redesignated by Pub. L. 100-485, title VI, § 608(d)(27)(E), Oct. 13, 1988, 102 Stat. 2423, provided that: “Effective as of the date of the enactment of this Act [July 1, 1988] and until the effective date of section 1919(c) of such Act [section 1396r(c) of this title, see Effective Date note set out under section 1396r of this title], section 1905(c) of the Social Security Act [subsec.

(c) of this section] is deemed to include the requirement described in section 1919(c)(3)(A) of such Act (as inserted by section 4211(a)(3) of OBRA).”

REGULATIONS FOR INTERMEDIATE CARE FACILITIES FOR MENTALLY RETARDED

Section 9514 of Pub. L. 99-272 provided that: “The Secretary of Health and Human Services shall promulgate proposed regulations revising standards for intermediate care facilities for the mentally retarded under title XIX of the Social Security Act [this subchapter] within 60 days after the date of the enactment of this Act [Apr. 7, 1986].”

LIFE SAFETY CODE RECOGNITION

Section 9515 of Pub. L. 99-272 provided that: “For purposes of section 1905(c) of the Social Security Act [subsec. (c) of this section], an intermediate care facility for the mentally retarded (as defined in section 1905(d) of such Act) which meets the requirements of the relevant sections of the 1985 edition of the Life Safety Code of the National Fire Protection Association shall be deemed to meet the fire safety requirements for intermediate care facilities for the mentally retarded until such time as the Secretary specifies a later edition of the Life Safety Code for purposes of such section, or the Secretary determines that more stringent standards are necessary to protect the safety of residents of such facilities.”

STUDY OF FEDERAL MEDICAL ASSISTANCE PERCENTAGE FORMULA AND OF ADJUSTMENTS OF TARGET AMOUNTS FOR FEDERAL MEDICAID EXPENDITURES; REPORT TO CONGRESS

Section 2165 of Pub. L. 97-35 directed the Comptroller General, in consultation with the Advisory Committee for Intergovernmental Relations, to study the Federal medical assistance percentage formula as applicable to distribution of Federal funds to States, with a view to revising the medicaid matching formula so as to take into account factors which might result in a more equitable distribution of Federal funds to States under this chapter, and to report to Congress on such study not later than Oct. 1, 1982.

COSTS CHARGED TO PERSONAL FUNDS OF PATIENTS IN INTERMEDIATE CARE FACILITIES; COSTS INCLUDED IN CHARGES FOR SERVICES; REGULATIONS

Section 8(c), (d)(2) of Pub. L. 95-292 required the Secretary of Health, Education, and Welfare to issue regulations, within 90 days after enactment of Pub. L. 95-292 but not later than July 1, 1978, defining those costs that may be charged to the personal funds of patients in intermediate care facilities who are individuals receiving medical assistance under a State plan approved under title XIX of the Social Security Act, and those costs that are to be included in the reasonable cost or reasonable charge for intermediate care facility services. See section 1302 of this title.

§ 1396e. Enrollment of individuals under group health plans

(a) Requirements of each State plan; guidelines

Each State plan—

(1) may implement guidelines established by the Secretary, consistent with subsection (b) of this section, to identify those cases in which enrollment of an individual otherwise entitled to medical assistance under this subchapter in a group health plan (in which the individual is otherwise eligible to be enrolled) is cost-effective (as defined in subsection (e)(2) of this section);

(2) may require, in case of an individual so identified and as a condition of the individual being or remaining eligible for medical assist-

ance under this subchapter and subject to subsection (b)(2) of this section, notwithstanding any other provision of this subchapter, that the individual (or in the case of a child, the child's parent) apply for enrollment in the group health plan; and

(3) in the case of such enrollment (except as provided in subsection (c)(1)(B) of this section), shall provide for payment of all enrollee premiums for such enrollment and all deductibles, coinsurance, and other cost-sharing obligations for items and services otherwise covered under the State plan under this subchapter (exceeding the amount otherwise permitted under section 1396o of this title), and shall treat coverage under the group health plan as a third party liability (under section 1396a(a)(25) of this title).

(b) Timing of enrollment; failure to enroll

(1) In establishing guidelines under subsection (a)(1) of this section, the Secretary shall take into account that an individual may only be eligible to enroll in group health plans at limited times and only if other individuals (not entitled to medical assistance under the plan) are also enrolled in the plan simultaneously.

(2) If a parent of a child fails to enroll the child in a group health plan in accordance with subsection (a)(2) of this section, such failure shall not affect the child's eligibility for benefits under this subchapter.

(c) Premiums considered payments for medical assistance; eligibility

(1)(A) In the case of payments of premiums, deductibles, coinsurance, and other cost-sharing obligations under this section shall be considered, for purposes of section 1396b(a) of this title, to be payments for medical assistance.

(B) If all members of a family are not eligible for medical assistance under this subchapter and enrollment of the members so eligible in a group health plan is not possible without also enrolling members not so eligible—

(i) payment of premiums for enrollment of such other members shall be treated as payments for medical assistance for eligible individuals, if it would be cost-effective (taking into account payment of all such premiums), but

(ii) payment of deductibles, coinsurance, and other cost-sharing obligations for such other members shall not be treated as payments for medical assistance for eligible individuals.

(2) The fact that an individual is enrolled in a group health plan under this section shall not change the individual's eligibility for benefits under the State plan, except insofar as section 1396a(a)(25) of this title provides that payment for such benefits shall first be made by such plan.

(d) Repealed. Pub. L. 105-33, title IV, § 4741(b)(2), Aug. 5, 1997, 111 Stat. 523

(e) Definitions

In this section:

(1) The term “group health plan” has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986, and includes the provision of continuation coverage